

Insurance Shoppers

Application Instructions For World Insurance - Brokerage

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

Mail completed application and check to:

Insurance Shoppers
Attn: New Enrollment
450 Hickory Street
Broomfield, CO 80020

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

Please contact us if you have any questions regarding the application or the application process. You may reach us at (866)747-7913 or e-mail us at jay@insuranceshoppers.net.

Insurance Shoppers

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:**

Insurance Shoppers

FAX# (303)439-9550

Dear Insurance Shoppers,

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 Insurance Shoppers at (866)747-7913 to verify receipt of my application.

****I understand that Insurance Shoppers 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 Insurance Shoppers. I will mail the original signed application to :

**Insurance Shoppers
Attn: New Enrollment
450 Hickory Street
Broomfield, CO 80020**

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

Signature: _____

Date: _____



A. General Information (please print)

1. a. Member's Name (First, Middle, Last)
b. Address (No., Street)
c. City, State & ZIP
2. For Telephone Interview
Best Phone #
Place Home ()
to Call 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 No, Full-time Student Yes 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".
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 Limited (Hospital/Surgical) Coinsurance: 100 80/20 60/40 Other
Deductible: \$500 \$1,000 \$1,500 \$2,500 \$5,000 \$10,000 Other
Options: Lifetime Maximum Increase Physician Office Copay Physician Office Copay/DXL Prescription Drug Copay
Outpatient Accident Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$3,000 \$5,000 Other
Outpatient Expense (Hosp/Surg only) Other
HD Advantage Type: PPO Traditional Coinsurance: 100 80/20 50/50 Other
Deductible: Individual: Amount \$ Family: Amount \$
Options: Lifetime Maximum Increase Comprehensive HSA Enhancement
Outpatient Accident Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$3,000 \$5,000 Other
Value Advantage Coinsurance: 70/30 50/50 Other
Deductible: \$1,000 \$1,500 \$2,500 \$5,000 \$7,500 \$10,000 Other
Options: Lifetime Maximum Increase Benefit Increase Option
Outpatient Accident Benefit: \$500 \$1,000 \$1,500 \$2,000 \$2,500 \$3,000 \$5,000 Other
2. Optional Life Benefit: (Available on all plans above)
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 # Relationship
If designated beneficiary is a minor (under 18), provide name of guardian who will hold proceeds in trust until beneficiary reaches age 18:
3. Name of PPO Selected:
4. Please check your choice of effective date of coverage: Underwriting Approval Date
Specified Future Date (1st - 28th - no sooner than 10 days after the application date.)
5. Payment Mode: Direct Bill - Annual Semiannual Quarterly Monthly - Check-O-Matic Credit Card
List Bill (If allowed in your state, current list bill form is required. Submit application fee only for initial premium on list bills.)
Payment of Initial Premium: Check Credit Card (available only for monthly modes)
\$ Total Amount Submitted with Application (The first full premium by mode and application fee must be submitted.)

Administrative Use Only



6. 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"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? <input type="checkbox"/> None <input type="checkbox"/> Gained _____ lbs. <input type="checkbox"/> Lost _____ lbs. | | |
| Cause of weight change <input type="checkbox"/> Self-diet <input type="checkbox"/> Physician Recommended <input type="checkbox"/> Unknown <input type="checkbox"/> 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.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 4. Has any person proposed for insurance: | | |
| a. ever been declined, postponed, ridered, or charged an extra premium for insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. ever been convicted of a felony? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. ever been evaluated or treated for alcoholism, frequently used alcoholic beverages to excess or intoxication, or been advised to modify drinking habits for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. ever had surgery or diagnostic testing or treatment, or has surgery or diagnostic testing been recommended or scheduled that has not been completed? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. ever had, been diagnosed or treated by a physician for any immune system disorder, including AIDS/ARC or positive HIV or HIV-related test disclosure limited to FDA-licensed blood test? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. ever received disability benefits or currently disabled? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. in the past 10 years been in a hospital, clinic, or other medical facility for treatment, confinement or observation? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. in the past 5 years participated in any racing, scuba diving, skydiving, rock climbing or any other hazardous activities? | <input type="checkbox"/> | <input type="checkbox"/> |
| k. in the past 5 years flown or plan to fly in the future, as a pilot or crew member? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. in the past 5 years had his/her driver's license suspended or revoked? | <input type="checkbox"/> | <input type="checkbox"/> |

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? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. congenital disorder, birth defects or developmental disorders, including, but not limited to: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> mental retardation <input type="checkbox"/> autism <input type="checkbox"/> cleft palate <input type="checkbox"/> club foot | | |
| <input type="checkbox"/> congenital heart defects <input type="checkbox"/> other _____ | | |
| c. the respiratory system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> allergies <input type="checkbox"/> asthma <input type="checkbox"/> pneumonia <input type="checkbox"/> emphysema <input type="checkbox"/> bronchitis | | |
| <input type="checkbox"/> shortness of breath <input type="checkbox"/> chronic cough <input type="checkbox"/> apnea <input type="checkbox"/> sinusitis <input type="checkbox"/> tuberculosis | | |
| <input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> other _____ | | |
| d. the circulatory system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> heart disease <input type="checkbox"/> heart defect <input type="checkbox"/> heart condition <input type="checkbox"/> mitral valve prolapse | | |
| <input type="checkbox"/> heart attack <input type="checkbox"/> chest pain <input type="checkbox"/> varicose veins <input type="checkbox"/> high blood pressure (hypertension) | | |
| <input type="checkbox"/> phlebitis <input type="checkbox"/> murmur <input type="checkbox"/> aneurysm <input type="checkbox"/> elevated cholesterol or triglycerides | | |
| <input type="checkbox"/> Raynaud's Disease <input type="checkbox"/> stroke, TIA <input type="checkbox"/> palpitations/irregular heartbeat | | |
| <input type="checkbox"/> Raynaud's Phenomenon <input type="checkbox"/> other _____ | | |
| e. the digestive system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> ulcer <input type="checkbox"/> esophagus <input type="checkbox"/> colitis <input type="checkbox"/> hepatitis, jaundice, or cirrhosis | | |
| <input type="checkbox"/> gall bladder <input type="checkbox"/> bowel <input type="checkbox"/> polyps <input type="checkbox"/> diverticulitis, diverticulosis | | |
| <input type="checkbox"/> gastritis <input type="checkbox"/> stomach <input type="checkbox"/> rectum <input type="checkbox"/> disorder of pancreas, spleen, liver | | |
| <input type="checkbox"/> hernia <input type="checkbox"/> intestinal disorder <input type="checkbox"/> hemorrhoids <input type="checkbox"/> other _____ | | |
| f. the nervous system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> epilepsy <input type="checkbox"/> seizure <input type="checkbox"/> headaches <input type="checkbox"/> Alzheimers <input type="checkbox"/> Parkinson's disease | | |
| <input type="checkbox"/> dizziness <input type="checkbox"/> fainting spells <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Multiple Sclerosis | | |
| <input type="checkbox"/> convulsions <input type="checkbox"/> paralysis <input type="checkbox"/> dementia <input type="checkbox"/> other _____ | | |
| g. a mental or nervous disorder, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> anxiety <input type="checkbox"/> A.D.D./A.D.H.D. <input type="checkbox"/> eating disorder <input type="checkbox"/> learning/behavior disorder | | |
| <input type="checkbox"/> psychiatric treatment or counseling <input type="checkbox"/> depression <input type="checkbox"/> psychosis | | |
| <input type="checkbox"/> other _____ | | |
| h. the genitourinary system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> prostate <input type="checkbox"/> kidney disorder or stones <input type="checkbox"/> urinary incontinence | | |
| <input type="checkbox"/> urinary tract infection <input type="checkbox"/> bladder <input type="checkbox"/> other _____ | | |
| i. the endocrine system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> diabetes <input type="checkbox"/> goiter <input type="checkbox"/> thyroid gland <input type="checkbox"/> high or low blood sugar | | |
| <input type="checkbox"/> glandular disorder <input type="checkbox"/> pituitary disorder <input type="checkbox"/> other _____ | | |
| j. the musculoskeletal system, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> arthritis <input type="checkbox"/> gout <input type="checkbox"/> TMJ/jaw problems <input type="checkbox"/> lupus erythematosus <input type="checkbox"/> rheumatism | | |
| <input type="checkbox"/> subluxation <input type="checkbox"/> physical handicap <input type="checkbox"/> fibromyalgia <input type="checkbox"/> loss of limb <input type="checkbox"/> knees | | |
| <input type="checkbox"/> the back, spine, or muscles <input type="checkbox"/> other _____ | | |
| k. cancer, tumors, cysts, growths or breast disorders? (Provide location, type and treatment received.) | <input type="checkbox"/> | <input type="checkbox"/> |
| l. skin disorder/problems, such as psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, or acne? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. the eyes, ears, nose, or throat, such as cataracts, glaucoma, speech or hearing impairment, otitis media or ear tubes? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. any disease or disorder of female/male reproductive systems or genitalia, including: | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> ovaries <input type="checkbox"/> impotency <input type="checkbox"/> reproductive organ <input type="checkbox"/> irregular menstruation | | |
| <input type="checkbox"/> infertility <input type="checkbox"/> uterus/cervix <input type="checkbox"/> premenstrual syndrome (PMS) | | |
| <input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> other _____ | | |

6. Questions for female applicants only.

- | | | |
|--|--------------------------|--------------------------|
| a. Any complications of pregnancy, including, but not limited to, caesarean section delivery or miscarriage? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |

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?
- Yes No
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?
- Yes No

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. #	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. #	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 policy(ies) and any incomplete, incorrect or misleading answers may be used to void any insurance provided to me and my dependents.
I understand that I (or the individual purchasing insurance for child-only coverage) and my spouse must both be between the ages of 16 and 64 to apply for insurance.
2. I understand no insurance exists unless and until a policy is delivered by World Insurance Company and accepted by me indicating coverage for myself and my dependents and the effective date. 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 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 policy 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 policy, during the period the policy 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.
 - b. 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 policy benefits, exclusions and limitations.
 - c. Any disputes arising under the policy are subject to an appeals procedure.
 - d. 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.

5. Self-Employed Business Group of One Determination (To be completed by all applicants.)

- | | <u>Yes</u> | <u>No</u> |
|--|--------------------------|--------------------------|
| 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

After consideration, it is my decision to waive coverage under the World Insurance Company Policy for the family member(s).

Authorization to obtain Information:

I hereby authorize any of the following to give to World Insurance Company or its reinsurers any information regarding me or my family as to employment, other insurance coverage, personal information, and medical care, advice or treatment: physician; medical practitioner, hospital; pharmacy; pharmacy benefit managers; clinic; any medical or medically-related facility; insurance company; my current agent and general agent; the Medical Information Bureau; employer; consumer reporting agency; or the Veterans Administration.

Medical Information includes any information with respect to any physical or medical condition and/or treatment (including psychiatric, drug or alcohol abuse treatment) of me, my spouse or my minor children.

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

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

The undersigned represents to the best of his or her knowledge and belief that all statements contained herein are complete and true. Under the penalties of perjury; I/we certify that the Social Security Number(s) provided are true, correct and complete.

The statements and answers set forth in this application, and in any supplement(s) attached to it, are, to the best of my knowledge and belief true, complete and correctly recorded, and shall form the basis of any policy that is issued.

Signature of Proposed Insured Date Signed

Signature of Spouse (if applying for coverage) Date Signed

Signature of Proposed Insured (if other than Parent or Legal Guardian for child-only coverage) Date Signed

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

Application dated at (City, State)

I, _____, acting on behalf of World Insurance Company, certify that the marketing and sale of the individual health policy complies with all of the provisions of Colorado's regulation concerning the sale of individual coverage to a business group of one. If this is not the case, I understand that the policy may be regulated as a small group policy. I further certify that I provided the applicant with a copy of the Standard Health Plans Description and the Colorado Health Plan Description for the plan applied for.

Signature of Agent 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.

- | | | |
|---|--------------------------|--------------------------|
| 3. Do you have any knowledge or reason to believe that replacement or duplication of existing insurance might be involved? | <u>Yes</u> | <u>No</u> |
| 4. Have you reviewed the entire application for corrections or omissions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you given the member the attached Fair Credit and M.I.B. notices? | <input type="checkbox"/> | <input type="checkbox"/> |

Special requests, remarks and instructions: _____

Jay Norris	TXZ09	
Agent Name — Please Print	Agent Code	Date

(866)747-7913		(303)439-9550
Agent Phone Number	Agent Cell Phone Number	Agent Fax Number

jay@insuranceshoppers.net

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.*



P.O. Box 3160
OMAHA, NEBRASKA 68103-0160

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by World Insurance Company. Your new policy will provide a 10-day free look period, within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Other (please specify) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer _____

Name and Address of Producer _____

Applicant's Signature _____

Date _____

M1037-CO (7-01)

(Rev. 8-05)

Notice to Agent: If applicable, have the proposed insured complete this page and the following page. Please submit this page with the application for insurance. Disregard completing this form if not applicable.

Submit with application for insurance.



* M 1 0 3 7 - C O *



P.O. Box 3160
OMAHA, NEBRASKA 68103-0160

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by World Insurance Company. Your new policy will provide a 10-day free look period, within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:

I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (*check one*):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Other (*please specify*) _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer _____

Name and Address of Producer _____

Applicant's Signature _____

Date _____

M1037-CO (7-01)

(Rev. 8-05)

Notice to Agent: If applicable, have the proposed insured complete this page and the following page. Please submit this page with the application for insurance. Disregard completing this form if not applicable.

Leave with the proposed insured.



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.

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 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 Agent/Broker _____

Date _____ Agent # **TXZ09**

PERSONAL PROFILE INTERVIEW

Please call 800-846-9981 for your Personal Profile Interview. The hours available to complete your Interview are Monday thru Friday 7 a.m. to 9 p.m. and Saturday 9 a.m. to 3 p.m. (Central Time).

Make checks payable to World Insurance Company

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

Completing Your Personal Profile Interview

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 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 800-846-9981, Monday through Friday between 7 a.m. and 9 p.m., Central Time, or Saturday, between 9 a.m. and 3 p.m.

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"™



Notice of Privacy Certificate 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 certificate 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 Certificate – 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 certificate 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.



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 certificate.

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 certificate.
- 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 emergencies; and (6) for the purposes of identifying or locating a suspect or other person.

Please leave with Proposed Insured in all cases

- 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 you 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.