



Omaha, Nebraska

# 1 2 3

## Montana Application Packet

**G4800W-MT Pkt**

**06 135 4800 020110 MT**

06 135 2571 0210 MT

*This state does not require  
association membership.*

# Application for Health Insurance

**Instructions:** The information in this application will be used to determine the applicant's eligibility for health insurance and allows selection of payment method. Applications must be submitted by or on behalf of the customer. If additional space is needed, please have applicant include a separate sheet and sign, date and attach to this application.

Please include the following completed forms with the application.

- Software Proposal – An accurate proposal is required.** This will identify which plan/PPO network/options are being applied for. (If applying for Dental Coverage under Master Policy AM3200, please include on the proposal. Please include correct premium for Dental Coverage.)
- Application for Insurance** – Applicant must answer all questions. Applicant and agent signature is required.
- HIPAA Compliant Authorization to Obtain Information** – Applicant must read and sign form.
- Authorization to Charge Credit Card OR Bank Draft** – Applicant completes if electing to pay with credit card or Bank Draft. Must include a voided check if electing Bank Draft.
- Initial Premium** – Including any fees, if applicable.
- State Mandated Forms** – If applicable.

Utilize the following materials on [www.worldsells.com](http://www.worldsells.com):

- Health Underwriting Guide – W1282

Have any questions about completing the application? Call your General Agent or our toll-free number at 800-733-5454. Product and Marketing questions should be directed to your General Agent or our Marketing Hot Line at 800-995-9010.



<b>To be completed by Agent</b>
Agent #

<b>Complete &amp; Submit</b>
<i>Home Office Use Only</i>
Application #

**A. General Information** (please print)

**1. Your Information**

Name (First, Middle, Last) \_\_\_\_\_

Address (Street, City, State, ZIP) \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Best Time to Call: AM PM Home Work Cell

Email Address (It may be used to send you important notices.) \_\_\_\_\_

Employer (Name, Street, City, State, ZIP) \_\_\_\_\_

Occupation/Duties \_\_\_\_\_ Work Phone Number \_\_\_\_\_

If unemployed or employed part-time, are you seeking full-time employment? ..... Yes No

Driver's License Number/State \_\_\_\_\_

**2. Your Spouse's Information** (where different)

Name (First, Middle, Last) \_\_\_\_\_

Address (Street, City, State, ZIP) \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Best Time to Call: AM PM Home Work Cell

Email Address (It may be used to send you important notices.) \_\_\_\_\_

Employer (Name, Street, City, State, ZIP) \_\_\_\_\_

Occupation/Duties \_\_\_\_\_ Work Phone Number \_\_\_\_\_

If unemployed or employed part-time, are you seeking full-time employment? ..... Yes No

Driver's License Number/State \_\_\_\_\_

3. Persons proposed for insurance. <i>List first, MI, and last names.</i>	Birthdate Mo./Day/Yr.	State of Birth	Ht. ft., in.	Wt. lbs.	Sex	Full-time Student	Social Security Number
You					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	

**4. Residency Information**

- a. Do all people requesting coverage live in the same household?..... Yes No
- b. Are all of you U.S. citizens, have established permanent resident status, and have been in the U.S. a minimum of two years? ... Yes No
- If "No" to a. or b., explain:** \_\_\_\_\_
- c. Are any of you planning to live, work or attend school outside the U.S. for more than 60 consecutive days?..... Yes No
- If "Yes" to c., explain:** \_\_\_\_\_

**5. Please complete if Life Benefit selected:**

Beneficiary (First, Middle Initial, Last) _____	Address (Street, City, State, ZIP Code) _____	Social Security Number _____	Relationship _____
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**B. HIPAA Eligible Individual Determination**

**You may be eligible for guaranteed issue health coverage if you qualify under the rules of the Health Insurance Portability and Accountability Act (HIPAA). The information you provide in this section will help determine whether you qualify under HIPAA. Please answer the following questions for all applicants.**

- Was there any period of 63 days or more during the past 18 months when you were not continuously covered by group or individual health insurance, Medicare, Medicaid or any other health insurance?..... Yes No
- If you answered "Yes" to question 1, were you offered coverage under COBRA or a similar state program, and
  - refused coverage? ..... Yes No
  - were not covered through COBRA for the full allowable period of coverage available?..... Yes No
  - are presently eligible for such coverage? ..... Yes No
- Are you presently eligible for, or will you be eligible for health coverage provided by an employer? ..... Yes No
- Was your most recent health insurance coverage terminated for non-payment of premium, misrepresentation or fraud?..... Yes No
- Do you currently have health insurance in force? ..... Yes No
- Was your most recent health insurance coverage through an employer-sponsored group plan? ..... Yes No

**If you answered "No" to questions 1-5, and "Yes" to question 6, you meet the definition of an Eligible Individual.**

- I elect to apply as a HIPAA Eligible Individual and understand the rates for this plan will be substantially higher than underwritten-plan rates.
- I am a HIPAA Eligible Individual, but elect to be underwritten and waive any available rights as an Eligible Individual. I understand I will be subject to pre-existing condition exclusions.

**C. General Medical Overview**

1. **Within the past 5 years**, have you or any applicant been treated for, been diagnosed as having, or had symptoms of any of the following medical conditions?
  - a. Heart attack, angina, congestive heart failure, heart surgery, bypass or angioplasty? ..... Yes No
  - b. Rheumatoid arthritis, connective tissue disorders or psoriatic arthritis? ..... Yes No
  - c. Addison's Disease, Cushing's Syndrome or pheochromocytoma (tumor of the adrenal gland)? ..... Yes No
  - d. Diabetes, including hyperglycemia, insulin resistance or impaired glucose tolerance? ..... Yes No
  - e. Inflammatory bowel disease including ulcerative colitis or Crohn's disease?..... Yes No
  - f. Chronic obstructive pulmonary disease (COPD) requiring oxygen, emphysema requiring oxygen or cystic fibrosis?..... Yes No
  - g. Schizophrenia, psychoses, Alzheimer's disease or dementias?..... Yes No
  - h. Stroke/TIA, Parkinson's disease? ..... Yes No
  - i. Liver failure, kidney failure/dialysis? ..... Yes No
  - j. Amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), muscular dystrophy (MD) or lupus (systemic)? ..... Yes No
  - k. Major organ transplant, including heart, lung, kidney or liver?..... Yes No
  - l. Cancer including, but not limited to, cancer of any organ, melanoma, sarcoma, leukemia, Hodgkin's or other lymphoma, but excluding basal or squamous cell skin cancers? ..... Yes No
2. Are any of you now pregnant, an expectant father, in the process of adopting a child, or planning to serve as a surrogate? .... Yes No
3. Are any of you eligible for Medicare due to a disability? ..... Yes No
4. a. Have you or any applicant ever been diagnosed as having, or been treated by a member of the medical profession as having AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or any other disease or disorder of the immune system? ..... Yes No
  - b. Have you or any applicant ever tested positive for AIDS/HIV (limited to FDA licensed tests)? ..... Yes No

**Note: Applicant(s) who answers "Yes" to any questions in this section is not eligible for coverage. Please indicate individual(s):** \_\_\_\_\_

**D. Comprehensive Medical and Additional History**

Please indicate "YES" or "NO" for each category. If you answer "YES", check (✓) the applicable condition and provide details in the space provided in the Explanation of Health Section. Categories do not necessarily include all the conditions related to that category, so please indicate "Other" for any conditions not listed.

**Within the last 10 years**, have you or any applicant been treated for, diagnosed with or had symptoms of any of the following:

1. **Ears/Eyes/Nose/Throat** ..... Yes No
 

<input type="checkbox"/> Ear infections/otitis	<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Double vision	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Rhinitis
<input type="checkbox"/> Meniere's disease	<input type="checkbox"/> Strabismus/lazy eye	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Optic Neuritis
<input type="checkbox"/> Ear tubes	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma/Increased eye pressure	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Enlarged tonsils/Adenoids	<input type="checkbox"/> Tonsillitis		<input type="checkbox"/> Other _____
2. **Lungs and Respiratory** ..... Yes No
 

<input type="checkbox"/> Allergic rhinitis	<input type="checkbox"/> Reactive airway disease	<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Chronic obstructive pulmonary disease
<input type="checkbox"/> Allergic sinusitis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sleep apnea	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chronic cough		
3. **Heart/Circulatory** ..... Yes No
 

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heart surgery (stent placement, coronary artery bypass, angioplasty, valve)	<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> Claudication
<input type="checkbox"/> Heart valve disorders	<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> High lipid (cholesterol or triglycerides)
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Angina	<input type="checkbox"/> Edema	<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Aneurysm	
<input type="checkbox"/> Irregular heart beat			
4. **Blood/Lymph/Anemia** ..... Yes No
 

<input type="checkbox"/> Anemia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hyperglycemia (high blood sugar)		
5. **Digestive** ..... Yes No
 

<input type="checkbox"/> Esophagitis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Gastric reflux/GERD	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hernia	<input type="checkbox"/> Recurrent indigestion	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Chronic diarrhea	
6. **Liver/Gallbladder/Pancreas** ..... Yes No
 

<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Fatty liver	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Spleen/pancreas disease	
7. **Urologic/Kidney/Bladder** ..... Yes No
 

<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Overactive bladder	<input type="checkbox"/> Interstitial cystitis	<input type="checkbox"/> Nephritis
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Pyelonephritis	<input type="checkbox"/> Other _____

**D. Comprehensive Medical and Additional History (Cont'd.)**

**8. Reproductive/Breast** .....  Yes  No

<input type="checkbox"/> Prostate disorder	<input type="checkbox"/> Ovarian disorders	<input type="checkbox"/> Cesarean section delivery	<input type="checkbox"/> Menstrual disorders
<input type="checkbox"/> Impotence	<input type="checkbox"/> Infertility	<input type="checkbox"/> Breast cysts/lumps	(painful, excessive or
<input type="checkbox"/> Abnormal Prostate Specific Antigen (PSA)	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Abnormal mammogram	irregular bleeding
<input type="checkbox"/> Abnormal PAP smear	<input type="checkbox"/> Complications of pregnancy	<input type="checkbox"/> Gynecomastia	<input type="checkbox"/> Other _____
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Human papillomavirus (HPV)	<input type="checkbox"/> Endometriosis	
	<input type="checkbox"/> Mastitis		

**9. Skin** .....  Yes  No

<input type="checkbox"/> Acne/rosacea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Shingles	<input type="checkbox"/> Keratosis
<input type="checkbox"/> Hemangioma	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Other _____

**10. Bone/Muscular/Connective Tissue** .....  Yes  No

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Sciatica
<input type="checkbox"/> Gout	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Curvature subluxation	<input type="checkbox"/> Fracture(s)
<input type="checkbox"/> Back/spine conditions	<input type="checkbox"/> Back pain	<input type="checkbox"/> Osteopenia/osteoporosis	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Herniated, bulging or degenerative discs	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Other _____
	<input type="checkbox"/> Degenerative joint disease	<input type="checkbox"/> Muscular pain	

**11. Prosthetic Devices/Plates, Pins, Screws** .....  Yes  No

<input type="checkbox"/> Plates, pins, screws	<input type="checkbox"/> Artificial limb	<input type="checkbox"/> Shunts	<input type="checkbox"/> Other _____
<input type="checkbox"/> Rods	<input type="checkbox"/> Pacemakers	<input type="checkbox"/> Valve/joint replacement	

**12. Nervous System** .....  Yes  No

<input type="checkbox"/> Dizziness/syncope	<input type="checkbox"/> Restless leg syndrome	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Epilepsy	
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Tourette's syndrome	
<input type="checkbox"/> Muscular weakness	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Convulsions	

**13. Endocrine/Thyroid** .....  Yes  No

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> High blood sugar	<input type="checkbox"/> Impaired glucose tolerance
<input type="checkbox"/> Goiter	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Insulin resistance	<input type="checkbox"/> Other _____

**14. Cancer/Tumors** .....  Yes  No

<input type="checkbox"/> Of internal organ	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> Adenoma	<input type="checkbox"/> Breast cancer
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sarcoma	<input type="checkbox"/> Basal or squamous cell skin cancer	<input type="checkbox"/> Neoplasm
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other lymphoma		<input type="checkbox"/> Other _____

**15. Psychological** .....  Yes  No

<input type="checkbox"/> Emotional disorder	<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Bipolar (manic depression)	<input type="checkbox"/> Obsessive compulsive disorder
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Psychiatric treatment or counseling	<input type="checkbox"/> Other _____
<input type="checkbox"/> Depression	<input type="checkbox"/> Chemical imbalance		

**16. Congenital Disorders/Birth Defects/Developmental Disorders** .....  Yes  No

<input type="checkbox"/> Down's syndrome	<input type="checkbox"/> Autism	<input type="checkbox"/> Cleft lip/palate	<input type="checkbox"/> Speech impairment
<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Club foot	<input type="checkbox"/> Delayed development	<input type="checkbox"/> Other _____

**17. Other Conditions**

a. In the past 10 years, have you or any applicant required an emergency room visit, hospital stay, surgery, or treatment?  Yes  No

b. In the past 10 years, have you or any applicant been recommended to have surgery or to receive treatment from a physician, chiropractor or other practitioner? .....  Yes  No

c. Do you or any applicant have any medical conditions/symptoms for which you have not seen a health care provider? ...  Yes  No

d. Have you or any applicant had any tests or procedures recommended that have not yet been performed? .....  Yes  No

**18. Medication Use**

a. Have you or any applicant taken or been recommended to take any prescription medication in the last 2 years? .....  Yes  No

b. In the last two years have you or any applicant taken any herbal or over-the-counter medication more often than once a week? .....  Yes  No

**19. Substance Abuse/Advice to Reduce or Eliminate Use**

a. In the past 5 years, have you or any applicant 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? .....  Yes  No

b. In the past 5 years, have you or any applicant ever used non-prescribed sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency? .....  Yes  No

**20. Tobacco Use**

In the past 12 months, has anyone used cigarettes, cigars, pipes, oral tobacco or nicotine replacements? .....  Yes  No

If "YES", list name(s): \_\_\_\_\_

**21. High Risk Activities**

In the past 2 years, has anyone participated in hazardous activities, including activities like hang-gliding, scuba diving, rodeoing or racing (including automobile, motorcycle, etc.)? .....  Yes  No

If "YES", list name(s): \_\_\_\_\_

Activity: \_\_\_\_\_ Frequency: \_\_\_\_\_

**D. Comprehensive Medical and Additional History (Cont'd.)**

**22. Driving Violations**

In the past 2 years, has anyone been convicted of any driving violation, including DUI, DWI, license suspension or revocation, or 3 or more speeding violations?..... Yes No

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Violation \_\_\_\_\_

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Violation \_\_\_\_\_

**23. Insurance Declination**

In the past 5 years, has anyone's health insurance been declined, rescinded, rated or issued with waivers?..... Yes No

Name(s) \_\_\_\_\_

Insurance Company(ies) \_\_\_\_\_ Date(s) \_\_\_\_\_

Reason(s) \_\_\_\_\_ Details \_\_\_\_\_

**24. Complete ONLY if applying for Critical Illness/Cancer Care**

Has any applicant's biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age 55 with any of the following: diabetes, heart disease, stroke, kidney disease, internal cancer or MS, Alzheimer's, Parkinson's? ..... Yes No

Name	Family member's relationship	Condition	Age at onset	Current age/ Age at death

**Explanation of Health**

Provide details for all questions 1 through 19 with "YES" answers. If you need additional space, please include a separate sheet and sign, date and attach to this application.

a. Name	Medical Condition	Date of Onset
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Dates of Treatment	Treatment ( <i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i> )
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Physician's Name	Physician's Location (City/State)	Phone Number
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b. Name	Medical Condition	Date of Onset
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Dates of Treatment	Treatment ( <i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i> )
--------------------	---

Physician's Name	Physician's Location (City/State)	Phone Number
------------------	-----------------------------------	--------------

c. Name	Medical Condition	Date of Onset
---------	-------------------	---------------

Dates of Treatment	Treatment ( <i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i> )
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Physician's Name	Physician's Location (City/State)	Phone Number
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d. Name	Medical Condition	Date of Onset
---------	-------------------	---------------

Dates of Treatment	Treatment ( <i>prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery</i> )
--------------------	---

Physician's Name	Physician's Location (City/State)	Phone Number
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**Physician Information**

Name of Primary Physician	Location City/State	Phone Number	Date Last Seen	Reason for Visit	Results
Primary					
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Please add any additional information you feel will be helpful in evaluating your application on a separate sheet and sign, date and attach to this application.

**E. Other Coverage**

1. Is any person applying for coverage covered by another plan? .....  Yes  No  
 If "Yes", list name(s): \_\_\_\_\_  
 If "Yes", check all that apply:  COBRA  Individual  Medicare/Medicaid  Other Coverage \_\_\_\_\_
2. Will the plan applied for replace the existing coverage(s)? .....  Yes  No  
 Effective date of other coverage(s): \_\_\_\_\_  
 Paid-to-date(s) or expected termination date(s) of their coverage(s): \_\_\_\_\_  
 \_\_\_\_\_  
 Name(s), policy number(s) and telephone number(s) of other carrier(s): \_\_\_\_\_  
 \_\_\_\_\_

**Please Note: Other coverage should not be terminated until a new policy is issued and accepted.**

**Please Read, Sign and Date**

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a policy is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- Any false statement or misrepresentation may result in loss or reduction of coverage or an increase in premium.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- I must tell the Company if the health of any applicant changes prior to delivery of the policy.
- The policy, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the policy is issued.
- Health conditions present before the application is signed will be covered only if listed on this application and not excluded from coverage.
- I will be informed of the status of coverage within 90 days.

I represent 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.

**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.**

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
(City/State) (Date) (Month) (Year)

**X** \_\_\_\_\_  
*Your Signature*

**X** \_\_\_\_\_  
*Your Spouse's Signature, if applying*

**X** \_\_\_\_\_  
*Dependent's Signature, if 18 or older*

**X** \_\_\_\_\_  
*Dependent's Signature, if 18 or older*

**X** \_\_\_\_\_  
*Dependent's Signature, if 18 or older*

**Please Complete for Applicant Demographics**

Business Name \_\_\_\_\_ Business Phone Number \_\_\_\_\_

Business Address (Street, City, State, ZIP) \_\_\_\_\_

Type of Business \_\_\_\_\_ Number of Employees \_\_\_\_\_

**For Agent Use Only**

I certify that the answers given to the foregoing questions in this application were provided by the applicant and accurately recorded. I have no information to add to the application that could affect the acceptance or rejection of the risk. I have provided the applicant with the Special Notice Federal Fair Credit Report Act and an outline of coverage where required.

Are you aware of any information, not recorded on the application, which might have a bearing on insurability of any person proposed for insurance? (If Yes, please list details below.).....  Yes  No

\_\_\_\_\_

**X** \_\_\_\_\_ **X** \_\_\_\_\_  
 Agent Name Agent Number Agent Signature Date

\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_  
 Agent Phone Number Agent Cell Phone Number Agent Fax Number Agent Email Address

**Administrative Details**

1. **Proposal Required. Submit with application – the proposal documents the type of coverage requested.**
2. **Choice of Requested Date of Coverage:**  Underwriting Approval Date  Specified Future Date (1st - 28th) \_\_\_\_\_
3. **Health Savings Account Information:**  Applicant requests HealthEquity open an HSA account according to the terms and conditions of the HealthEquity Service Agreement located at [www.healthequity.com](http://www.healthequity.com)
4. **Payment Mode: Direct Bill:**  Annual  Semiannual  Quarterly **Monthly:**  Bank Draft  Credit Card  
 List Bill (If requesting a new list bill [if allowed in your state], the current list bill forms are required. Submit only application fee, if any, for initial premiums.)
5. **Payment for Initial Premium:**  Check  Bank Draft  Credit Card  
 \$ \_\_\_\_\_ Total Amount Submitted With Application (The first full premium by mode and the application fee must be submitted with this application.)

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



### HIPAA Authorization

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to World Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; or the Medical Information Bureau (MIB).

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.

- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.
- I have the right to ask for and obtain a copy of any consumer report made about me to the Company.

I agree that a copy of this Authorization is as valid as the original.

\_\_\_\_\_

Date

\_\_\_\_\_ **X**

Your Name (Please Print) Your Signature

\_\_\_\_\_ **X**

Your Spouse's Name (if applying) (Please Print) Your Spouse's Signature (if applying)

\_\_\_\_\_ **X**

Your Child's Name (if 18 or older) Your Child's Signature (if 18 or older)

\_\_\_\_\_ **X**

Your Child's Name (if 18 or older) Your Child's Signature (if 18 or older)

Your Child(ren)'s Name(s) if younger than 18 (Please Print)

1. \_\_\_\_\_ 3. \_\_\_\_\_

2. \_\_\_\_\_ 4. \_\_\_\_\_

**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 hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

**Person(s) to be Insured (Please Print)**

**My relationship to applicant(s) (Please Print)**

**X** \_\_\_\_\_  
Personal Representative

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Authorization to Disclose Information

I authorize World Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention. I understand that I do not have to authorize this disclosure to MIB.

Issuance of coverage will not be conditioned on me signing this authorization. ....  Yes  No

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company 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.

I understand that this authorization will expire 24 months from the date I sign it.

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

\_\_\_\_\_

Date

\_\_\_\_\_ **X**

Your Name (Please Print) Your Signature

\_\_\_\_\_ **X**

Your Spouse's Name (if applying) (Please Print) Your Spouse's Signature (if applying)

**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 hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

**Person(s) to be Insured (Please Print)**

**My relationship to applicant(s) (Please Print)**

**X** \_\_\_\_\_  
Personal Representative

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



# Disclosure Forms for Applicant

The information in this section must be left with the applicant.

***Agent Instructions:*** The following forms should be left with your customer.

- Disclosure** – Agent Signature is required on the Conditional Receipt, if *FULL* premium, and all applicable fees are submitted with application.
- Notice of Privacy Policy and Insurance Information Practices**
- Notice of Privacy Practices – Medical**

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.

*For South Carolina Residents Only: Disclosure Statement* – You must already be or become a member of the association to be eligible for coverage under the group policy. The member is responsible for all costs related to association membership, including but not limited to the initial association membership fee and the amount of the annual association dues. Membership fees and/or dues are in addition to the policy premium. The association holds the master policy. The premium charged and the terms and conditions of coverage are determined between the association and us. The premium, terms and conditions of coverage may be changed by agreement of the association group policyholder and us, without your consent.

**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 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901.

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.

X Signature of Applicant \_\_\_\_\_

Signature of Agent/Broker \_\_\_\_\_

Date \_\_\_\_\_ Agent # \_\_\_\_\_

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue a policy/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 (where applicable), 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 not be completed.

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 (where applicable), for this policy/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 policy/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 policy/certificate applied for.
2. This conditional receipt terminates 45 days after the application date, when the policy/certificate applied for is declined or withdrawn, or when the policy/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**

**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.**

# Notice of Privacy Practices for AmericanEnterprise Group Companies FINANCIAL

**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.**

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, World Insurance Company, and World Corp Insurance Company (“Company”) we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

## What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records (“non-public personal information”). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

## What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- to process your application and issue your policy.
- to pay your claims.
- to make any policy changes you may request.
- to offer you additional opportunities to improve your financial security.

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

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

## Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

## How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

## What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

## How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

## Questions?

**If you have any questions, please call  
our toll-free Customer Service line.**

**1-800-247-2190**

# Notice of Privacy Practices for AmericanEnterprise Group Companies 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.**

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, World Insurance Company, and World Corp Insurance Company, (“Company”) we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about “information” or “health information” in this notice we mean individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Individually identifiable health information is health information that:

- Is created or received by the Company’s designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

## How We Use or Share Information

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

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs.

- To use or disclose your information to provide you with information about health related benefits and services that you may be interested in.
- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

There are also state and federal laws that may require or permit us to release your information to others without your authorization.

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services and the Iowa Division of Insurance.
- To share information for public health activities. For example, we may report information to government authorities conducting public health investigations.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law. For example audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding. For example pursuant to a valid court order or subpoena.
- To report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information to a funeral director as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes, or tissue.

- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law.

If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information.** If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

### What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Service Center. Contact information for our Customer Service Center is located at the end of this Notice.

- **You have the right to ask us to restrict** how we use or disclose your information for payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care and uses and disclosures for disaster relief purposes. Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions.
- **You have the right to request confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain.** All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Service Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission.** 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 representative, and must

state the reasons for the requested amendment. Amendment request forms are available from our Customer Service Center at the address below.

- **You have the right to receive an accounting** of certain disclosures of your information. Please note that we are not required to release:
  - Any information collected prior to April 14, 2003.
  - Information disclosed or used for treatment, payment, and/or health care operations purposes.
  - Information disclosed to you or pursuant to your authorization.
  - Information that is incidental to a use or disclosure otherwise permitted.
  - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
  - Information disclosed for national security or intelligence purposes.
  - Information disclosed to correctional institutions, law enforcement officials or health oversight agencies.
  - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Accounting requests forms are available from our Customer Service Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period.

### Exercising Your Rights

- You have a right to receive a copy of this notice upon request at any time. You can also view a copy of this notice on our website at [www.americanenterprise.com](http://www.americanenterprise.com). We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail and post it on our website.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Service Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint.**

### Contact Information

If you have any questions or complaints, please contact us at:

**Notice of Privacy Practices  
American Enterprise Group Companies,  
Customer Service Center  
P.O. Box 9371, Des Moines, IA 50306-9371**

You can call us at: **1-800-247-2190.**

[www.americanenterprise.com](http://www.americanenterprise.com)