



A. General Information *(please print)*

1. a. Member's Name (First, Middle, Last) _____
 b. Address (No., Street) _____
 c. City, State & ZIP • Within city limits? Yes No

2. Phone No. _____ Best time to call _____
 a. Home (___) _____
 b. 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 _____

Persons proposed for insurance. List first, MI, and last names.	Relationship to member	Ht. ft.,in.	Wt. lbs.	Birthdate Mo./Day/Yr.	Birth state	Sex	Tobacco use in the past 2 yrs.		Full-time Student		Social Security Number	Driver's License Number/State
							Yes	No	Yes	No		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
									<input type="checkbox"/>	<input type="checkbox"/>		
									<input type="checkbox"/>	<input type="checkbox"/>		

7. a. Parent/Guardian (if child-only coverage) _____ b. Address (No., Street, City, State and ZIP) _____ c. Phone # _____ d. Social Security # _____

8. a. Payor (If different from above) _____ b. Address (No., Street, City, State and ZIP) _____ c. Phone # _____ d. Social Security # _____

9. Provide details under Additional Remarks in Section E for any questions answered "No".

a. Is each person to be covered a U.S. citizen?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
b. Are all persons to be covered living at the same residence?	<input type="checkbox"/>	<input type="checkbox"/>
c. Do all persons to be covered live or plan to live only in the U.S. or Canada?	<input type="checkbox"/>	<input type="checkbox"/>

B. Type of Coverage Requested

1. Name and Plan (check one):
 WorldCare Plans: WorldCare 100 WorldCare 80 WorldCare 70 Traditional 80
 OR Traditional 50 WorldCare Limited (hospital/surgical) Other _____
 WorldCare HDHP (MSA-eligible) Plans: HDHP 100 PPO HDHP 80 PPO Traditional HDHP 100 Traditional HDHP 80

2. Deductible (check one):
 WorldCare Plans: \$500 \$1,000 \$1,500 \$2,500 \$5,000 \$10,000 Other _____
 WorldCare HDHP (MSA-eligible) Plans: Single Low Single High Family Low Family High

3. Name of PPO Selected: _____

4. Optional Benefits: Maximum Benefit (increase lifetime maximum) Outpatient Accident Expense \$500 \$1000
 (check appropriate box) Life Benefit for Covered Member \$10,000 \$25,000 \$50,000
 Life Benefit for Covered Spouse \$10,000 \$25,000 \$50,000
 Outpatient Expense Benefit (WorldCare Limited only) Other _____

Please complete if Life Benefit for Covered Member selected:

Beneficiary (First, Middle Initial, Last) _____	Social Security No. _____	Relationship _____
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If a minor (under age 18) is designated as the beneficiary, provide the name of the guardian who will hold proceeds in trust for the benefit of the minor until minor reaches age 18: _____
 (If no beneficiary is designated, benefit will be paid to the estate of the insured.)

5. Please check your choice of effective date of coverage:
 Application Date Underwriting Approval Date Specified Future Date _____

6. Payment Mode: Annual Semiannual Quarterly Check-O-Matic List Bill Direct Monthly
 Other _____ \$ _____ Total Amount Submitted With Application

All checks must be made payable to World Insurance Company. If requesting a new list bill (if allowed in your state), the current list bill form is required. The first full premium by mode and the application fee must be submitted with this application.

Administrative Use Only



7. If yes to any of the following, complete section below and submit any required replacement forms.

- | | | |
|---|--------------------------|--------------------------|
| | <u>Yes</u> | <u>No</u> |
| a. Is there any medical insurance (individual or group) in force or pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Is replacement or change of existing medical insurance in this company or elsewhere involved in this application? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Was any person proposed for insurance covered under a health benefit plan within 90 days of the requested effective date of this policy? | <input type="checkbox"/> | <input type="checkbox"/> |

Name	Name of Insurance Company	Address for Insurance Carrier	Type of Plan	Start Date	Termination Date

- d. Do you agree to discontinue any inforce or pending coverage upon the issue of a World Insurance Company Certificate?
 If no, explain under Additional Remarks in Section E.
- e. Are any of the persons proposed for insurance covered by Medicare?

8. Health Insurance Portability and Accountability Act of 1996 (HIPAA) — Eligible Individual Determination.

HIPAA requires that each health insurance issuer that offers health insurance in the individual market (as defined by HIPAA) in a state may not decline to offer coverage to, nor deny enrollment of an individual who meets the definition of an "Eligible Individual" under federal law, nor may the issuer impose any preexisting condition exclusions on that individual with respect to such coverage.

Please indicate "Yes" or "No" to the following:

- | | | |
|---|--------------------------|--------------------------|
| | <u>Yes</u> | <u>No</u> |
| (a) As of the date on which you are applying for coverage, have you been insured under creditable coverage for at least 18 months with no more than a 62-day gap (90 days in Colorado)? | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Was your most recent period of creditable coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) If you were offered the option of continuation of coverage under COBRA or a similar state continuation program, did you complete the allowable period of coverage as an insured or dependent? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "No", please explain _____ | | |
| (d) Are you eligible for any of the following as an insured or dependent (check appropriate box): | | |
| (1) a Group Health Plan? | <input type="checkbox"/> | <input type="checkbox"/> |
| (2) Part A or Part B of Medicare? | <input type="checkbox"/> | <input type="checkbox"/> |
| (3) a State plan under Medicaid, or successor program? | <input type="checkbox"/> | <input type="checkbox"/> |
| (e) Do you have other health insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| (f) Was your most recent health insurance terminated for nonpayment of premiums, misrepresentation or fraud? | <input type="checkbox"/> | <input type="checkbox"/> |
| (g) Does your current employer or your spouse's employer, offer a group health plan (employer-sponsored)? | <input type="checkbox"/> | <input type="checkbox"/> |
| If "Yes", provide the reason you decline to enroll: _____ | | |
| _____ | | |
| _____ | | |
| h. Please provide your prior employer's name, complete address, and telephone number: _____ | | |
| _____ | | |
| _____ | | |
| Dates of prior employment — From _____ to _____ | | |

If you answered "Yes" to questions (a) through (c), and "No" to questions (d) through (g), you meet the definition of a HIPAA "eligible individual".

Please check appropriate box:

- i. I am electing to apply as an "Eligible Individual" with no preexisting limitation. I understand that the rates for the "Eligible Individual" plan will be substantially higher than the underwriting plan rates.
- j. I am electing to be underwritten and as such I understand that I am waiving my right to apply for coverage as an "Eligible Individual".

If you check i. above, please attach your certification(s) of creditable coverage for the past 18 months to this application.

C. Health Statement

1. When did you, the **Proposed Insured**, last consult a physician, chiropractor or other practitioner? Month/Year _____
 Name of physician or clinic _____ Phone Number _____
 Address _____
 Reason for consultation _____ Tests Performed _____
 Findings _____
 Remaining effects _____
 How much has your weight changed in the past year? None Gained ____ lbs. Lost ____ lbs.
 Cause of weight change Self-diet Physician Recommended Unknown Medication _____

2. When did your Spouse, if applying for coverage, 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 (#a-ac), please check the appropriate box and provide details in Section D.

	Yes	No
3. Has any person proposed for insurance:		
a. ever been declined, postponed, ridered, rated or charged an extra premium for insurance?	<input type="checkbox"/>	<input type="checkbox"/>
b. in the past five years participated in any racing, scuba diving, skydiving, rock climbing or any other hazardous activities? (If yes, complete Avocation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
c. flown or plan to fly as a pilot or crew member? (If yes, complete Aviation Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
d. been convicted of a felony?	<input type="checkbox"/>	<input type="checkbox"/>
e. had his/her driver's license suspended or revoked for driving while intoxicated (alcohol and/or any other drugs) or for a moving violation in the past 10 years? (If due to intoxication, complete Drug & Alcohol Use Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
f. ever been evaluated for alcoholism/chemical dependency or frequently used alcoholic beverages to intoxication or excess or been advised to modify drinking or other habits for any reason? (If yes, complete Drug & Alcohol Use Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
g. used sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substance, or received treatment for drug abuse or chemical dependency? (If yes, complete Drug & Alcohol Use Questionnaire.)	<input type="checkbox"/>	<input type="checkbox"/>
h. been in a hospital, clinic, or other medical facility in the past 10 years for treatment, confinement or observation?	<input type="checkbox"/>	<input type="checkbox"/>
i. had surgery or has diagnostic testing, treatment, or surgery been recommended or scheduled that has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
j. ever had, been diagnosed with or treated for any immune system disorder, including Acquired Immune Deficiency (AIDS) or positive Human Immunodeficiency Virus (HIV) or HIV-related test disclosure limited to Federal Drug Administration (FDA) licensed blood test?	<input type="checkbox"/>	<input type="checkbox"/>
k. taken medication of any kind or had any medication prescribed within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
l. does any person have any fixation/prosthetic devices present including but not limited to plates, screws, pins, implants (including breast implants), pacemakers, valve replacements or transplants?	<input type="checkbox"/>	<input type="checkbox"/>

4. **To the best of your knowledge and belief, has any person proposed for insurance in the past 10 years had any indication, diagnosis or treatment of:**

m. blood or lymph disorders including but not limited to anemia or lymphadenopathy?	<input type="checkbox"/>	<input type="checkbox"/>
n. congenital disorder, birth defects or developmental disorders including but not limited to:		
<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"/>
o. the respiratory system, including:		
<input type="checkbox"/> allergies*	<input type="checkbox"/> asthma*	<input type="checkbox"/> pneumonia
<input type="checkbox"/> emphysema	<input type="checkbox"/> bronchitis*	<input type="checkbox"/> chronic cough
<input type="checkbox"/> sinusitis*	<input type="checkbox"/> tuberculosis	<input type="checkbox"/> cystic fibrosis
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> apnea	<input type="checkbox"/> other _____
(If yes, complete Respiratory Questionnaire.*)		<input type="checkbox"/>

Yes No

p. the circulatory system including: heart disease heart defect heart condition high blood pressure (hypertension)
 heart attack chest pain varicose veins mitral valve prolapse
 phlebitis murmur aneurysm elevated cholesterol
 Raynaud's palpitations/irregular heartbeat stroke, Transient Ischemic Attack

q. the digestive system, including: ulcer esophagus colitis hepatitis, jaundice, or cirrhosis
 pancreas gall bladder bowel diverticulitis, diverticulosis
 gastritis stomach rectum disorder of pancreas, spleen, liver
 spleen hernia intestinal disorder
 hemorrhoids polyps other _____

r. the nervous system, including: epilepsy seizure headaches Alzheimers Parkinson's disease
 dizziness fainting spells cerebral palsy multiple sclerosis
 convulsions paralysis dementia other _____

s. a mental or nervous disorder, including: anxiety* learning/behavior disorder Attention Deficite Disorder (A.D.D.)
(If yes, complete Mental/Nervous Disorder Questionnaire.*) eating disorder psychiatric treatment Attention Deficite Hyperactivity Disorder (A.D.H.D.)
 depression* or counseling* other _____

t. the genitourinary system including: prostate kidney disorder or stones urinary incontinence
 bladder urinary tract infection other _____

u. any disease or disorder of female/male reproductive systems or genitalia, including: ovaries irregular menstruation sexually transmitted disease
 impotency reproductive organ premenstrual syndrome (PMS)
 infertility uterus/cervix other _____

(1) Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?
 Expected delivery date: _____

If u(1) is answered Yes, medical coverage cannot be issued. Questions (2)-(4) for female applicants only.

(2) Any complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?

(3) Date of last pap smear _____ Results _____

(4) 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?

v. the endocrine system, including: high or low blood sugar diabetes goiter thyroid gland
 glandular disorder pituitary disorder other _____

w. the musculoskeletal system, including: gout arthritis the back, spine, or muscles* Temporomandibular Joint
Back/Neck Questionnaire.*) subluxation* rheumatism lupus erythematosus Disorder(TMJ) or jaw problems
 fibromyalgia loss of limb physical handicap other _____

x. cancer, tumors, cysts, growths or breast disorders: (For cancer, provide location, type of cancer and treatment received.)?

y. skin disorder/problems, such as cancer, psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, acne, etc.?

z. the eyes, ears, nose, or throat, including cataracts, glaucoma, speech or hearing impairment, otitis media, ear tubes?

5a. Has any person proposed for insurance consulted or been treated or examined by a physician, chiropractor, or other practitioner for any reason other than disclosed above in the past 10 years?

b. To the best of your knowledge, does any person to be insured have any mental or physical impairment, handicap, retardation, disease, disorder or deformity?

c. Have you taken medications of any kind or had any medications prescribed within the past 30 days?
 (If yes, describe below)

Name of Person to Whom Answer Applies	Name of Medication	Dosage of Medication	Frequency	Name & Address of Physician

F. 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)/certificate(s) 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) must be an active, dues paying member of the Association and that I and my spouse must both be between the ages of 16 and 64 to apply for insurance.

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

2. I understand no insurance exists unless and until a certificate is delivered by World Insurance Company and accepted by me indicating coverage for myself and my dependents and the effective date, and that Association dues are required to purchase and continue insurance. If at any time prior to such notification, any person applying for coverage consults a physician, is hospitalized or has any change in health, I agree to inform World Insurance Company immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by World Insurance Company nor to bind World Insurance Company to any promise of coverage.

I, the undersigned, understand that World Insurance Company will confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call is a routine process for those applying for coverage. (Please Note: this telephone call will be tape-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 condition or if the health condition of any of my dependents changes between the date of this application is signed and the date I receive written notification of approval, providing coverage is approved by World Insurance Company.

3. I acknowledge that:
 - a. I understand that the opportunity to apply for group insurance is contingent upon membership in the association (this application cannot be used to apply for membership in the association; a separate application must be submitted); and
 - b. I certify that the following information is correct and true as it relates to the health insurance being applied for:
 - (1) no portion of the premium will be paid, during the period the certificate is in force, by or on behalf of my employer, either directly, or through wage adjustments or other means of reimbursement;
 - (2) neither I, nor my spouse, nor my dependents, nor my employer intends to treat the certificate, during the period other certificate is in force, as part of a plan or program under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.
 - c. I have read this application and the brochure and I understand and accept the terms and conditions provided in all these materials including, but not limited to, the certificate benefits, exclusions and limitations.
 - d. Any disputes arising under the certificate are subject to an appeals procedure.
 - e. When applying for child-only coverage, I also understand and agree that:
 - (1) the member is the individual who is purchasing coverage for the member under the child plan.
 - (2) the member is the person who will receive all correspondence and communications from World Insurance Company regarding this child-only coverage.
 - (3) the member is responsible for paying all premiums when due.
 - f. Please Note: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information may be in violation of state law. Use of the mail to defraud is a violation of federal law.

g. Authorization to obtain Information:

I 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, certificate reinstatement or a change of benefits. I agree this authorization is valid for thirty (30) 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 certificate that is issued.

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

Application dated at (City, State)

Agent's Certification

Check Box 1 or 2.

- 1. I certify that during an in-person interview with the member, I saw each person proposed for coverage, I have truly and accurately recorded in this application all the information supplied and have witnessed the signatures of the proposed insured(s).
- 2. If other than 1. above, explain in detail how the completion of the application differed from 1. and the reasons for the differences.

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| 3. Do you have any knowledge or reason to believe that replacement or duplication of existing insurance might be involved? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 insured. (If yes, please list details below.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you given the member the attached Fair Credit, M.I.B. notices and the conditional receipt (if payment of the full first premium is being submitted with application)? | <input type="checkbox"/> | <input type="checkbox"/> |

Special requests, remarks and instructions: _____

Agent Name — Please Print _____
Agent Signature

Agent Phone Number _____
Agent Fax Number _____
Agent e-mail Address

Agent Code _____
Date

Authorization to Honor Checks Drawn by World Insurance Company

TO: **BANK**
Bank
Address

As a convenience to me, I authorize you to make payments to World Insurance Company, Omaha, NE, by withdrawing funds from my account by check, draft or automatic debit entry. I agree that your rights with respect to each such charge will be the same as if it were personally executed by me. This authorization is to remain in effect until you receive notice from me to revoke it.

X _____ X _____
(Date) (Authorized Signature as Shown on Account)

X _____
Account No. (Joint Account or Other Authorized Signature)

Attach Voided Check.

WORLD INSURANCE COMPANY, P. O. Box 3160, Omaha, Nebraska 68103-0160

M1313 (COM) (10-90)

TO: *The Bank named above*

As consideration to you to handle drafts drawn by World Insurance Company on customers of your bank for payment of premiums on insurance certificates, World Insurance Company agrees:

- (1) To indemnify and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- (2) In the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

WORLD INSURANCE COMPANY

Tom D. Eilers
President

Please leave with Proposed Insured in all cases
WORLD INSURANCE COMPANY
P.O. Box 3160, Omaha, NE 68103-0160

NOTICE TO PROPOSED INSURED

Thank you for your application for insurance.

We are required by Public Law 91-508, the Fair Credit Reporting Act and Privacy Act Prenotification, to inform you that as part of our underwriting procedure, an investigative consumer report may be obtained that will provide applicable information concerning character, general reputation, personal characteristics and mode of living.

Further information on the nature and scope of such report, if one is made, is available to you upon written request to the Underwriting Department at the above address.

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU

Information you provide will be treated as confidential except that World Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the M.I.B. will supply such company with the information it may have in its files.

Upon receipt of the request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

World Insurance Company or its reinsurers also may release information in its files to other life insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted.

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will come from you, and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have the right of access and correction with respect to the information collected about you except information that relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please contact World Insurance Company, P.O. Box 3160, Omaha, NE 68103-0160.

INSTRUCTIONS: Complete Conditional Receipt *ONLY* when premium 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.

CONDITIONAL RECEIPT

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 premium by mode and application fee for this certificate, and
- 2) Those proposed for insurance at the time of application are insurable without special exception and at standard rates under the Company's regular underwriting rules and practices for the certificate applied for; and
- 3) In Section II on the application, the "Application Date" was selected as the requested effective date of coverage.

Terms of Condition Insurance:

- 1) This conditional receipt is governed by the terms of the certificate applied for.
- 2) This conditional receipt terminates 60 days after the application date, when the certificate applied for is declined or withdrawn, or when the certificate applied for becomes effective, whichever occurs first.
- 3) If all the above terms and conditions have been met, each certificate will be issued regardless of any changes in insurability that occurs after the application was taken.

No Representative of The Company Is Authorized to Modify This Conditional Receipt

Signature of Applicant _____

Signature of Agent/Broker _____

Date _____

Agent # _____

Make checks payable to World Insurance Company