WORLD INSURANCE
Omaha, Nebraska

Authorization to Disclose Premium Information to Employer

(Applicable if Premium Payment Mode is List Bill.)

I authorize World Insurance Company (herein called World) to disclose my monthly premium information to my employer so that premium can be remitted to World under the List Bill program. I understand that I do not have to authorize this disclosure. Issuance of coverage will not be conditioned upon the signing of this authorization. However, I understand if I elect not to sign this authorization, my premiums cannot be remitted through my employer and I will be responsible for remitting my premium to World.

I understand that I have the right to revoke this authorization at any time except to the extent World has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103-0160. I agree that a photographic copy of this authorization is as valid as the original.

I understand that this authorization will expire on the earliest of the following: (1) the date my coverage terminates and all applicable premiums have been collected or returned; (2) the date World is notified by my employer to no longer remit my premium information; or (3) the date I notify World that I no longer wish my employer to received premium information.

I acknowledge that I, or my personal representative, am entitled to, and have received, a copy of this form.

After carefully reviewing this authorization, I have decided to voluntarily sign it.

_____ _____
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*

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I, *(Personal Representative(s) – please print)* _____ , hereby certify and attest that I am the duly authorized personal representative of *(Person(s) to be Insured – please print)* _____ , _____ , _____ _____ , _____ . My relationship to the person(s) to be insured is *(Parent, Guardian, Legal Custodian, Power of Attorney, etc.)* _____ . I have the lawful authority to enter into this authorization on behalf of the person(s) to be insured. I have read the provisions in this Authorization. I agree that the Company may use the information obtained about the person(s) to be insured for the purposes set forth herein.

X _____ _____
Signature of Personal Representative(s) *Printed Name of Personal Representative(s)*