



EZ App in Three Easy Steps

Use this easy checklist to guarantee the quickest handling of your Non-Medical Application.

- 1.** Review World Insurance Company's Underwriting Guide* and the Declined Conditions list (on next page) with your customer to determine if he/she is likely to be eligible for insurance with World. (If necessary, call 800-733-5454 or complete and fax in the Pre-Underwriting Review (Form W1169) to have an underwriter assist you in determining if an application should be submitted.)
- 2.** Complete the attached non-medical application for major medical with your customer. Be sure you both sign the Conditional Receipt before you leave it with your customer.
- 3.** Details are critical! Prepare your customers for the Personal Profile Interview by giving them the "Completing Your Personal Profile Interview" handout (attached). Make sure they call for the interview as soon as possible. (We don't need the application to begin the underwriting process.)

Checklist:

Forward the following required forms:

- Application
- **Software Proposal**
- State Mandated Forms (if appropriate)
- Preferred Rating Questionnaire (M1184), if applicable
- Initial Premium

Payment collection is easier than ever! World has 3 options available (*see page 1*):

- Check-O-Matic (*A voided check is required.*)
- Credit Card (*for initial monthly premium and application fees*)
- Check

If you have any questions, call our Underwriting Information Line at 800-733-5454. Product and Marketing questions should be directed to your General Agent or our Marketing Hot Line at 800-600-7760.

**Our Underwriting Guide, software and forms are available at www.worldsells.com.*

Declined Conditions List

Please review the following conditions with your customer to determine their insurability with World Insurance.

This is not an all-inclusive list.

Addison's Disease	Kaposi's Sarcoma
Alcoholism (<i>within 5 years</i>)	Kidney Dialysis/Renal Failure/Polycystic Kidney
Alzheimer's Disease	Leukemia
Aneurysm	Lou Gehrig's Disease/ALS
Autism	Lymphoma
Bipolar Disorder	Meniere's Disease (<i>present</i>)
Cancer/Melanoma	Mental Retardation (<i>age 0-9 or severe</i>)
Cerebral Palsy	Multiple Sclerosis
Chronic Obstructive Pulmonary Disease	Muscular Dystrophy
Cirrhosis of the Liver	Myasthenia Gravis
Clotting Deficiency	Narcolepsy (<i>within 3 years or uncontrolled</i>)
Congestive Heart Failure/Cardiomegaly	Obesity (<i>morbid</i>)/gastric stapling
Coronary Congenital Defects	Optic Neuritis
Coronary Artery Disease/angina (<i>angioplasty, bypass, or MI</i>)	Organ or Bone Marrow Transplants (<i>pre and post</i>)
Crohn's Disease/Ulcerative Colitis/Regional Enteritis	Pacemaker
Cystic Fibrosis	Paget's Disease
Diabetes	Pancreatitis (<i>acute within 1 year of treatment or recurrent</i>)
Down Syndrome	Paralysis
Driving while intoxicated (<i>within 2 years</i>)	Parkinson's Disease
Drug Abuse or Substance Abuse (<i>within 10 years</i>)	Pending Surgery
Eating Disorders (<i>within 3 years of treatment</i>)	Peripheral Neuropathy/Peripheral Vascular Disease
Emphysema	Pneumocystis Pneumonia
Esophageal Varices	Polymyositis
Fibromyalgia (<i>severe</i>)	Polyneuritis
Glomerulonephritis (<i>chronic</i>)	Pregnancy (<i>current, including dependents or expectant fathers</i>)
Heart Disease (<i>mitral or aortic stenosis, angina, cardiomyopathy, congestive heart failure, endocarditis, fibrillation, atherosclerosis, valve replacement</i>)	Primary Pulmonary Hypertension
Hemiplegia	Psychotic Disorders/Major Depression/Bipolar/Schizophrenia
Hemolytic Anemia	Rheumatoid Arthritis
Hemophilia/Thrombocytopenia	Sarcoidosis
Hepatitis (<i>A&E within 6 months, all others declined</i>)	Sickle Cell Anemia
HIV+, AIDS, or AIDS-Related Complex (ARC)	Sleep Apnea (<i>uncontrolled or severe</i>)
Hodgkin's Disease	Spina Bifida (<i>unoperated, symptomatic or with complications</i>)
Hyperthyroidism (<i>toxic, not operated</i>)	Stroke/CVA
Intestinal Bypass (<i>Ileal Bypass</i>)	Suicide Attempt (<i>within 6 years or multiple attempts</i>)
Intracranial Hemorrhage/Stroke/TIA	Systemic Lupus Erythematosus
	Ventricular Septal Defect

Common Ratable Conditions

Hypertension (<i>controlled</i>)	Overweight	Hyperlipidemia	Tobacco Use
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Occupations/Non-Medical Status Not Eligible for Health Insurance

Actors and Actresses	Government Employees
Amusement Park Employees	Guides — Fishing and Hunting
Asbestos/Toxic Chemical Workers	Horse Racing Personnel
Athletes — Professional or College	Livestock Breakers or Trainers
Boxers, Prize Fighters, Pugilists	Logging /Mill Workers
Circus or Carnival Workers	Massage Therapist (<i>Not Licensed/Certified</i>)
Drivers — Participating in racing, speed or endurance tests	Missionaries (<i>Outside U.S.</i>)
Enameling Factories (<i>Dusters, Mixers, Grinders, Laborers</i>)	Mining — Underground Workers
Entertainers	Models
Explorers	Musicians
Explosives Workers or those handling, using or transporting explosives, including contractors	Oil/Natural Gas workers, including off-shore operations
Fireworks Manufacturers	Postal Workers
Fishermen	Pyrotechnists
Foreign Nationals (in US less than one year, no permanent visa)	Rodeo Riders
Foreign Travel (more than five times per year or residing in foreign country for over five months)	Singers
	Structural Steel Workers
	Unemployed

D. In-Force Medical Coverage

10. **Statement:** a) You normally do not require more than one policy; b) If you purchase this policy, you may want to evaluate your health coverage and decide if you need multiple coverages; c) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplement policy; and d) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program.

Questions: (If "Yes" for any proposed insured, please complete section below and submit any required replacement forms.) To the best of your knowledge:

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| a. Do you have another insurance policy or contract in force? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, with which company? (Name and address) _____ | | |
| If so, do you intend to replace your current accident and sickness insurance with this policy (contract)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, with which company? (Name and address) _____ | | |
| What kind of policy? _____ | | |
| c. Are you covered for medical assistance through the state Medicaid program? | <input type="checkbox"/> | <input type="checkbox"/> |
| As a Specified Low Income Medicare Beneficiary (SLMB)? | <input type="checkbox"/> | <input type="checkbox"/> |
| As a Qualified Medicare Beneficiary (QMB)? | <input type="checkbox"/> | <input type="checkbox"/> |
| For other Medicaid medical benefits? | <input type="checkbox"/> | <input type="checkbox"/> |

E. Representations

I represent, to the best of my knowledge and belief, that all statements and answers in this application, and in any supplement(s) attached, are true, complete and correct. I understand and acknowledge that:

1. I have received and reviewed the "Completing Your Personal Profile Interview" handout. I must call World within 3-5 days to complete a Personal Profile Interview (Interview).
2. Any insurance policy issued relies on my responses in this application and during the recorded Interview. This application and any amendments become part of, and are a basis for, the policy.
3. I must inform World if any information provided on this application or during the Interview becomes inaccurate or is updated before any policy is issued.
4. Except as otherwise provided in the Conditional Receipt, no insurance will be in force unless approved by World and accepted by me.
5. Any information that I provide or is gathered through this application process can be shared with persons necessary to facilitate issuing the coverage, including my agent or broker.
6. If any of these conditions are not met, World has the right to rescind its offer of coverage and the full extent of World's liability will be limited to the premium received.
7. I certify that the following information is correct and true as it relates to the health insurance being applied for:
 - a. no portion of the premium will be paid by or on behalf of my employer, either directly or through wage adjustments or other means of reimbursement.
 - b. neither I, nor my spouse, nor my dependents, nor my employer intends to treat the policy as part of a plan or program offered by my employer under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.
8. I authorize payment as noted in Section C of this application.

- | | | |
|---|--------------------------|--------------------------|
| 9. Self-Employed Business Group of One Determination (To be completed by all applicants.) | Yes | No |
| a. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care to your employees? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Do you have a gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? <i>Note: Substantial part of your income means income derived from business activities of the Business Group of One that are sufficient to pay for the annual premiums for the Business Group of One's health benefit plan?</i> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Do you work a minimum of 24 hours a week on a permanent basis? | <input type="checkbox"/> | <input type="checkbox"/> |
- Yes to all questions qualifies applicant as a Self-Employed Business Group of One.**

For those meeting the definition of a Self-Employed Business Group of One, please complete this section.

I acknowledge that I meet the definition of a self-employed business group of one. I understand that by purchasing an individual policy instead of a small group policy, I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carried for a period of three years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase are plan design, attained age of insured, health related factors, utilization trends, number of individuals insured, policy duration from issue, and a factor that reflects the cost of care in the specific geographical area of where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited by plan design, my age, overall cost and utilization trends (index rate), my family size, and a factor that reflects the cost of care where I live.

I have been given a health plan benefit description form showing the benefits under Colorado's small group Standard Health Benefits Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

The state of Colorado requires that If a Business Group of One is applying for an individual medical plan, and is applying for family coverage, World Insurance Company must accept or reject the entire family, unless the proposed insured waives coverage for a family member who has other coverage in force.

I certify that the following family members have other health insurance coverage in force. (List the names of all your dependents, whether listed on the application or not.)

Name	Relationship	Type of Coverage and Name of Carrier	Effective Date

Please Note: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Application signed at City, State _____

_____ Signature of Member	_____ Date Signed
_____ Signature of Spouse <i>(If applying for coverage)</i>	_____ Date Signed
_____ Signature of Parent or Legal Guardian <i>(If other than Member)</i> for child-only coverage	_____ Date Signed
_____ Signature of Member <i>(If other than Parent or Legal Guardian for child-only coverage)</i>	_____ Date Signed

F. Agent Information

Agency Name _____ Agency Number _____
 Agent Name _____ Agent Number _____
 Agent Code _____ Agent Fax Number _____ Agent Phone Number _____
 Agent E-Mail Address* _____
 Agent Signature _____
 Special Instructions: _____

* If you have not registered yet, or if your e-mail address has changed, please visit www.worldsells.com. Communication regarding this application will be through your World Mail Account address.

G. Authorization to Honor Checks Drawn by World Insurance Company

To begin Check-O-Matic withdrawals:

Withdrawal date will be effective date of policy.

Bank Name _____

Address _____

City _____ State _____

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	*(Transit Number) _____	1234
	Date _____	
	_____ \$	
		_____ Dollars
Bank Name _____		
Memo _____		
(Routing No.) _____	(Account No.) _____	(Check No.) _____

Routing & Transit No. (9 digits) _____ Account No. _____ Next Check No. _____

A voided check is required. Do not send a deposit slip.

TO: The Bank named above

As consideration to you to handle drafts drawn by World Insurance Company on customers of your bank for payment of premiums on insurance policies, World Insurance Company agrees:

- (1) To indemnify and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- (2) In the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

WORLD INSURANCE COMPANY

Michael E. Abbott

Michael E. Abbott, President, CEO

Remember to submit the Software Proposal along with all forms!

Conditional Receipt

INSTRUCTIONS: Complete Conditional Receipt ONLY when full premium, including all application fees, is being submitted with the application, or full Credit Card Authorization is completed. 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 policy;
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 policy; 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 policy applied for.

Terms of Conditional Insurance:

1. This conditional receipt is governed by the terms of the policy applied for.
2. This conditional receipt terminates 45 days after the application date, when the policy applied for is declined or withdrawn, or when the policy 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 Spouse _____

Signature of Agent/Broker _____

Date _____ Agent # _____

*Make checks payable to World Insurance Company.
Application Fees are non-refundable unless required by state law.*

WORLD INSURANCE COMPANY
P.O. Box 3160, Omaha, NE 68103-0160

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 policy, 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.

Leave This Sheet With The Customer – DO NOT SUBMIT!

Completing Your EZ App Personal Profile

Thank you for choosing World Insurance Company to provide insurance protection for you and your family. As part of World's process for issuing your coverage, every adult applying for coverage will be asked to participate in a telephone interview to complete a personal profile of information important to the application process.

How To Complete Your EZ App Personal Profile Interview

Use the space below to capture information for ready reference.

1. Gather the names, addresses and phone numbers of all health care providers (physicians, specialists, chiropractors, etc.) you or any applicants for coverage have consulted in the past 10 years. Please include information about hospitals, outpatient surgical facilities and medical tests.
2. Gather information about the medications you or any applicant are currently taking or have taken in the past.
3. We will call you as close as possible to the time/day you specified on the application. You will want to set aside approximately 20-30 minutes in a setting where you are able to discuss confidential health information. If it is more convenient for you to call us, you may do so at 800-995-9051, Monday through Friday between 7 a.m. and 9 p.m., Central Time, or Saturday, between 9 a.m. and 3 p.m. **Please identify that you have completed an EZ App.**

Personal Information

Please use this space to record your healthcare provider information and your medical history for your personal interview.

Healthcare Providers

Name	Address	Phone	Dates Visited/Reason

Medications – Past and Present

Name	Dosage and Frequency	Dates Taken



"YOUR PARTNER IN INDIVIDUAL HEALTH INSURANCE SINCE 1903"™

Personal Profile Interview

Please review the following medical conditions and check any that you or any person applying for coverage were diagnosed with, received treatment for, or consulted a health care provider for in the past 10 years. These conditions may be associated with the specific medical category under which they're listed. However, they are examples of the medical category and do not necessarily include all the conditions related to that category. Therefore, if you have a particular illness or condition which does not appear on the list or you are uncertain which category it's associated with, please tell your interviewer. Please list other health insurance coverage including policy numbers and insurance carriers.

Policy # _____ Carrier Name: _____

Driving Record

Any adverse driving history: Date(s): _____

DUI/DWI (past 5 years) _____

Reckless Driving _____

Moving Violations
(past 2 years) _____

Driver's License Number _____

Hazardous Activity

Participation in any hazardous activity during the past 5 years:

Automobile Racing

Ultralight Flying

Skydiving

Powerboat Racing

Hang Gliding

Scuba Diving

Motorcycle Racing

Other _____

Medical Conditions List

Condition	Date Cond. Began	Person Being Treated/Treatment Provided
Complications of Pregnancy		
<input type="checkbox"/> Ectopic Pregnancy		
<input type="checkbox"/> Gestational Diabetes		
<input type="checkbox"/> Miscarriage		
<input type="checkbox"/> Pre-term Labor		
<input type="checkbox"/> Pre-eclampsia		
<input type="checkbox"/> C-Section		
<input type="checkbox"/> Other _____		
Pap Smear		
<input type="checkbox"/> Cervical Dysplasia		
<input type="checkbox"/> Inflammation		
<input type="checkbox"/> Cervicitis		
<input type="checkbox"/> Cervical Cancer		
<input type="checkbox"/> Atypical Squamous Cells (ASCUS)		
<input type="checkbox"/> Other _____		
Reproductive System Disorders		
<input type="checkbox"/> Sexually Transmitted Disease (STDs)		
<input type="checkbox"/> Infertility		
<input type="checkbox"/> Ovaries		
<input type="checkbox"/> Endometriosis		
<input type="checkbox"/> Rectocele		
<input type="checkbox"/> PMS		
<input type="checkbox"/> Cervix		
<input type="checkbox"/> Irregular Menses		
<input type="checkbox"/> Ovarian Cyst		
<input type="checkbox"/> Cystocele		
<input type="checkbox"/> Polycystic Ovarian Disease		
<input type="checkbox"/> Vagina		
<input type="checkbox"/> Uterus		
<input type="checkbox"/> Uterine Fibroids		
<input type="checkbox"/> Prolapsed Uterus		
<input type="checkbox"/> Penis		
<input type="checkbox"/> Testes		
<input type="checkbox"/> Other _____		

Medical Conditions List *(continued)*

Condition	Date Cond. Began	Person Being Treated/Treatment Provided
Heart/Circulatory		
<input type="checkbox"/> High Blood Pressure		
<input type="checkbox"/> Heart Attack		
<input type="checkbox"/> Heart Disease or Defect		
<input type="checkbox"/> Stroke or TIA		
<input type="checkbox"/> Chest Pain		
<input type="checkbox"/> Varicose Veins		
<input type="checkbox"/> Phlebitis		
<input type="checkbox"/> Heart Murmur		
<input type="checkbox"/> Mitral Valve Prolapse		
<input type="checkbox"/> Elevated Cholesterol or Triglycerides		
<input type="checkbox"/> Peripheral Vascular		
<input type="checkbox"/> Disease		
<input type="checkbox"/> Irregular Heart Beat		
<input type="checkbox"/> Other _____		
<i>Please provide the most current date and reading for blood pressure, cholesterol and triglycerides (including HDL, LDL and total cholesterol).</i>		
Blood Pressure _____		
Cholesterol HDL: _____		
LDL: _____		
Triglycerides _____		
Immune Deficiency		
<input type="checkbox"/> Swollen Lymph Nodes		
<input type="checkbox"/> Chronic Fatigue		
<input type="checkbox"/> Skin Rashes		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Loss of Appetite		
<input type="checkbox"/> Fever		
<input type="checkbox"/> Unexplained Infections		
<input type="checkbox"/> Pneumonia		
<input type="checkbox"/> Weight Loss		
<input type="checkbox"/> Oral Thrush		
Blood/Lymph/Anemia		
<input type="checkbox"/> Anemia (type)		
<input type="checkbox"/> Swollen Lymph Nodes		
<input type="checkbox"/> Lymphadenopathy		
<input type="checkbox"/> Chronic Fatigue Syndrome		
Digestive Disorders		
<input type="checkbox"/> Ulcer/Intestinal Disorder		
<input type="checkbox"/> Crohn's		
<input type="checkbox"/> Hemorrhoids or Polyps		
<input type="checkbox"/> Spleen Disorder		
<input type="checkbox"/> GERD		
<input type="checkbox"/> Gastritis		
<input type="checkbox"/> Colitis		
<input type="checkbox"/> Ulcerative Colitis		
<input type="checkbox"/> Hernia		
<input type="checkbox"/> Liver Disorder		
<input type="checkbox"/> Jaundice		
<input type="checkbox"/> Stomach		
<input type="checkbox"/> Gallbladder		

Medical Conditions List *(continued)*

Condition	Date Cond. Began	Person Being Treated/Treatment Provided
<input type="checkbox"/> Irritable Bowel Syndrome		
<input type="checkbox"/> Pancreas Disorder		
<input type="checkbox"/> Hepatitis		
<input type="checkbox"/> Cirrhosis		
<input type="checkbox"/> Diverticulitis or Diverticulosis		
<input type="checkbox"/> Other _____		
Genitourinary System Disorders		
<input type="checkbox"/> Kidney Stones		
<input type="checkbox"/> Prostate Disorder		
<input type="checkbox"/> Kidney Disorder		
<input type="checkbox"/> Cystitis		
<input type="checkbox"/> Glomerulonephritis		
<input type="checkbox"/> Bladder Infections		
<input type="checkbox"/> Nephritis		
<input type="checkbox"/> Other _____		
Bone/Muscle/Connective Tissue Disorders		
<input type="checkbox"/> Arthritis or Rheumatism		
<input type="checkbox"/> Low Back Pain		
<input type="checkbox"/> ACL Tear		
<input type="checkbox"/> Back/Spine Disorder		
<input type="checkbox"/> Scoliosis		
<input type="checkbox"/> Bursitis/Tendonitis		
<input type="checkbox"/> Gout		
<input type="checkbox"/> Fractures		
<input type="checkbox"/> Spinal Fusion		
<input type="checkbox"/> Manipulation Therapy		
<input type="checkbox"/> Herniated Disc		
<input type="checkbox"/> Sprain/Strain		
<input type="checkbox"/> Fibromyalgia		
<input type="checkbox"/> Carpal Tunnel Syndrome		
<input type="checkbox"/> Lupus/Systemic Lupus Erythematosus (SLE)		
<input type="checkbox"/> Muscular/Neuromuscular Disorder		
<input type="checkbox"/> Degenerative Joint Disease		
<input type="checkbox"/> Bunions		
<input type="checkbox"/> Other _____		
Fixation/Prosthetic Device		
<input type="checkbox"/> Plates		
<input type="checkbox"/> Implants		
<input type="checkbox"/> Pacemaker		
<input type="checkbox"/> Screws		
<input type="checkbox"/> Breast Implants		
<input type="checkbox"/> Valve Replacement		
<input type="checkbox"/> Pins		
<input type="checkbox"/> Shunts		
<input type="checkbox"/> Joint Replacement		
<input type="checkbox"/> Transplants		
Diabetes/Thyroid		
<input type="checkbox"/> Diabetes		
<input type="checkbox"/> High Blood Sugar		
<input type="checkbox"/> Hyperglycemia		
<input type="checkbox"/> Hypothyroid		
<input type="checkbox"/> Pituitary Disorder		

Medical Conditions List *(continued)*

Condition	Date Cond. Began	Person Being Treated/Treatment Provided
<input type="checkbox"/> Low Blood Sugar		
<input type="checkbox"/> Hyperthyroid		
<input type="checkbox"/> Goiter		
<input type="checkbox"/> Hypoglycemia		
<input type="checkbox"/> Other _____		
Lungs and Respiratory System		
<input type="checkbox"/> Hayfever/Allergies		
<input type="checkbox"/> Sinus Infections		
<input type="checkbox"/> Asthma		
<input type="checkbox"/> Bronchitis		
<input type="checkbox"/> Tuberculosis		
<input type="checkbox"/> Pneumonia		
<input type="checkbox"/> Chronic Cough or Shortness of Breath		
<input type="checkbox"/> Emphysema		
<input type="checkbox"/> Sleep Apnea		
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease		
<input type="checkbox"/> Other _____		
Skin Disease		
<input type="checkbox"/> Acne		
<input type="checkbox"/> Skin Cancer		
<input type="checkbox"/> Rosacea		
<input type="checkbox"/> Eczema		
<input type="checkbox"/> Psoriasis		
<input type="checkbox"/> Other _____		
Tumor/Cyst/Growth		
<input type="checkbox"/> Tumor		
<input type="checkbox"/> Cyst		
<input type="checkbox"/> Polyp		
<input type="checkbox"/> Growth		
<input type="checkbox"/> Other _____		
Ears/Eyes/Nose Disorders		
<input type="checkbox"/> Ear Infections		
<input type="checkbox"/> Ear Tubes		
<input type="checkbox"/> Hearing Loss		
<input type="checkbox"/> Speech/Hearing Impairment		
<input type="checkbox"/> Meniere's Disease		
<input type="checkbox"/> Tinnitus		
<input type="checkbox"/> Labyrinthitis		
<input type="checkbox"/> Tonsils/Adenoids		
<input type="checkbox"/> Deviated Septum		
<input type="checkbox"/> Cataracts		
<input type="checkbox"/> Glaucoma		
<input type="checkbox"/> Other _____		
Nervous System Disorders		
<input type="checkbox"/> Unconsciousness or Fainting Spells		
<input type="checkbox"/> Paralysis		
<input type="checkbox"/> Cerebral Palsy		
<input type="checkbox"/> Dementia or Alzheimer's		
<input type="checkbox"/> Vertigo or Dizziness		
<input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/> Bell's Palsy		

Medical Conditions List *(continued)*

Condition	Date Cond. Began	Person Being Treated/Treatment Provided
<input type="checkbox"/> Parkinson's Disease		
<input type="checkbox"/> Epilepsy/Seizures/Convulsions		
<input type="checkbox"/> Headaches/Migraines		
<input type="checkbox"/> Other _____		
Mental/Nervous Disorders		
<input type="checkbox"/> Psychiatric Treatment or Counseling		
<input type="checkbox"/> Anorexia		
<input type="checkbox"/> Psychosis		
<input type="checkbox"/> Anxiety		
<input type="checkbox"/> Bulimia		
<input type="checkbox"/> Panic Attacks		
<input type="checkbox"/> Learning or Behavior Disorder		
<input type="checkbox"/> Depression		
<input type="checkbox"/> Attention Deficit Disorder		
<input type="checkbox"/> Obsessive Compulsive Disorder		
<input type="checkbox"/> Psychoneurotic Disorders		
<input type="checkbox"/> Other _____		
Diagnostic Testing		
<input type="checkbox"/> EKG (Electrocardiogram)		
<input type="checkbox"/> Stress Test		
<input type="checkbox"/> CT Scan		
<input type="checkbox"/> Colonoscopy		
<input type="checkbox"/> EEG		
<input type="checkbox"/> Blood Test		
<input type="checkbox"/> Chest X-Ray		
<input type="checkbox"/> Angiogram		
<input type="checkbox"/> Ultrasound		
<input type="checkbox"/> EGD (Endoscopy)		
<input type="checkbox"/> Bone Density		
<input type="checkbox"/> Echocardiogram		
<input type="checkbox"/> MRI		
<input type="checkbox"/> Mammogram		
<input type="checkbox"/> Holter Monitor		
<input type="checkbox"/> Urinalysis		
<input type="checkbox"/> Other _____		
Congenital Disorders/Birth Defects/ Developmental Disorders		
<input type="checkbox"/> Down Syndrome		
<input type="checkbox"/> Cleft Lip/Palate		
<input type="checkbox"/> Speech Therapy		
<input type="checkbox"/> Mental Retardation		
<input type="checkbox"/> Club Foot		
<input type="checkbox"/> Occupational Therapy		
<input type="checkbox"/> Autism		
<input type="checkbox"/> Congenital Heart Defects		
<input type="checkbox"/> Physical Therapy		
<input type="checkbox"/> Other _____		



Notice of Privacy Policy and Insurance Information Practices

Your privacy is important to us. This notice is being provided to you pursuant to the requirements of federal and state laws and/or regulations addressing the privacy of nonpublic personal consumer information, which may include financial and health information. This notice details the privacy policy and insurance information practices of World Insurance Company, as it relates to your nonpublic personal information.

Information Collected – We may collect nonpublic personal information about you to provide and administer products and services. We collect information about you from a variety of sources, such as:

- Information we receive from you or through our affiliates or subsidiaries, producers or other individuals, on applications, forms or interviews, such as salary information or health history. We may also collect identifying information such as name, address, social security number and age.
- Information about your transactions with us, our affiliates, or others, such as information about insurance premium payments, coverage selections, and claims history.
- Information received from a third party or consumer reporting agency, such as creditworthiness and credit history, or motor vehicle driving record report.
- Information received from medical providers regarding treatment of health conditions and payment for that treatment.

Disclosure Policy – We may disclose the personal information we collect to service, process or administer business operations, as permitted by law. Examples of how we may disclose your information are as follows:

- To process your applications and issue your coverage.
- To pay your claims.
- To provide service, perform policy maintenance or make any coverage changes you may request.
- To offer products or services that may be of interest to you.

We may disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf or with whom we have joint marketing agreements. The agreements prohibit the third party from disclosing or using the information other than to carry out the function on our behalf for which the information was collected or disclosed.

We will not, however, disclose your health information for marketing purposes.

Financial information – We do not disclose nonpublic personal financial information about you to nonaffiliated third parties, except as permitted or required by law.

Health Information – We do not disclose nonpublic personal health information, other than as permitted or required by law, unless you specifically authorize us in writing in advance to release such information.

Fair Credit Reporting Act – We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law.

Confidentiality and Security – We restrict access to nonpublic personal information about you to those employees who need to know that information for a business purpose in order to provide products and services to you. We maintain physical, electronic, and procedural safeguards that comply with requirements to protect your nonpublic personal information. Additionally, we maintain policies about the proper physical security of workplaces and records.

Former Customers – We do not disclose nonpublic personal information about former customers except as permitted or required by law.

If you have any questions regarding this notice, please contact us at World Insurance Company, (800) 786-7557.

We reserve the right to change the privacy practices of World Insurance Company. If we do so, we will communicate any material changes to you as required by law.

This notice applies to all prospects, applicants, customers and former customers who have inquired about or purchased insurance products used primarily for personal, family or household purposes.



P.O. Box 3160
Omaha, NE 68103-0160
(402) 496-8000

Notice of Privacy Practices – Medical

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

You have a right to know how your medical information is used and shared by us. PLEASE READ THIS NOTICE. It explains how we use information about you and when we can share that information with others. This Notice applies to current and former insureds, as well as covered dependents. Whenever we use the word “you” and “your”, it applies to everyone covered under your policy.

Protected Health Information (“PHI”) means information that is about you or identifies you. It includes demographic information, as well as information about your past, present or future physical or mental health or condition, the provision of your health care or the past, present or future payment of your health care. It does not include employment records or educational records covered by the Family Educational rights and Privacy Act.

We are legally required to keep your PHI confidential and private. We must also provide you with this notice which explains our legal duties and privacy practices and abide by it. We reserve the right to change our privacy practices which will apply to all PHI we maintain. If we make material changes to our privacy practices, we will provide you a copy of our revised Notice of Privacy Practices. At least every three years, we will let you know how you can access our Notice of Privacy Practices. If two or more insureds are named on your insurance contract, we will send only one notice to the insureds.

Confidentiality and Security – We view the security of your confidential and private information as a top priority and we strive to maintain appropriate physical, electronic and procedural safeguards to protect it. Only employees who need your information to perform their jobs can access your information. Additionally, we train our work force on protecting your PHI.

USES AND DISCLOSURES OF PHI – We do not use or share your PHI without your valid authorization unless permitted or required by law. Your authorization must be in writing and we have a form available for your use. You may contact our Customer Service Department at the address listed at the bottom of this notice to obtain a valid authorization form.

Subject to state and federal laws, we are required or permitted to use and/or share your PHI without your authorization in certain circumstances, such as:

- To you, the subject of the PHI.

- To the U.S. Department of Health and Human Services for purposes of compliance with federal privacy rules.
- For your treatment, payment and/or health care operations. Examples of sharing for **treatment** purposes may be to provide a doctor or healthcare facility involved in your care information they request to assist in your care. Examples of **payment** purposes may be to collect premiums, determine eligibility for coverage, subrogation, billing activities, claims management, or disclosure to consumer reporting agencies. Examples of **health care operations** might include general administrative and business functions necessary for us to perform business such as underwriting, premium rating and other activities needed to issue, renew or replace an insurance policy.
- Persons assisting in your care and/or payment for care. If you are available and do not object, we may share your information with a family member, friend or someone involved with your care or payment for care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interest, we may share limited information without your approval.
- Required by law. We may use and/or share your information to the extent required to comply with the law.
- Public health activities. We may share your PHI with a public health authority that collects or receives information such as required reporting of disease, injury, birth or death and for required public health investigations.
- Reporting about victims of abuse, neglect or domestic violence. We may share PHI with a public health authority, governmental entity or agency if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect or domestic violence.
- Health oversight activities. We may use and/or share PHI for audits, investigations and inspections to government agencies that oversee the healthcare system, government programs, and civil rights laws.
- Judicial and administrative proceedings. We may use and/or share your PHI in the course of a judicial or administrative proceeding, order or a court or administrative tribunal and in response to a subpoena, discovery request or other lawful purposes.
- Law enforcement purposes. We may use and/or share your PHI for (1) lawful processes and otherwise required by law; (2) concerning crime victims; (3) suspicious deaths; (4) crimes on our premises; (5) reporting crimes in

Please leave with Proposed Insured in all cases

- emergencies; and (6) for the purposes of identifying or locating a suspect or other person.
- Information about decedents. We may use and/or share PHI with coroners and medical examiners to identify a deceased person, determine a cause of death, or as authorized by law. We may use and/or share PHI with funeral directors as necessary to carry out their duties.
 - Organ, eye or tissue donation purposes. We may use and/or share PHI with organ procurement organizations or other entities associated with the banking or transplantation of organs, eyes or tissues.
 - Avert a serious threat to health or safety. We may use and/or share PHI to prevent or lessen a serious and imminent threat to the health or safety of you or the public.
 - Specialized government functions. We may use and/or share PHI for military and veteran activities, national security and intelligence activities, protective services to the President or other authorized persons.
 - Workers' compensation. We may use and/or share PHI as necessary to comply with workers' compensation laws.

OTHER LAWS – If there is a law applicable to you that provides greater protection or greater rights regarding your PHI, we will comply with that law.

OTHER DISCLOSURES – We may disclose PHI to our business associates who help us conduct our business. They may not use or reuse your PHI except for providing the services we have contracted with them to perform on our behalf. Our business associates are also contractually obligated to maintain appropriate safeguards to protect PHI. Also, we may communicate directly with you about contract benefits or other covered products to enhance your current benefits.

Other disclosures require your valid authorization. Specific authorizations may be required for the release of psychotherapy notes and marketing with certain exceptions. You may revoke in writing any authorization you provide us.

YOUR RIGHTS

- You have the **right to request restrictions** on the use and disclosure of PHI in writing to carry out your treatment, payment or health care operations. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** Restriction forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to request confidential communications** from us by alternative means or at alternative locations. This request must be in writing. We will accommodate reasonable requests. Confidential Communication forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to inspect and copy your PHI** we maintain about you in our designated record set, with some exceptions, as defined by law. All requests must be made in writing and signed by your or your personal representative. Access request forms are available from our Customer Service Department at the address listed below.

- You have the **right to request an amendment** to certain components of your PHI to correct inaccuracies. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests must be in writing, signed by you or your personal representative, and must state the reasons for the requested amendment. Amendment request forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to receive an accounting of certain disclosures** made by us after April 14, 2003 of your personal health information. Please note that we are not required to provide you with an accounting of the information that was collected prior to April 14, 2003; used or disclosed for treatment, payment, and/or healthcare operations; disclosed to you or pursuant to your authorization; incidental to a use or disclosure otherwise permitted by law; disclosed for a facility's directory or to a person involved in your care or other notification purposes; disclosed for national security or intelligence purposes; disclosed to correctional institutions, law enforcement officials or health oversight agencies; used or disclosed as part of a limited data set for research, public health or health care purposes.

Your request must be made in writing and you can obtain an accounting request form from our Customer Service Department at the address listed below. The first accounting in any 12-month period is free of charge; however, a fee will be charged for any subsequent request for an accounting during that same time period.

- You have the **right to obtain a copy of this notice** upon request at any time. We are required to abide by the terms of this notice. We reserve the right to change our privacy practices and the terms of this notice at any time and to make the new notice effective for all protected health information we maintain. If we do revise this notice, a copy will be sent to you at the time of the change.

COMPLAINTS – You may file a written complaint if you believe your privacy rights have been violated by submitting your complaint to our Customer Service Department at the address listed below. You may also file your complaint directly to the Secretary of the U.S. Department of Health and Human Services. If you file a complaint, we will not retaliate against you for that action.

CONTACT INFORMATION – If you have any questions regarding this notice, please contact us at:
World Insurance Company
P.O. Box 3160
Omaha, NE 68103-0160
800-786-7557 (Monday through Friday 7:30 a.m. to 5:00 p.m., Central Time)

EFFECTIVE DATE – This notice is effective as of April 14, 2003 and thereafter until amended or revised by us.



P.O. Box 3160 • Omaha, NE 68103-0160