

# Request for Coverage



## AGENT INSTRUCTIONS

Please complete and submit the following sections.

- Request for Coverage                       Rate Quote  
 Signed HIPAA Authorization             Automatic Payment or Credit Card Authorization

### PLEASE ANSWER THE FOLLOWING QUESTIONS BEFORE CONTINUING WITH THE APPLICATION PROCESS

1. When would be the best time for a representative of World Corp Insurance Company to contact you to complete your telephone interview? .....  A.M.  P.M.
2. a. Requested Policy Date for **Medicare Supplement\*** (Check one): .....  Application Date  Specified Future Date \_\_\_\_\_  
b. Requested Policy Date for **Short Term Convalescent Care\*** (Check one): ..  Application Date  Specified Future Date \_\_\_\_\_  
c. Requested Policy Date for **Final Expense\*** (Check one): .....  Application Date  Specified Future Date \_\_\_\_\_
3. Payment Mode:  
**Direct Bill:**  Annual     Semiannual     Quarterly     Monthly  
**or**  
**Monthly:**     Bank Draft     Credit Card
- Payment of Initial Premium:**     Check     Credit Card (available only for monthly modes)

#### Total Amount Submitted with Application

*(First full premium by mode and application fee (if applicable) must be submitted.)*

\$
----

The information in the following section will be used to determine the customer's eligibility for health insurance and to specify the payment information. The application must be submitted on behalf of the customer by the agent.

**COMPLETE AND SUBMIT**

\*All plans may not be available in all states.

# Request For Coverage



- Medicare Supplement Insurance
- Short Term Convalescent Care
- Final Expense

You and your spouse may request coverage on this application if you are applying for the same plan(s) and contract issue date(s).

<span style="font-size: 2em; font-weight: bold;">1</span> COMPLETE FOR ALL COVERAGES <b>ABOUT YOU</b>	<span style="font-size: 2em; font-weight: bold;">2</span> COMPLETE FOR ALL COVERAGES <b>ABOUT YOUR SPOUSE</b> (If requesting coverage)																																																																																																								
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<span style="font-size: 2em; font-weight: bold;">3</span> COMPLETE FOR: Medicare Supplement <b>YOU MAY BE GUARANTEED ACCEPTANCE</b>	You	Your Spouse
A. What is your Medicare Part B effective date? .....	MM / DD / YYYY	MM / DD / YYYY
B. What is your Medicare Claim Number? .....		
C. Are you within 6 months of your 65th birthday? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
D. Did you enroll in Medicare Part B within the last 6 months? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If you answered "YES" TO QUESTIONS C and D, you are considered an OPEN ENROLLEE for Medicare supplement coverage. If you're requesting ONLY Medicare supplement, you can skip to Section 7.</b>		
E. If you lost or are losing other health insurance coverage: Did you receive a notice from that health insurance company stating you were eligible for guaranteed issue of a Medicare supplement insurance policy OR that you had certain rights to buy a policy? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
<b>If you answered "YES" to QUESTION E, and are unable to provide a termination notice, please complete all sections of this request form.</b>		

<span style="font-size: 2em; font-weight: bold;">4</span> COMPLETE FOR ALL COVERAGES <b>GENERAL HEALTH</b>	You	Your Spouse
If you answer "YES" to any question in Section 4, coverage is not available.		
A. In the past 5 years, have you: <ul style="list-style-type: none"> <li>been treated for or diagnosed as having diabetes requiring insulin;</li> <li>been treated for or advised to have a bone marrow or organ transplant;</li> <li>been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? .....</li> </ul>	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

# 4

COMPLETE FOR ALL COVERAGES

## GENERAL HEALTH (continued)

**You**

**Your Spouse**

B. In the past 2 years have you:

- been treated for or diagnosed as having internal cancer, melanoma, leukemia, Hodgkin's Disease, or lymphoma;
- had heart surgery (including bypass or balloon);
- been treated or diagnosed as having congestive heart failure, heart attack, peripheral vascular disease (poor circulation in your extremities), or had angioplasty or stent placement of any vessel;
- used oxygen for any chronic lung disease (for example, emphysema or chronic obstructive pulmonary disease [COPD]);
- been treated for or diagnosed as having had a stroke or Transient Ischemic Attack (TIA);
- been treated for or diagnosed as having disabling arthritis or connective tissue disease (for example, lupus);
- been diagnosed as having cirrhosis of the liver, chronic renal failure, kidney failure, or have you had dialysis;
- been treated for or diagnosed as having Amyotrophic Lateral Sclerosis (ALS), Parkinson's or Multiple Sclerosis;
- been treated for or diagnosed as having alcoholism or drug addiction;
- been or are now bedridden or confined to a wheelchair? .....

YES  NO

YES  NO

C. Do you have or have you been told by a medical professional that you have Alzheimer's Disease, Organic Brain Syndrome or senile dementia? .....

YES  NO

YES  NO

# 5

COMPLETE FOR ALL COVERAGES

## MEDICAL QUESTIONS

**You**

**Your Spouse**

If you or your spouse answer "YES" to any of the following four questions, please provide details in the space allotted following question D. If you need additional space, attach a separate page that you've signed and dated.

- A. Do you require assistance or supervision to perform any of the following everyday living activities: dressing, eating, bathing, toileting (including use of catheter), or walking (including use of cane, walker or motorized scooter)? .....
- B. Have you been advised by a member of the medical profession to have surgery, including cataract surgery, that has not yet been performed? .....
- C. Have you been hospitalized or confined to a nursing facility within the past 60 days or been hospitalized 3 or more times in the past 2 years? .....
- D. Are you receiving or have you received treatment within the past 2 years for mental, nervous or seizure disorder? .....

YES  NO

YES  NO

YES  NO

YES  NO

YES  NO

YES  NO

YES  NO

YES  NO

**You**

**Your Spouse**

Question	Details	Question	Details

E. Do you or your spouse take prescription drugs? .....  YES  NO  
If "YES," please provide details below.

Your Medication (copy from label) and Reason	Your Spouse's Medication (copy from label) and Reason
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.

F. Please provide the date and reason for your and your spouse's last visit to a physician.

Your Physician's Name	Phone Number	Your Spouse's Physician's Name	Phone Number
	Area Code		Area Code
Date of Visit	Reason for Visit	Date of Visit	Reason for Visit
MM / DD / YYYY		MM / DD / YYYY	

<b>6</b>	<b>COMPLETE FOR:</b> - Medicare Supplement - Final Expense	<b>YOU MAY BE ELIGIBLE FOR PREFERRED RATES</b>		<b>You</b>	<b>Your Spouse</b>
		A. Have you used tobacco in any form in the last 2 years? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		B. Are you a diabetic controlled by diet or oral medication? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		C. Do you regularly take 3 or more maintenance prescription medications (for example, medication for blood pressure, asthma or heart disease)? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

<b>7</b>	<b>COMPLETE FOR:</b> - Medicare Supplement	<b>PLEASE ANSWER THE FOLLOWING</b>		<b>You</b>	<b>Your Spouse</b>	
		A. Are you covered for medical assistance through the state <b>MEDICAID</b> program? <b>NOTE:</b> If you are participating in a <b>"Spend-Down Program"</b> and have not met your <b>"Share of Cost,"</b> please answer <b>"NO"</b> to this question. ....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		If <b>"YES,"</b> will Medicaid pay your premium for this Medicare supplement policy? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		If <b>"YES,"</b> do you receive any benefits from Medicaid <b>other than</b> payments toward your Medicare Part B premium? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		B. If you had coverage from any Medicare plan other than original Medicare within the past 63 days, fill in your start and end date. If you are still covered under this plan, leave <b>"END"</b> blank. (Examples of other plans include a Medicare Advantage plan or a Medicare HMO or PPO.) .....	<b>Start</b> MM / DD / YYYY	<b>Start</b> MM / DD / YYYY	<b>End</b> MM / DD / YYYY	<b>End</b> MM / DD / YYYY
		If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Was this your first time in this type of Medicare plan? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		Did you drop a Medicare supplement policy to enroll in the Medicare plan? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		C. Do you have another Medicare supplement policy in force? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		If <b>"YES,"</b> with what company, and what plan do you have? .....	COMPANY	COMPANY	PLAN	PLAN
		If <b>"YES,"</b> do you intend to replace your current Medicare supplement policy with this policy? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
		D. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? .....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
If <b>"YES,"</b> with what company, and what kind of policy? .....	COMPANY	COMPANY	POLICY	POLICY		
If <b>"YES,"</b> what are your dates of coverage under the other policy? .....	<b>Start</b> MM / DD / YYYY	<b>Start</b> MM / DD / YYYY	<b>End</b> MM / DD / YYYY	<b>End</b> MM / DD / YYYY		
If you are still covered under the other policy, leave <b>"END"</b> blank.	<b>End</b> MM / DD / YYYY	<b>End</b> MM / DD / YYYY				

<b>8</b>	<b>COMPLETE FOR:</b> - Final Expense	<b>YOUR LIFE COVERAGE AND BENEFICIARY REQUEST</b>			
		<b>Designate Your Primary Beneficiary</b>	<b>Relationship to You</b>	<b>Designate Your Spouse's Primary Beneficiary</b>	<b>Relationship to Your Spouse</b>
<b>Designate Your Contingent Beneficiary</b>	<b>Relationship to You</b>	<b>Designate Your Spouse's Contingent Beneficiary</b>	<b>Relationship to Your Spouse</b>		
Please specify the policy owner, if someone other than yourself, for either of the following: <input type="checkbox"/> Your Policy <input type="checkbox"/> Your Spouse's Policy					
<b>Owner Name</b>	<b>Age</b>	<b>Relationship to You</b>	<b>Address</b>		
<b>Owner's Social Security Number or Tax ID Number</b>	Are you requesting the Automatic Premium Loan Option? .... <input type="checkbox"/> YES <input type="checkbox"/> NO				



# 9

COMPLETE FOR:  
Final Expense

## YOUR CURRENT LIFE COVERAGE

You

Your Spouse

Do you currently have life insurance or an annuity in force or pending with World Corp or any other company? .....

YES  NO

YES  NO

Are you changing or replacing existing life insurance coverage or an annuity? .....

YES  NO

YES  NO

If "YES," what is the name and city/state of your previous company? (Use box[es] below.)

Your Company	City/State	Your Spouse's Company	City/State
1.		1.	
2.		2.	

# 10

COMPLETE FOR  
ALL COVERAGES

## PLEASE READ AND SIGN

### FOR MEDICARE SUPPLEMENT:

You do not need more than one Medicare policy or certificate.

If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need Medicare supplement coverage.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later became covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient

prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). You have been provided with an Outline of Coverage and The Guide to Health Insurance for People with Medicare and you understand your insurance will not become effective until you are eligible for Medicare.

### FOR ALL COVERAGES:

Your signature verifies that you understand your insurance will not become effective until your first month's premium has been received and your application has been approved by World Corp; that you understand that you will be informed whether or not your application has been accepted within 90 days (60 days in Missouri) or be given the reason for further delay.

**WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive (is - District of Columbia) may be guilty of a crime and could be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.**

I certify that the answers and statements in this application are complete and true to the best of my knowledge and belief. I understand World Corp does not authorize any agent to accept risks, pass on the acceptability for insurance, or make, change or end any insurance contract. I have read or have had read to me the completed application, including Section 10, and I understand it.

## PLEASE READ AND SIGN

**Colorado Residents:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**Kentucky Residents:** I understand that any person who submits an application or files a claim containing any materially false information or conceals, with intent to defraud or knowingly that he or she is facilitating a fraud against an insurer, is guilty of insurance fraud.

**New Mexico Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Ohio Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Your Signature

X

Your Spouse's Signature, if applying

X

Date

MM / DD / YYYY

### FOR AGENT USE ONLY

Have you personally sold any other health insurance policies to the proposed insured(s) that are still in force OR sold any policies no longer in force in the past 5 years?  YES  NO If "YES," please list policies.

Policy Description for Proposed Insured

In Force?
<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO

Policy Description for Spouse

In Force?
<input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/> YES <input type="checkbox"/> NO

I certify the information in this application was provided by the applicant(s) and correctly recorded. I have no information to add that could affect the acceptance or rejection of the risk(s).

If requesting life insurance, will this policy (policies) replace or change any existing insurance?  YES  NO

Licensed Agent Signature X

Date MM / DD / YYYY

Agent Name

Agent Number

# 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 Corp 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).

Signed

Your Name (Please print)

Your Signature

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

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

1.

2.

**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.

Personal Representative (Please print)

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 Corp Insurance Company, P. O. Box 2155, Omaha NE 68103-2155.
- 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.

Your Child's Name (if 18 or older)

Your Child's Signature (if 18 or older)

Your Child's Name (if 18 or older)

Your Child's Signature (if 18 or older)

3.

4.

Person(s) to be Insured (Please print)

1.

2.

3.

4.

My relationship to applicant(s) (Please print)

1.

2.

3.

4.

## AUTHORIZATION TO CHARGE CREDIT CARD FOR PREMIUM

Available only for monthly modes.

Not available in all states.

### Credit Card Authorization

VISA      I authorize World Corp Insurance Company to bill my VISA/MasterCard account for full premium, and any applicable application fee. **NOTE: We will debit your account upon policy activation which may not coincide with the effective date of the policy.**

MasterCard

### Account Number

				-					-								
--	--	--	--	---	--	--	--	--	---	--	--	--	--	--	--	--	--

### Expiration Date

MM / YYYY

### Telephone Number

Area Code

Your Signature

Date

X

MM / DD / YYYY

## AUTHORIZATION TO HONOR CHECKS DRAWN BY WORLD CORP INSURANCE COMPANY

**If you select the Bank Draft option, please complete the following:**  
 I (we) hereby authorize World Corp Insurance Company to initiate debit entries to the account and depositor (Depository) indicated below, to debit the same to such account. This authority is to remain in full force and effect until World Corp and Depository have received

written notification from me (or either of us) of its termination in such time and in such manner to afford World corp and Depository a reasonable opportunity to act on it. I understand that the initial withdrawal will be made upon activation, and renewals will be on the effective date of the policy.

Signature of Payor(s)

Date Signed

X

MM / DD / YYYY

### To begin Bank Draft withdrawals

Initial withdrawal upon activation - renewal withdrawals will be effective date of policy.

### Applicant's Bank or Financial Institution Name (including branch, if any)

### Your Bank or Financial Institution's Address

City

State

Zip Code

### To add this policy to an existing Bank Draft

Existing EFT Number

Policy/Certificate Number



### Routing and Transit # (9 digits)

Account #

Next Check #

You must submit a voided check. Do not send a deposit slip. Please print clearly.

### TO: The Bank named above

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

*Michael E. Abbott*

Chairman, President & Chief Executive Officer

# Disclosures

## **AGENT INSTRUCTIONS**

### **Please leave with your customer.**

- Complete receipt **ONLY** when full premium is being submitted with application.
- If premium is not being submitted **DO NOT** complete the receipt.
- All information in this section must be left with the customer.

**LEAVE WITH THE CUSTOMER**

# 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.

At American Enterprise 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.

## NOTICE OF PRIVACY PRACTICES—MEDICAL (continued)

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
  - 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)

# NOTICE OF PRIVACY PRACTICES—FINANCIAL

## Privacy Policy and Insurance Information Practices

*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 American Enterprise 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 (“nonpublic 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**

## **SPECIAL NOTICE—FOR YOUR PROTECTION**

Thank you for your application for insurance. In completing this application for insurance, it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. You may ask for an interview if a consumer report is made as a result of this application. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation.

Information you provide will be treated as confidential except that the insurance company or its reinsurers may make a brief report thereon to the Medical Information Bureau (MIB), 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 MIB 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.

The 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 coverage 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 refer to the Notice of Privacy Practices that you have been provided.

### **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.

## **INFORMATION ABOUT YOUR PREMIUM**

The total premium you pay each year for your coverage may vary depending on the mode (frequency of payment) and the method you select for premium payment. If you would like a comparison of premium amounts based on payment modes, just ask your agent.

## **MEDICARE SUPPLEMENT 12-MONTH INITIAL RATE GUARANTEE**

Your Medicare Supplement coverage includes an initial 12-month rate guarantee. For the first 12 months of your coverage, your premium will not increase because of a change in premium for the coverage or because you are one year older. During the initial 12-month rate guarantee, your premium may be adjusted because of a change in residence.

Should a necessary premium change be made after the initial 12 months of coverage, it will only be made on a renewal date, but no change will be made unless it is made on all plans in the same class, as determined by us. Premiums may increase because you are one year older.

# RECEIPT

Received on this date subject to the provisions stated below:

## HEALTH INSURANCE

\$

## LIFE INSURANCE

\$

### INITIAL PREMIUM FOR HEALTH INSURANCE

The initial premium will be refunded if the insurance applied for is not issued and delivered to the applicant within 90 days (in Missouri, 60 days) from the date of this receipt. In the event the coverage is not issued and delivered to the applicant, the Company shall in no event be liable for any amount greater than the amount shown above. All premium checks must be made payable to the Company (or

Association, if applicable). The Company will have no liability and no insurance will be in force until they determine at their Home Office (according to their rules and practices): that each person proposed for insurance is insurable; they issue coverage that is accepted by the Owner; and the first full premium is paid during the lifetime of the Proposed Principal Insured.

### LIFE INSURANCE CONDITIONAL RECEIPT

If all conditions of this Receipt are met, this Receipt will provide insurance, subject to the conditions of the policy applied for, effective on the latest of (a) the date of the application or (b) the date of completion of underwriting requirements. The coverage under this Receipt shall end on the earliest of: (a) 60 days after the date of this Receipt; (b) when the Company sends a refund of the premiums; or (c) the date the policy applied for goes into effect.

The amount of insurance which may become effective under this Receipt will not exceed the lesser of: (a) the amount of insurance applied for, or (b) \$10,000 (including life and accidental death benefits).

IF ANY OF THE CONDITIONS BELOW ARE NOT MET, OR IF A PROPOSED INSURED DIES BY SUICIDE, LIABILITY WILL BE LIMITED TO THE RETURN OF THE AMOUNT SHOWN ABOVE AS TENDERED.

I, the applicant, understand and agree to the terms, conditions and limits of this receipt as follows:

- The full first premium for the policy and benefits applied for is paid.
- Each Proposed Insured has completed any required medical examinations, tests, interviews, or provided any other requested requirements.
- Each Proposed Insured is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and the amount applied for, without modification of plan, premium rates or amount of coverage.
- On the Effective Date, there has been no change in the state of health or other factors affecting the insurability of each Proposed Insured.
- All required portions of the application have been completed and each question answered truthfully and completely.
- The amount of insurance requested does not exceed \$10,000.

No Agent has the authority to alter or waive any of the terms or conditions of this Receipt.

Remitter, if different from Principal Insured

Proposed Principal Insured

Agent