

Application for Health Insurance *Ohio*

Agent Instructions: The information in this section will be used to determine the applicant's eligibility for health insurance and to specify which payment method is requested. Applications must be submitted on behalf of the customer by the agent. Please include the following completed forms with the application.

- Association Application**
- Software Proposal** – Please attach an accurate proposal. 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.)
- Preferred Rating Questionnaire** – M1184, if applicable.
- 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.
- Agent Certification** – Agent completes and signs form.
- Authorization to Charge Credit Card OR Automatic Payment Plan** – Applicant completes if electing to pay with credit card or automatic payment plan. Must include a voided check if electing automatic payment plan.
- Initial Premium** – Including any fees.
- State Mandated Forms** – If applicable.

Utilize the following materials on 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.

A. General Information <i>(please print)</i>													
1. a. Member's Name <i>(First, Middle, Last)</i>					2. For Telephone Interview							<i>Best time to call</i>	
b. Address <i>(No., Street)</i>					Phone # _____							<input type="checkbox"/> AM <input type="checkbox"/> PM	
c. City, State & ZIP					Best Place to Call <input type="checkbox"/> Home (____) _____								
					<input type="checkbox"/> Work (____) _____								
3. a. Member's Employer Address					4. Spouse's Name <i>(First, Middle, Last)</i>								
b. Occupation/Title/Duties					5. a. Spouse's Employer Address								
					b. Occupation/Title/Duties								
6.	Persons proposed for insurance. List first, MI, and last names.	Relationship to Insured	Ht. ft., in.	Wt. lbs.	Birthdate Mo./Day/Yr.	Sex	Tobacco Use last 2 yrs. Yes No		Full-time Student Yes No		Social Security Number	Driver's License Number/State	
							<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"/>			
							<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7. a. Parent/Guardian <i>(if child-only coverage)</i>		b. Address <i>(No., Street, City, State and ZIP)</i>								c. Phone #			
8. a. Payor <i>(if different from above)</i>		b. Address <i>(No., Street, City, State and ZIP)</i>								c. Phone #			
9. Provide details under Additional Remarks in Section F for any questions answered "No".											Yes	No	
a. Is each person to be covered a U.S. citizen?											<input type="checkbox"/>	<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"/>	

Administrative Use Only

B. Type of Coverage Requested
1. Proposal Required. Submit with application – the proposal indicates the type of coverage requested.
2. Please check your choice of Effective Date of Coverage: <input type="checkbox"/> Underwriting Approval Date <input type="checkbox"/> Specified Future Date _____ <i>(1st - 28th)</i>
3. If applying for an HSA plan, and you wish to enroll in a Health Savings Account with HealthEquity, please check here and complete a W1286, and include with the application and proposal. <input type="checkbox"/> I wish to enroll in a Health Savings Account with HealthEquity
4. Payment Mode: Direct Bill: <input type="checkbox"/> Annual <input type="checkbox"/> Semiannual <input type="checkbox"/> Quarterly Monthly: <input type="checkbox"/> Check-O-Matic <input type="checkbox"/> Credit Card <input type="checkbox"/> List Bill <i>(If requesting a new list bill [if allowed in your state], the current list bill form is required. (Submit only application fee, if any, for initial premiums on list bill. Application Fees are non-refundable unless required by state law.)</i> <input type="checkbox"/> Other _____
Payment for Initial Premium: <input type="checkbox"/> Check <input type="checkbox"/> Credit Card <i>(available only for Monthly Modes)</i>
\$ _____ Total Amount Submitted With Application <i>(The first full premium by mode, association dues, and the application fee must be submitted with this application.)</i>
Application Fees are non-refundable unless required by state law.

If "yes" for any member, please complete section below and submit any required replacement forms.

Yes No

a. In the 90 days prior to the requested effective date of this certificate, is there any medical coverage (individual or group) in force or pending, including Medicare?

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

b. Does any member agree to discontinue any inforce or pending coverage upon the issue of a World certificate? If "no", explain under Additional Remarks in Section F?

c. Is replacement or change of existing medical insurance in this company or elsewhere for any member involved in this application?

d. Are any of the persons proposed for insurance covered by Medicare? If "yes", explain under Additional Remarks in Section F?

C. Health Statement

Yes No

1. Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? *If "yes", medical coverage cannot be issued.*

2. When did you, the Member, 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 _____

3. To be completed by spouse if applying for coverage.
 When did you, the Spouse, last consult a physician, chiropractor or other practitioner? Month/Year _____
 Name of physician or clinic _____ Phone Number _____
 Address _____
 Reason for consultation _____ Tests Performed _____
 Findings _____
 Remaining effects _____
 How much has your weight changed in the past year? None Gained ____ lbs. Lost ____ lbs.
 Cause of weight change Self-diet Physician recommended Unknown Medication _____

If you answer "yes" to any of the following questions (4a-4l), please provide details in Section D.

4. Has any person proposed for insurance: Yes No

a. ever been declined, postponed, ridered, or charged an extra premium for insurance?

b. ever been convicted of a felony?

c. ever been evaluated or treated for alcoholism, frequently used alcoholic beverages to excess or intoxication, or been advised to modify drinking habits for any reason?

d. ever used sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency?

e. ever had surgery or diagnostic testing or treatment, or has surgery or diagnostic testing been recommended or scheduled that has not been completed?

f. ever had, been diagnosed or treated by a physician for any immune system disorder, including AIDS/ARC or positive HIV or HIV-related test disclosure limited to FDA-licensed blood test?

g. ever received disability benefits or currently disabled?

h. had any fixation/prosthetic devices that are currently present, including but not limited to, plates, screws, pins, implants (including breast implants), pacemakers, valve replacements or transplants?

i. in the past 10 years been in a hospital, clinic, or other medical facility for treatment, confinement or observation?

j. in the past 5 years participated in any racing, scuba diving, skydiving, rock climbing or any other hazardous activities?

k. in the past 5 years flown or plan to fly in the future, as a pilot or crew member?

l. in the past 5 years had his/her driver's license suspended or revoked?

If you answer "yes" to any of the following questions (5-8), please provide details in Section D.

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

	Yes	No
a. blood or lymph disorders, including, but not limited to, anemia, lymphadenopathy or Chronic Fatigue Syndrome?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. congenital disorder, birth defects or developmental disorders, including, but not limited to:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Down's Syndrome <input type="checkbox"/> mental retardation <input type="checkbox"/> autism <input type="checkbox"/> cleft palate <input type="checkbox"/> club foot		
<input type="checkbox"/> congenital heart defects <input type="checkbox"/> other _____		
c. the respiratory system, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> allergies <input type="checkbox"/> asthma <input type="checkbox"/> pneumonia <input type="checkbox"/> emphysema <input type="checkbox"/> bronchitis		
<input type="checkbox"/> shortness of breath <input type="checkbox"/> chronic cough <input type="checkbox"/> apnea <input type="checkbox"/> sinusitis <input type="checkbox"/> tuberculosis		
<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> other _____		
d. the circulatory system, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> heart disease <input type="checkbox"/> heart defect <input type="checkbox"/> heart condition <input type="checkbox"/> mitral valve prolapse		
<input type="checkbox"/> heart attack <input type="checkbox"/> chest pain <input type="checkbox"/> varicose veins <input type="checkbox"/> high blood pressure (hypertension)		
<input type="checkbox"/> phlebitis <input type="checkbox"/> murmur <input type="checkbox"/> aneurysm <input type="checkbox"/> elevated cholesterol or triglycerides		
<input type="checkbox"/> Raynaud's Disease <input type="checkbox"/> stroke, TIA <input type="checkbox"/> palpitations/irregular heartbeat		
<input type="checkbox"/> Raynaud's Phenomenon <input type="checkbox"/> other _____		
e. the digestive system, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ulcer <input type="checkbox"/> esophagus <input type="checkbox"/> colitis <input type="checkbox"/> hepatitis, jaundice, or cirrhosis		
<input type="checkbox"/> gall bladder <input type="checkbox"/> bowel <input type="checkbox"/> polyps <input type="checkbox"/> diverticulitis, diverticulosis		
<input type="checkbox"/> gastritis <input type="checkbox"/> stomach <input type="checkbox"/> rectum <input type="checkbox"/> disorder of pancreas, spleen, liver		
<input type="checkbox"/> hernia <input type="checkbox"/> intestinal disorder <input type="checkbox"/> hemorrhoids <input type="checkbox"/> other _____		
f. the nervous system, including:.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> epilepsy <input type="checkbox"/> seizure <input type="checkbox"/> headaches <input type="checkbox"/> Alzheimers <input type="checkbox"/> Parkinson's disease		
<input type="checkbox"/> dizziness <input type="checkbox"/> fainting spells <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/> convulsions <input type="checkbox"/> paralysis <input type="checkbox"/> dementia <input type="checkbox"/> other _____		
g. a mental or nervous disorder, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> anxiety <input type="checkbox"/> A.D.D./A.D.H.D. <input type="checkbox"/> eating disorder <input type="checkbox"/> learning/behavior disorder		
<input type="checkbox"/> psychiatric treatment or counseling <input type="checkbox"/> depression <input type="checkbox"/> psychosis		
<input type="checkbox"/> other _____		
h. the genitourinary system, including:.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> prostate <input type="checkbox"/> kidney disorder or stones <input type="checkbox"/> urinary incontinence		
<input type="checkbox"/> urinary tract infection <input type="checkbox"/> bladder <input type="checkbox"/> other _____		
i. the endocrine system, including:.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> diabetes <input type="checkbox"/> goiter <input type="checkbox"/> thyroid gland <input type="checkbox"/> high or low blood sugar		
<input type="checkbox"/> glandular disorder <input type="checkbox"/> pituitary disorder <input type="checkbox"/> other _____		
j. the musculoskeletal system, including:.....	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> arthritis <input type="checkbox"/> gout <input type="checkbox"/> TMJ/jaw problems <input type="checkbox"/> lupus erythematosus <input type="checkbox"/> rheumatism		
<input type="checkbox"/> subluxation <input type="checkbox"/> physical handicap <input type="checkbox"/> fibromyalgia <input type="checkbox"/> loss of limb <input type="checkbox"/> knees		
<input type="checkbox"/> the back, spine, or muscles <input type="checkbox"/> other _____		
k. cancer, tumors, cysts, growths or breast disorders? (Provide location, type and treatment received.)	<input type="checkbox"/>	<input type="checkbox"/>
l. skin disorder/problems, such as psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, or acne?	<input type="checkbox"/>	<input type="checkbox"/>
m. the eyes, ears, nose, or throat, such as cataracts, glaucoma, speech or hearing impairment, otitis media or ear tubes?.....	<input type="checkbox"/>	<input type="checkbox"/>
n. any disease or disorder of female/male reproductive systems or genitalia, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ovaries <input type="checkbox"/> impotency <input type="checkbox"/> reproductive organ <input type="checkbox"/> irregular menstruation		
<input type="checkbox"/> infertility <input type="checkbox"/> uterus/cervix <input type="checkbox"/> premenstrual syndrome (PMS)		
<input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> other _____		

6. Questions for female applicants only.

a. Any complications of pregnancy, including, but not limited to, caesarean section delivery or miscarriage?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Date of last pap smear _____ Results _____ Dr. Name & Address _____		
c. Have you been instructed to have a repeat pap smear or any follow-up treatment or tests as a result of your last pap smear?	<input type="checkbox"/>	<input type="checkbox"/>

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

	<input type="checkbox"/>	<input type="checkbox"/>
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8. To the best of your knowledge and belief, does any person to be insured have any mental or physical impairment, handicap, retardation, disease, disorder or deformity?.....

	<input type="checkbox"/>	<input type="checkbox"/>
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F. Additional Remarks

G. Verification of Information

By signing below:

1. I represent that, to the best of my knowledge and belief, all answers are accurate, complete and true. I understand that World Insurance Company is relying on my answers in deciding whether to approve this application and that full and complete disclosure of the requested health information must occur for insurance to go into effect and that if I omit any of the requested health information, no insurance will go into effect for myself or my dependents. I understand the agent has no authority to alter or waive this, or any other condition of coverage.

I have not disclosed to the agent any health information which is not disclosed on this application. I understand that this application, if accepted, shall become a part of the 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 preadmission 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 the 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 recorded.) I also understand that my application will not be considered if verification is not completed. I understand that I must tell World Insurance Company if my health or if the health of any of my dependents changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved by World Insurance Company.

3. I acknowledge that:

- a. I understand that the opportunity to apply for association 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 the 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 person who will receive all correspondence and communications from World Insurance Company regarding this child-only coverage.
 - (2) the member is the individual who is purchasing coverage for the member under the child plan.
 - (3) the member is responsible for paying all premiums when due.
- f. Please Note: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.
- g. Authorization to obtain Information:

I understand World Insurance Company or its reinsurers will gather information regarding me or my family. This information may include the Medical Information Bureau; employer(s); consumer reporting agency; or the Veterans Administration.

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 twenty-four (24) months from the date signed. I know I or my authorized representative has the right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I, the undersigned represent to the best of my knowledge and belief, that all statements contained herein are complete and true. Under the penalties of perjury, I certify that the Social Security Number(s) provided are true, correct and complete.

Application dated at (City, State) _____

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

Signature of Agent Agent Code Date Signed

Printed Name of Agent

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)

_____ X _____
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 (Please Print)

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 (Please Print)

