

# Health Insurance for America

## Application Instructions For World Insurance - Brokerage

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Health Insurance for America for review along with the completed application. If you do not have access to a fax machine, send the completed application to Health Insurance for America along with the required first month's payment.

### HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

### IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose a check for the required payment made payable to World Insurance - Brokerage** if you are not paying by credit card.

Mail completed application and check to:

**Health Insurance for America**

**Attn: New Enrollment**

**2261 Shawnee Ct**

**Suite 101**

**Fort Collins, CO 80525**

Health Insurance for America will review your application for completeness and accuracy before we submit it to World Insurance - Brokerage for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 866-254-5121 or e-mail us at [info@hsaforamerica.com](mailto:info@hsaforamerica.com).

# Health Insurance for America

## FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**Health Insurance for America**

**FAX# 309-414-8717**

Dear Health Insurance for America,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_

Please contact me at this phone number \_\_\_\_\_ after you have reviewed my application for completeness and accuracy.

I will contact Health Insurance for America at 866-254-5121 to verify receipt of my application.

**\*\*I understand that Health Insurance for America will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Health Insurance for America. I will mail the original signed application to :

**Health Insurance for America**

**Attn: New Enrollment**

**2261 Shawnee Ct**

**Suite 101**

**Fort Collins, CO 80525**

I will send the original application as soon as I have been contacted by Health Insurance for America with confirmation that my application has been received by fax and reviewed for completeness.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_



A. General Information (please print)

1. a. Member's Name (First, Middle, Last)
b. Address (No., Street)
c. City, State & ZIP
2. For Telephone Interview
Best Place to Call
3. a. Member's Employer
b. Occupation/Title/Duties
4. Spouse's Name (First, Middle, Last)
5. a. Spouse's Employer
b. Occupation/Title/Duties

Table with 11 columns: Persons proposed for insurance, Relationship to member, Ht., Wt., Birthdate, Sex, Tobacco Use, Full-time Student, Social Security Number, Driver's License Number/State.

7. a. Parent/Guardian (if child-only coverage)
b. Address (No., Street, City, State and ZIP)
c. Phone #
8. a. Payor (If different from above)
b. Address (No., Street, City, State and ZIP)
c. Phone #

9. Provide details under Additional Remarks in Section F for any questions answered "No".
a. Is each person to be covered a U.S. citizen?
b. Are all persons to be covered living at the same residence?
c. Do all persons to be covered live or plan to live only in the U.S. or Canada?

B. Type of Coverage Requested

1. Name and Plan (check one):
WorldCare Flex Plans: Flex PPO 100, Flex PPO 80, Flex PPO 70, Flex Traditional 80
WorldCare HDHP (MSA-eligible) Plans: HDHP 100 PPO, HDHP 80 PPO, Traditional HDHP 100, Traditional HDHP 80
2. Deductible (check one):
WorldCare Flex Plans: \$500, \$1,000, \$1,500, \$2,500, \$5,000, \$10,000, Other
WorldCare HDHP (MSA-eligible) Plans: Single Low, Single High, Family Low, Family High
3. Name of PPO Selected:
4. Optional Benefits: Maximum Benefit, Outpatient Accident Expense, Prescription Drug Copay, Physician Office Visit Copay, Outpatient Expense Benefit, Other
5. Please check your choice of effective date of coverage: Underwriting Approval Date, Specified Future Date
6. Choice Dental Ann. Cov. Max: \$1,000, \$1,500, Optional Orthodontics
7. Payment Mode: Annual, Semiannual, Quarterly, Check-O-Matic, List Bill, Total Amount Submitted With Application, Payment of Initial Premium: Credit Card, Check

Administrative Use Only



**8. If "yes" for any proposed insured, please complete section below and submit any required replacement forms.** Yes  No

a. In the 90 days prior to the requested effective date of this certificate, is there any medical coverage (individual or group) in force or pending, including Medicare?

Name	Name of Insurance Company	Address for Insurance Carrier	Type of Plan	Start Date	Termination Date

b. Does any proposed insured agree to discontinue any inforce or pending coverage upon the issue of a World certificate? If "no", explain under Additional Remarks in Section F?

c. Is replacement or change of existing medical insurance in this company or elsewhere for any proposed insured involved in this application?

d. Are any of the persons proposed for insurance covered by Medicare? If "yes", explain under Additional Remarks in Section F?

**9. Health Insurance Portability and Accountability Act of 1996 (HIPAA) — Eligible Individual Determination.**

HIPAA requires that each health insurance issuer that offers health insurance in the individual market (as defined by HIPAA) in a state may not decline to offer coverage to, nor deny enrollment of an individual who meets the definition of an "Eligible Individual" under federal law, nor may the issuer impose any preexisting condition exclusions on that individual with respect to such coverage.

**Please indicate "Yes" or "No" to the following:**

a. As of the date on which you are applying for coverage, have you been insured under creditable coverage for at least 18 months with no more than a 62-day gap (90 days in Colorado)?

b. Was your most recent period of creditable coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?

c. If you were offered the option of continuation of coverage under COBRA or a similar state continuation program, did you complete the allowable period of coverage as an insured or dependent?    
If "No", please explain \_\_\_\_\_

d. Are you eligible for any of the following as an insured or dependent (check appropriate box):

- 1. a Group Health Plan?
- 2. Part A or Part B of Medicare?
- 3. a State plan under Medicaid, or successor program?

e. Do you have other health insurance?

f. Was your most recent health insurance terminated for nonpayment of premiums, misrepresentation or fraud?

g. Does your current employer or your spouse's employer, offer a group health plan (employer-sponsored)?    
If "Yes", provide the reason you decline to enroll: \_\_\_\_\_

h. Please provide your prior employer's name, complete address, and telephone number: \_\_\_\_\_

Dates of prior employment — From \_\_\_\_\_ to \_\_\_\_\_

If you answered "Yes" to questions a. through c., and "No" to questions d. through g., you meet the definition of a HIPAA "eligible individual".

**Please check appropriate box:**

i. I am electing to apply as an "Eligible Individual" with no preexisting limitation. I understand that the rates for the "Eligible Individual" plan will be substantially higher than the underwriting plan rates.

j. I am electing to be underwritten and as such I understand that I am waiving my right to apply for coverage as an "Eligible Individual".

**If you check i. above, please attach your certification(s) of creditable coverage for the past 18 months to this application.**

**C. Health Statement**

1. Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?    
**If "yes", medical coverage cannot be issued.**

2. When did you, the **Proposed Insured**, last consult a physician, chiropractor or other practitioner? Month/Year \_\_\_\_\_

Name of physician or clinic \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Reason for consultation \_\_\_\_\_ Tests Performed \_\_\_\_\_

Findings \_\_\_\_\_

Remaining effects \_\_\_\_\_

How much has your weight changed in the past year?  None  Gained \_\_\_\_\_ lbs.  Lost \_\_\_\_\_ lbs.

Cause of weight change  Self-diet  Physician Recommended  Unknown  Medication \_\_\_\_\_

**3. To be completed by spouse if applying for coverage.**

When did you, the **Spouse**, last consult a physician, chiropractor or other practitioner? Month/Year \_\_\_\_\_  
 Name of physician or clinic \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 Reason for consultation \_\_\_\_\_ Tests Performed \_\_\_\_\_  
 Findings \_\_\_\_\_  
 Remaining effects \_\_\_\_\_  
 How much has your weight changed in the past year?  None  Gained \_\_\_\_\_ lbs.  Lost \_\_\_\_\_ lbs.  
 Cause of weight change  Self-diet  Physician recommended  Unknown  Medication \_\_\_\_\_

**If you answer "yes" to any of the following questions (4a-4l), please provide details in Section D.**

- 4. Has any person** proposed for insurance: Yes No
- a. ever been declined, postponed, ridered, or charged an extra premium for insurance?
  - b. ever been convicted of a felony?
  - c. ever been evaluated or treated for alcoholism, frequently used alcoholic beverages to excess or intoxication, or been advised to modify drinking habits for any reason?
  - d. ever used sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency?
  - e. ever had surgery or diagnostic testing or treatment, or has surgery or diagnostic testing been recommended or scheduled that has not been completed?
  - f. ever had, been diagnosed or treated by a physician for any immune system disorder, including AIDS/ARC or positive HIV or HIV-related test disclosure limited to FDA-licensed blood test?
  - g. ever received disability benefits or currently disabled?
  - h. had any fixation/prosthetic devices that are currently present, including but not limited to, plates, screws, pins, implants (including breast implants), pacemakers, valve replacements or transplants?
  - i. in the past 10 years been in a hospital, clinic, or other medical facility for treatment, confinement or observation?
  - j. in the past 5 years participated in any organized racing, scuba diving, skydiving, rock climbing or any other hazardous activities?
  - k. in the past 5 years flown or plan to fly in the future, as a pilot or crew member?
  - l. in the past 5 years had his/her driver's license suspended or revoked?

**If you answer "yes" to any of the following questions (5-8), please provide details in Section D.**

- 5. To the best of your knowledge and belief, in the past 10 years, has any person proposed for insurance had any indication, diagnosis or treatment of:** Yes No
- a. blood or lymph disorders, including, but not limited to, anemia, lymphadenopathy or Chronic Fatigue Syndrome?
  - b. congenital disorder, birth defects or developmental disorders, including, but not limited to:  
    - Down's Syndrome  mental retardation  autism  cleft palate  club foot
    - congenital heart defects  other \_\_\_\_\_
  - c. the respiratory system, including:  
    - allergies  asthma  pneumonia  emphysema  bronchitis
    - shortness of breath  chronic cough  apnea  sinusitis  tuberculosis
    - cystic fibrosis  other \_\_\_\_\_
  - d. the circulatory system, including:  
    - heart disease  heart defect  heart condition  mitral valve prolapse
    - heart attack  chest pain  varicose veins  high blood pressure (hypertension)
    - phlebitis  murmur  aneurysm  elevated cholesterol or triglycerides
    - Raynaud's Disease  stroke, TIA  palpitations/irregular heartbeat
    - Raynaud's Phenomenon  other \_\_\_\_\_
  - e. the digestive system, including:  
    - ulcer  esophagus  colitis  hepatitis, jaundice, or cirrhosis
    - gall bladder  bowel  polyps  diverticulitis, diverticulosis
    - gastritis  stomach  rectum  disorder of pancreas, spleen, liver
    - hernia  intestinal disorder  hemorrhoids  other \_\_\_\_\_
  - f. the nervous system, including:  
    - epilepsy  seizure  headaches  Alzheimers  Parkinson's disease
    - dizziness  fainting spells  cerebral palsy  multiple sclerosis
    - convulsions  paralysis  dementia  other \_\_\_\_\_

(Continued)

- Yes**   **No**
- g. a mental or nervous disorder, including: .....
- anxiety    A.D.D./A.D.H.D.    eating disorder    learning/behavior disorder  
 psychiatric treatment or counseling    depression    psychosis  
 other \_\_\_\_\_
- h. the genitourinary system, including: .....
- prostate    kidney disorder or stones    urinary incontinence  
 urinary tract infection    bladder    other \_\_\_\_\_
- i. the endocrine system, including: .....
- diabetes    goiter    thyroid gland    high or low blood sugar  
 glandular disorder    pituitary disorder    other \_\_\_\_\_
- j. the musculoskeletal system, including: .....
- arthritis    gout    TMJ/jaw problems    lupus erythematosus    rheumatism  
 subluxation    physical handicap    fibromyalgia    loss of limb    knees  
 the back, spine, or muscles    other \_\_\_\_\_
- k. cancer, tumors, cysts, growths or breast disorders? (Provide location, type and treatment received.) .....
- l. skin disorder/problems, such as psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, or acne? .....
- m. the eyes, ears, nose, or throat, such as cataracts, glaucoma, speech or hearing impairment, otitis media or ear tubes? .....
- n. any disease or disorder of female/male reproductive systems or genitalia, including: .....
- ovaries    impotency    reproductive organ    irregular menstruation  
 infertility    uterus/cervix    premenstrual syndrome (PMS)  
 sexually transmitted disease    other \_\_\_\_\_

**6. Questions for female applicants only.**

- a. Any complications of pregnancy, including, but not limited to, caesarean section delivery or miscarriage? .....
- b. Date of last pap smear \_\_\_\_\_ Results \_\_\_\_\_  
Dr. Name & Address \_\_\_\_\_
- c. Have you been instructed to have a repeat pap smear or any follow-up treatment or tests as a result of your last pap smear? .....

7. In the past 10 years, has any person proposed for insurance consulted, been treated or examined by a physician, chiropractor, or other practitioner for any reason other than disclosed above? .....
8. To the best of your knowledge and belief, does any person to be insured have any mental or physical impairment, handicap, retardation, disease, disorder or deformity? .....

**D. Health Statement Details**

List complete details with respect to questions 4 thru 8. If additional space is needed, please use Section F for additional remarks.

Ques. No.	Person's Name	Dates of Treatment	Drugs & Dosage Prescribed, if any	Illness or Condition Treated	Remaining Effects (if none, list none.)	Complete Name, Address & Phone Number of Chiropractors, Physicians and Hospitals

(Continued)



## G. Verification of Information

### By signing below:

1. I represent that, to the best of my knowledge and belief, all answers are accurate, complete and true. I understand that World Insurance Company is relying on my answers in deciding whether to approve this application and that full and complete disclosure of the requested health information must occur for insurance to go into effect and that if I omit any of the requested health information, no insurance will go into effect for myself or my dependents. I understand the agent has no authority to alter or waive this, or any other condition of coverage.

I have not disclosed to the agent any health information which is not disclosed on this application. I understand that this application, if accepted, shall become a part of the policy(ies) and any incomplete, incorrect or misleading answers may be used to void any insurance provided to me and my dependents.

I understand that I (or the individual purchasing insurance for child-only coverage) must be an active, dues-paying member of the Association and that I and my spouse must both be between the ages of 16 and 64 to apply for insurance.

2. I understand no insurance exists unless and until a certificate is delivered by World Insurance Company and accepted by me indicating coverage for myself and my dependents and the effective date, and that Association dues are required to purchase and continue insurance. If at any time prior to such notification, any person applying for coverage consults a physician, is hospitalized or has any change in health, I agree to inform World Insurance Company immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by World Insurance Company nor to bind World Insurance Company to any promise of coverage.

I, the undersigned, understand that World Insurance Company will confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call is a routine process for those applying for coverage. (Please Note: this telephone call will be recorded.) I also understand that my application will not be considered if verification is not completed. I understand that I must tell World Insurance Company if my health or if the health of any of my dependents changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved by World Insurance Company.

3. I acknowledge that:

a. I understand that the opportunity to apply for group insurance is contingent upon membership in the association (this application cannot be used to apply for membership in the association; a separate application must be submitted); and

b. I certify that the following information is correct and true as it relates to the health insurance being applied for:

(1) no portion of the premium will be paid, during the period the certificate is in force, by or on behalf of my employer, either directly, or through wage adjustments or other means of reimbursement;

(2) neither I, nor my spouse, nor my dependents, nor my employer intends to treat the certificate, during the period the certificate is in force, as part of a plan or program under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.

c. I have read this application and the brochure and I understand and accept the terms and conditions provided in all these materials including, but not limited to, the certificate benefits, exclusions and limitations.

d. Any disputes arising under the policy are subject to an appeals procedure.

e. When applying for child-only coverage, I also understand and agree that:

(1) the member is the person who will receive all correspondence and communications from World Insurance Company regarding this child-only coverage.

(2) the member is the individual who is purchasing coverage for the proposed insured under the child plan.

(3) the member is responsible for paying all premiums when due.

f. Please Note: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.

g. Authorization to obtain Information:

I understand World Insurance Company or its reinsurers will gather information regarding me or my family. This information may include the Medical Information Bureau; employer(s); consumer reporting agency; or the Veterans Administration.

I UNDERSTAND the information obtained by use of this Authorization will be used by World Insurance Company to determine eligibility for insurance or benefit determination. Any information obtained will not be released by World Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.

I know I have the right to make a written request within a reasonable time to receive additional, detailed information about the nature and scope of this investigation. I understand that this information will be used by World Insurance Company to determine eligibility for insurance, policy reinstatement or a change of benefits. I agree this authorization is valid for twenty-four (24) months from the date signed. I know I or my authorized representative has the right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I, the undersigned represent to the best of my knowledge and belief, that all statements contained herein are complete and true. Under the penalties of perjury, I certify that the Social Security Number(s) provided are true, correct and complete.

*Managed Care Acknowledgement*

I, the undersigned applicant, hereby acknowledge that the following information was provided at the time of the application:

1. The number, mix and distribution of participating providers. (The list shall be updated at least every 30-days and will be published on an Internet service site made available by World at no cost to me.)
2. The existence of limitations and disclosure of such limitations on choices of health care providers; and
3. A summary of any agreements or contracts between the managed care plan and any health care provider or hospital.

Application dated at (City, State) \_\_\_\_\_

Signature of Member \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Spouse (if applying for coverage) \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Member (if other than Parent or Legal Guardian) for child-only coverage \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Parent or Legal Guardian (if other than Member) for child-only coverage \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Agent Code 30633 Date Signed \_\_\_\_\_

Printed Name of Agent Wilev Long

G1051-GA

### Authorization to Use or Disclose Health Information

Full name of proposed policyholder/certificateholder (please print) \_\_\_\_\_ Date of birth \_\_\_\_\_

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider ("Providers") that has provided payment, treatment or services to me or on my behalf or on behalf of my minor dependents to disclose my or my minor dependents' entire medical records and any other protected health information concerning me or my minor dependents to World Insurance Company ("World"). This includes but is not limited to information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. I also authorize World to use/disclose my or my minor dependents' entire medical records and any other protected health information concerning me or my minor dependents to any of my Providers.

By my signature below, I understand that any agreements I have made to restrict my or my minor dependents' protected health information does not apply to this authorization and I instruct my Providers or World to release and disclose my or my minor dependents' entire medical record without restriction.

This health information is to be used or disclosed under this authorization so that World or my Providers may: 1) underwrite the application for coverage, make eligibility, risk rating, policy/certificate issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with World or 6) for general treatment, payment or health care operations.

This authorization shall remain in force for [24 months] following the date of the signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to World at 11808 Grant Street, Omaha, Nebraska 68164. I understand that a revocation is not effective to the extent that any of my Providers or World has relied on this authorization or to the extent that World has a legal right to contest a claim under an insurance policy/certificate or to contest the policy/certificate itself. I understand that any information that is disclosed pursuant to this authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the complete medical records, World may not be able to process my application for insurance. I understand a copy of this authorization will be provided to me.

Signature of Policyholder/Certificate Holder \_\_\_\_\_ Date \_\_\_\_\_

Signature of Spouse (if covered) \_\_\_\_\_ Date \_\_\_\_\_

**Signature of each Covered Dependent age 18 and over:**

Dependent Signature \_\_\_\_\_ Dependent Signature \_\_\_\_\_

Dependent Signature \_\_\_\_\_

*If signed by a legal representative of policyowner, please indicate the legal representative's authority to act on behalf of the policyowner.*

Signature of Legal Representative \_\_\_\_\_ Authority \_\_\_\_\_ Date \_\_\_\_\_





# Application for NCA Membership

I am applying for membership in the National Consumer Alliance Association (NCA). As an adult U.S. Citizen or permanent resident, my NCA application will be approved and I will have access to NCA member benefits. My dues will be \$7.50 a month, or \$90 annually.

I also will be able to apply for World Insurance Company's WorldCare Flex health insurance through my membership with NCA. If my application for insurance is approved, I will be issued a certificate of health insurance from World.

**I am applying for:**

**NCA membership and WorldCare Flex health insurance**

**NCA membership only**

Date of Application \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Signature \_\_\_\_\_

Please give this completed form and membership fee to your World insurance agent, who will forward it along with your WorldCare health insurance application. If you're not applying for WorldCare Flex, your agent will forward the membership form and fee alone.



## THE WORLD FOR LESS

Your NCA  
Membership Benefits

# Health Insurance You Can Afford

As an NCA member, you'll be eligible to apply for World Insurance Company's WorldCare Flex health insurance.

WorldCare Flex was developed specifically for NCA members and families seeking quality health insurance at an affordable price.

To help you match coverage to your needs, WorldCare Flex offers six plan options – three PPO major medical plans, two traditional any-doctor major medical plans, and one providing hospital/surgical coverage only.

WorldCare Flex insurance is fully underwritten and acceptance is based on individual health history, which helps to keep premium rates affordable.

For more information about this quality health insurance for NCA members, please ask your agent for a WorldCare Flex brochure and premium quote.

## Discover Your Discounts

Eligibility to apply for WorldCare Flex is just one NCA membership benefit. You're also entitled to these valuable NCA discounts:

### ► Healthy Options

**Vision:** save 20 percent at LensCrafters

**Hearing:** 60 percent off hearing aids

**Emergency Medical Info:** wallet card with your vital info

**Vitamins & Nutrition:** 15 percent discount on supplements

**Medical Air Service:** emergency air ambulance

### ► Mobile Alternatives

**Car Rental:** savings at Alamo, Avis, Hertz and National

**Relocation Services:** 45-58 percent off moving expenses

**Motor Club:** 50 percent savings on a variety of auto services

**Auto Warranty Club:** up to 60 percent dealership savings

### ► Entertaining Ideas

**Hotel:** 50 percent discount on accommodations

**Movies:** up to 50 percent off movie tickets nationwide

**Travel Club:** discounts on air travel, cruises, motorcoach tours

**Theme Parks:** special savings at popular U.S. theme parks

### ► Business Choices

**Office Supplies:** up to 36 percent off already discounted prices

**Office Equipment:** immediate financing and rebates on leased equipment

**Payroll Processing:** discounted processing and reports

**Filing Systems:** 15 percent savings on home and office filing systems

**Motivational Publications:** 40 percent discount on books and tapes

**Background Reports/Investigative Services:** 15 percent savings

### ► Digital Connections

**Internet Access:** discounted Internet access

**Long Distance:** 5.9 cents per minute state-to-state, 24-7

### ► Consumer Notions

**HoptheShops.com:** discounts at over 100 stores and e-tailers

**Floral:** 10 percent discount on floral products

**Magazines:** up to 70 percent off regular subscription rates

## About NCA

Established in 1987, the National Consumer Alliance Association gives members access to high-quality products and services at reasonable prices. NCA is based in Chesterfield, Mo.

## About World Insurance Company

World has provided affordable health insurance to individuals and families since 1903. The company is based in Omaha, Neb.

In addition to WorldCare Flex health insurance, World offers Medicare supplement, short-term medical, dental and life insurance.

*Your NCA membership kit will contain complete details on the discounted products and services available to you as a member. Taking advantage of these discounts will be as easy as showing your NCA card or providing your member number!*

# NCA

National Consumer Alliance Association

**NOTICE TO PROPOSED INSURED**

Thank you for your application for insurance.

We are required by Public Law 91-508, the Fair Credit Reporting Act and Privacy Act Prenotification, to inform you that as part of our underwriting procedure, an investigative consumer report may be obtained that will provide applicable information concerning character, general reputation, personal characteristics and mode of living.

Further information on the nature and scope of such report, if one is made, is available to you upon written request to the Underwriting Department at the above address.

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

**NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU**

Information you provide will be treated as confidential except that World Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the M.I.B will supply such company with the information it may have in its files.

Upon receipt of the request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

World Insurance Company or its reinsurers also may release information in its files to other life insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue a certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will come from you, and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have the right of access and correction with respect to the information collected about you except information that relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please contact World Insurance Company, P.O. Box 3160, Omaha, NE 68103-0160.

**CONDITIONAL RECEIPT**

**INSTRUCTIONS:** Complete Conditional Receipt ONLY when full premium, including all application fees, is being submitted with the application. Applicant is to sign the receipt. Agent is to witness signature and date the receipt. If premium is not being submitted, this receipt must remain attached to the application.

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_ paid with the attached insurance application to World Insurance Company.

*Conditions* – World Insurance Company agrees to insure those proposed for insurance if:

1. The payment received with the application is equal to the full first modal premium, including all application fees, for this certificate,
2. All medical or lab tests, if required, have been completed and no adverse medical condition(s) have been detected which would result in the declination or amendment of the certificate; and
3. All those proposed for insurance are insurable on the date of application without special exception and at standard or preferred rates under the Company's regular underwriting rules and practices for the certificate applied for.

*Terms of Conditional Insurance:*

1. This conditional receipt is governed by the terms of the certificate applied for.
2. This conditional receipt terminates 45 days after the application date, when the certificate applied for is declined or withdrawn, or when the certificate applied for becomes effective, whichever occurs first. The effective date will be the earlier of a) underwriting approval date or b) specified future effective date (no sooner than 10 days after application date).

**No Representative of the Company is authorized to modify this Conditional Receipt**

Signature of Applicant \_\_\_\_\_ Signature of Agent/Broker \_\_\_\_\_

Date \_\_\_\_\_ Agent # **30633** \_\_\_\_\_

*Make checks payable to World Insurance Company*

Application Fees are non-refundable unless required by state law.