
Phone:
Fax:

Thank you for downloading an application.

Please complete and sign the application.

Option 1) If paying by: Check or Money Order:

- Make check and money order payable to:
World Insurance Company.
- Mail it to:

Option 2) If paying by C. O. D. : (You are Billed on receipt of policy.)

- Fax it to:
(Faxed applications are
processed the same day.)

OR

- Mail it to:

For all other inquires please call:
Or e-mail us at:



A. General Information (please print)

1. a. Member's Name (First, Middle, Last)
b. Address (No., Street)
c. City, State & ZIP
3. a. Member's Employer Address
b. Occupation/Title/Duties
2. For Telephone Interview
Best Phone No.
Place to Call
4. Spouse's Name (First, Middle, Last)
5. a. Spouse's Employer Address
b. Occupation/Title/Duties
6. Persons proposed for insurance.
7. a. Parent/Guardian (if child-only coverage)
8. a. Payor (if different from above)
9. Provide details under Additional Remarks in Section F for any questions answered "No".

B. Type of Coverage Requested

1. Name and Plan (Proposal must be attached to application when submitted):
Flex Advantage Type: PPO Traditional
Coinsurance: 100 80/20 70/30 50/50 Other
Deductible: 500 1000 1500 2500 5000 10000 Other
Options: Lifetime Maximum Increase Prescription Drug Copay Physician Office Copay
HDHP/HD Advantage
Value Advantage

Please complete if Life Benefit for Covered Member selected: (If no beneficiary is designated, benefit will be paid to the estate of the insured.)
Beneficiary (First, Middle Initial, Last)
Social Security No.
Relationship

If designated beneficiary is a minor (under 18), provide name of guardian who will hold proceeds in trust until beneficiary reaches age 18:

2. Name of PPO Selected:
3. Please check your choice of effective date of coverage:
4. Choice Dental (Dental proposal must be attached to application when submitted)
5. Payment Mode:
Payment of Initial Premium:

Administrative Use Only



6. 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? ..

C. Health Statement

1. Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? Yes No

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 or other 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 as having 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 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?

- 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, certificate 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.

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

30633
Agent Code

Date Signed

Wilev Lona
Printed Name of Agent

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 policyholder, please indicate the legal representative's authority to act on behalf of the policyholder.

Signature of Legal Representative

Authority

Date

Application for NCA Membership

I am applying for membership in the National Consumer Alliance Association (NCA). I represent that I am eligible for membership in NCA. My dues will be \$7.50 a month, or \$90 annually.

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

I am applying for:

NCA membership and World 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 insurance agent, who will forward it along with your World health insurance application. If you're not applying for health insurance, your agent will forward the membership form and fee alone.

NCA
National Consumer Alliance Association

THE WORLD FOR LESS

Your
NCA
Membership
Benefits

Health Insurance You Can Afford

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

Our health insurance is developed specifically for NCA members and families seeking quality health insurance at an affordable price.

To help you match coverage to your needs, World offers a variety of plan options.

World 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 product brochure and premium quote.

Discover Your Discounts

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

► **Healthy Options** – When shopping for new glasses, NCA members receive a **20%** discount on purchases, as well as a **10%** discount on eye exams and contact lenses at some LensCrafters outlets. Additional retail eyewear discounts, up to **50%**, are available for frames, single vision lenses, and bifocals at thousands of provider locations.

But the savings aren't limited to vision. There's also discounts of up to **60%** for quality hearing aids, and discounts on dental care expenses through more than **24,000** providers. NCA members don't have to deal with complicated claim forms, maximums or deductibles.

A variety of vitamin and nutritional supplements carry a **15%** discount, savings of up to **30%** can be realized for complementary and alternative medicinal services, such as acupuncture, massage therapy and nutritional counseling.

And if you just have a health-related question, you can call **24-hour Nurse Line**. This service provides unlimited access to registered nurses, via a toll-free number, 24 hours a day, 365 days a year.

► **Mobile Alternatives** – For your next trip, you'll find special savings when you rent from Alamo, Hertz, Avis or National car rental agencies.

► **Entertaining Ideas** – NCA membership makes family vacations and weekend getaways even better with savings of **50% on accommodations** at more than 3,100 hotels, motels, inns and resorts. You also have access to discounts on business and leisure travel, which includes cruises and motorcoach tours.

► **Business Choices** – Your business's bottom line will become even brighter when you save up to **36% on already discounted prices** on a large selection of office supplies. And if you happen to need financing assistance with office equipment, rebates and discounts are available through Lease Now, Inc.

For employment security, background reports and investigation services are available at discounted rates through an internationally renowned investigative and consulting company.

► **Insurance** – Another plus of NCA membership is **\$2,000** in accidental death and dismemberment insurance through a national provider. It's a benefit that provides additional security and savings to NCA members.

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 World individual health insurance, World offers short-term medical and dental 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

Please leave with Proposed Insured in all cases
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 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.