Benefits Manager, Inc

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 Benefits Manager, Inc for review along with the completed application. If you do not have access to a fax machine, send the completed application to Benefits Manager, Inc 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:

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creed Ln.
Layton, UT 84041

Benefits Manager, Inc 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 (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Benefits Manager, Inc

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:

Benefits Manager, Inc
FAX# (801)444-7389

Dear Benefits Manager, Inc,

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 Benefits Manager, Inc at (888)310-9623 to verify receipt of my application.

**I understand that Benefits Manager, Inc 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 Benefits Manager, Inc. I will mail the original signed application to :

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creed Ln.
Layton, UT 84041

I will send the original application as soon as I have been contacted by Benefits Manager, Inc with confirmation that my application has been received by fax and reviewed for completeness.

Signature: _____ Date: _____

WORLD INSURANCE

Application to World Insurance Company
P.O. Box 3160 • Omaha, NE 68103-0160

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 time to call ☐ AM ☐ PM

Best Place to Call ☐ Home (____) _____ Phone No. _____

☐ Work (____) _____ _____

3. a. Member's Employer Address

b. Occupation/Title/Duties

4. Spouse's Name *(First, Middle, Last)*

5. a. Spouse's Employer Address

b. Occupation/Title/Duties

6.

Persons proposed for insurance. List first, MI, and last names.	Relationship to member	Ht. ft., in.	Wt. lbs.	Birthdate Mo./Day/Yr.	Sex	Tobacco Use last 2 yrs. Yes	Tobacco Use last 2 yrs. No	Full-time Student Yes	Full-time Student No	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".*

	Yes	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*** *(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 ☐$10,000 ☐Other _____

Options: ☐Lifetime Maximum Increase ☐Prescription Drug Copay ☐Physician Office Copay

☐Accident Benefit ☐$500 ☐$1000 ☐Other _____

Life Benefit: *Member:* ☐$10,000 ☐$25,000 ☐$50,000 *Spouse:* ☐$10,000 ☐$25,000 ☐$50,000

HDHP/HD Advantage Coinsurance: ☐100 ☐80/20 ☐Other _____

Deductible: ☐*Individual:* Amount $ _____ ☐*Family:* Amount $ _____

Options: ☐_____ ☐_____

Value Advantage Coinsurance: ☐70/30 ☐50/50 ☐Other _____

Deductible: ☐$1000 ☐$1500 ☐$2500 ☐$5000 ☐$7500 ☐$10,000 ☐Other _____

Options: ☐Lifetime Maximum Increase ☐Benefit Increase Option ☐Accident Benefit ☐$500 ☐$1000

Life Benefit: *Member:* ☐$10,000 ☐$25,000 ☐$50,000 *Spouse:* ☐$10,000 ☐$25,000 ☐$50,000

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:*** ☐Underwriting Approval Date

☐Specified Future Date *(No sooner than 10 days after the application date.)* _____

4. ***Choice Dental*** **(Dental proposal must be attached to application when submitted)**

Annual Coverage Maximum: ☐$750 ☐$1000 ☐$1500 *Please list dependents (if applying for coverage) in Section A6.*

5. ***Payment Mode:*** ☐Annual ☐Semiannual ☐Quarterly ☐Check-O-Matic

☐List Bill *(If requesting a new list bill [if allowed in your state], the current list bill form is required.)*

$_____ Total Amount Submitted With Application *(The first full premium by mode and the application fee must be submitted with this application.)*

Payment of Initial Premium: ☐Credit Card (available only for monthly modes – first month only)

☐Check *(All checks must be made payable to World Insurance Company.)*

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

Yes No

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 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? ☐ ☐

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 _____

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

E. Medications

1. Within the past 3 years, has any person proposed for insurance taken any prescription, alternative, complementary, herbal or natural medications other than noted in Section D? *(If "yes", describe below)* ..... Yes ☐ No ☐
2. Within the past 1 year, has any person proposed for insurance taken any supplements, or over-the-counter medications for a period longer than 5 consecutive days? *(If 'yes', describe below)* ..... Yes ☐ No ☐

Ques. No.	Name of Person	Name of Medication	Dosage & Frequency of Medication	Illness or Condition Treated	Date Last Taken	Name & Address of Physician

F. Additional Remarks

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 certificate(s); and an intentional misrepresentation of material fact 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.

   I understand precertification of certain outpatient procedures and tests, as well as preadmission certification of all hospital admissions (emergency and non-emergency) is required. Any benefits which may be payable will be reduced according to the terms of the certificate, if precertification is not received.

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 certificate 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, 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

_____ TX58 _____
Signature of Agent — Agent Code — Date Signed

_Mike Oliphant _____
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

Agent Certification

Check Box 1 or 2.

☐ 1. I certify that during an in-person interview with the Member, I saw each person proposed for coverage, I have truly and accurately recorded in this application all the information supplied and have witnessed the signatures of the proposed insured(s).

☐ 2. If other than #1 above, explain in detail how the completion of the application differed from #1 and the reasons for the differences.

_____

_____

_____

_____

	Yes	No
3. Do you have any knowledge or reason to believe that replacement or duplication of existing insurance might be involved?	☐	☐
4. Have you reviewed the entire application for corrections or omissions?	☐	☐
5. Are you aware of any information, not recorded on the application, which might have a bearing on the insurability of any person proposed for insurance. (If yes, please list details below.)	☐	☐
6. Have you given the member the attached Fair Credit and M.I.B. notices?	☐	☐

Special requests, remarks and instructions: _____

_____

_____

_____

Mike Oliphant
Agent Name — Please Print

TX58
Agent Code

_____
Date

(888)310-9623
Agent Phone Number

_____
Agent Cell Phone Number

(801)444-7389
Agent Fax Number

mikeoliphant@benefitsmanager.r
Agent e-mail Address
Register @ www.worldsells.com to receive e-mail notification from World.

_____
Agent Signature

If you are not registered at www.worldsells.com, please do so today.
Registration on World's Virtual Home Office is quick and easy.
You can also log on to update your e-mail address if you are already registered.

Authorization to Charge Credit Card for Initial Premium

Available only for monthly modes. Not available in all states.

☐ **VISA** ☐ **MasterCard**

Credit Card Authorization: *I authorize World Insurance Company to bill my VISA/MASTERCARD account for full initial association dues, initial premium and application fee.*

Account Number					—					—					—				Exp. Date			/		

X_____ Date _____

Signature

Phone Number					—				—				

Authorization to Honor Checks Drawn by World Insurance Company

If you select the Check-O-Matic option, please complete the following:

I (we) hereby authorize World Insurance Company (World) to initiate debit entries to the account and depository (Depository) indicated below, to debit the same to such account. This authority is to remain in full force and effect until World and Depository have received written notification from me (or either of us) of its termination in such time and in such manner to afford World and Depository a reasonable opportunity to act on it.

I understand that the withdrawal will be made within 5 days of the effective date of my policy/certificate.

Signature of Payor _____ *Date Signed* _____

☐ **To begin Check-O-Matic withdrawals:**

Select a desired withdrawal date: *(1-28)* _____

Bank Name _____

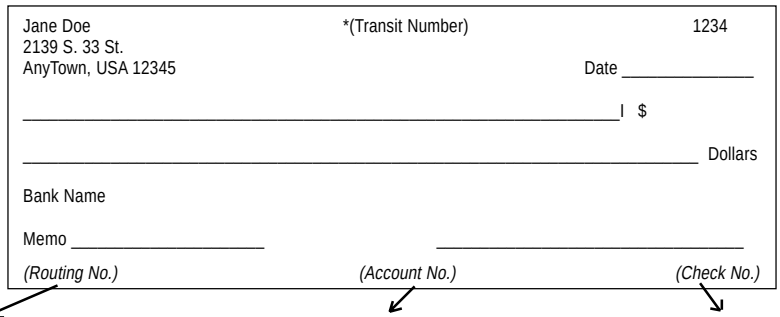
Address _____

City _____ State _____

☐ **To add this policy/certificate to an existing Check-O-Matic:**

Existing COM Number _____

Policy/Certificate Number _____



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

You must either submit a voided check, or complete the routing and account information. Do not send a deposit slip. Please print clearly.

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 certificates, 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

Tom D. Eilers

President

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

J1005 (2-04)

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 # TX58

Make checks payable to World Insurance Company

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