



A. General Information (please print)

1. a. Member's Name (First, Middle, Last)
b. Address (No., Street)
c. City, State & ZIP
2. For Telephone Interview
Best time to call
Phone No.
Best Place to Call
3. a. Member's Employer
b. Occupation/Title/Duties
4. Spouse's Name (First, Middle, Last)
5. a. Spouse's Employer
b. Occupation/Title/Duties

Table with 11 columns: Persons proposed for insurance, Relationship to member, 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

7. a. Parent/Guardian (if child-only coverage)
b. Address (No., Street, City, State and ZIP)
c. Phone #
8. a. Payor (If different from above)
b. Address (No., Street, City, State and ZIP)
c. Phone #

9. Provide details under Additional Remarks in Section F for any questions answered "No".
a. Is each person to be covered a U.S. citizen?
b. Are all persons to be covered living at the same residence?
c. Do all persons to be covered live or plan to live only in the U.S. or Canada?

B. Type of Coverage Requested

1. Name and Plan (Proposal must be attached to application when submitted):
FreedomCare Coinsurance: 100 80 70 50 Other
Deductible: 1,000 2,000 2,500 3,000 5,000 7,500 10,000 Other
Options: Maximum Benefit (Increase Lifetime Maximum) Other
Life Benefit: Member: 10,000 25,000 50,000 Spouse: 10,000 25,000 50,000
FreedomCare HSA Coinsurance: 100 80 50 Other
Deductible: Individual: Amount \$ Family: Amount \$
Options: Maximum Benefit (Increase Lifetime Maximum) Comprehensive HSA Enhancement
Life Benefit: Member: 10,000 25,000 50,000 Spouse: 10,000 25,000 50,000
Please complete if Life Benefit for Covered Member selected: (If no beneficiary is designated, benefit will be paid to the estate of the insured.)
Beneficiary (First, Middle Initial, Last) Social Security No. Relationship

If designated beneficiary is a minor (under 18), provide name of guardian who will hold proceeds in trust until beneficiary reaches age 18:

2. Name of PPO Selected:
3. Please check your choice of effective date of coverage: Underwriting Approval Date Specified Future Date (1st - 28th - no sooner than 10 days after the application date.)
4. Individual Dental (Dental proposal must be attached to application when submitted) Please Note: Dental coverage is provided under World Insurance Company Master Policy AM3200. Annual Coverage Maximum: 750 1000 1500 Please list dependents (if applying for coverage) in Section A6.
5. Payment Mode: Annual Semiannual Quarterly Check-O-Matic (same date as the effective date of coverage.) List Bill (If requesting a new list bill [if allowed in your state], the current list bill form is required.) Total Amount Submitted With Application (The first full premium by mode and the application fee must be submitted with this application.) Payment of Initial Premium: Credit Card (available only for monthly modes - first month only) Check (All checks must be made payable to World Insurance Company.)

Administrative Use Only



6. If "yes" for any proposed insured, 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? Yes No

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

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

c. Is replacement or change of existing medical insurance in this company or elsewhere for any proposed insured involved in this application? Yes No

d. Are any of the persons proposed for insurance covered by Medicare? If "yes", explain under Additional Remarks in Section F? Yes No

7. 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:

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)? Yes No

b. Was your most recent period of creditable coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan? Yes No

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? Yes No
 If "No", please explain _____

d. Are you eligible for any of the following as an insured or dependent (check appropriate box): Yes No

1. a Group Health Plan? Yes No

2. Part A or Part B of Medicare? Yes No

3. a State plan under Medicaid, or successor program? Yes No

e. Do you have other health insurance? Yes No

f. Was your most recent health insurance terminated for nonpayment of premiums, misrepresentation or fraud? Yes No

g. Does your current employer or your spouse's employer, offer a group health plan (employer-sponsored)? Yes No
 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. Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father? Yes No

If "yes", medical coverage cannot be issued.

2. 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 _____

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 convicted of a felony?
 - b. 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?
 - c. ever used sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency?
 - d. ever had surgery or diagnostic testing or treatment, or has surgery or diagnostic testing been recommended or scheduled that has not been completed?
 - e. 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?
 - f. ever received disability benefits or currently disabled?
 - g. 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?
 - h. in the past 10 years been in a hospital, clinic, or other medical facility for treatment, confinement or observation?
 - i. in the past 5 years participated in any racing, scuba diving, skydiving, rock climbing or any other hazardous activities?
 - j. in the past 5 years flown or plan to fly in the future, as a pilot or crew member?
 - k. 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?
 - b. congenital disorder, birth defects or developmental disorders, including, but not limited to:
 - Down's Syndrome mental retardation autism cleft palate club foot
 - congenital heart defects other _____
 - c. the respiratory system, including:
 - allergies asthma pneumonia emphysema bronchitis
 - shortness of breath chronic cough apnea sinusitis tuberculosis
 - cystic fibrosis other _____
 - d. the circulatory system, including:
 - heart disease heart defect heart condition mitral valve prolapse
 - heart attack chest pain varicose veins high blood pressure (hypertension)
 - phlebitis murmur aneurysm elevated cholesterol or triglycerides
 - Raynaud's Disease stroke, TIA palpitations/irregular heartbeat
 - Raynaud's Phenomenon other _____
 - e. the digestive system, including:
 - ulcer esophagus colitis hepatitis, jaundice, or cirrhosis
 - gall bladder bowel polyps diverticulitis, diverticulosis
 - gastritis stomach rectum disorder of pancreas, spleen, liver
 - hernia intestinal disorder hemorrhoids other _____
 - f. the nervous system, including:
 - epilepsy seizure headaches Alzheimers Parkinson's disease
 - dizziness fainting spells cerebral palsy multiple sclerosis
 - convulsions paralysis dementia other _____

(Continued)

- Yes** **No**
- g. a mental or nervous disorder, including:
- anxiety A.D.D./A.D.H.D. eating disorder learning/behavior disorder
 psychiatric treatment or counseling depression psychosis
 other _____
- h. the genitourinary system, including:
- prostate kidney disorder or stones urinary incontinence
 urinary tract infection bladder other _____
- i. the endocrine system, including:
- diabetes goiter thyroid gland high or low blood sugar
 glandular disorder pituitary disorder other _____
- j. the musculoskeletal system, including:
- arthritis gout TMJ/jaw problems lupus erythematosus rheumatism
 subluxation physical handicap fibromyalgia loss of limb knees
 the back, spine, or muscles other _____
- k. cancer, tumors, cysts, growths or breast disorders? (Provide location, type and treatment received.)
- l. skin disorder/problems, such as psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, or acne?
- m. the eyes, ears, nose, or throat, such as cataracts, glaucoma, speech or hearing impairment, otitis media or ear tubes?
- n. any disease or disorder of female/male reproductive systems or genitalia, including:
- ovaries impotency reproductive organ irregular menstruation
 infertility uterus/cervix premenstrual syndrome (PMS)
 sexually transmitted disease other _____

6. Questions for female applicants only.

- a. Any complications of pregnancy, including, but not limited to, caesarean section delivery or miscarriage?
- 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?

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?
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?

D. Health Statement Details

List complete details with respect to questions 4 thru 8. *If additional space is needed, please use Section F for additional remarks.*

Ques. No.	Person's Name	Dates of Treatment	Drugs & Dosage Prescribed, if any	Illness or Condition Treated	Remaining Effects (if none, list none.)	Complete Name, Address & Phone Number of Chiropractors, Physicians and Hospitals

(Continued)

Ques. No.	Person's Name	Dates of Treatment	Drugs & Dosage Prescribed, if any	Illness or Condition Treated	Remaining Effects (if none, list none.)	Complete Name, Address & Phone Number of Chiropractors, Physicians and Hospitals

E. Medications

1. Within the past 3 years, has any person proposed for insurance taken any prescription, alternative, complementary, herbal or natural medications other than noted in Section D? (If "yes", describe below) Yes No
2. Within the past 1 year, has any person proposed for insurance taken any supplements, or over-the-counter medications for a period longer than 5 consecutive days? (If 'yes', describe below) Yes No

Ques. No.	Name of Person	Name of Medication	Dosage & Frequency of Medication	Illness or Condition Treated	Date Last Taken	Name & Address of Physician

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 applica-

tion, 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 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 proposed insured under the child plan.
 - (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 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 _____

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.

CONDITIONAL RECEIPT

INSTRUCTIONS: Complete Conditional Receipt ONLY when full premium, including all application fees, 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.

Received from _____ the sum of \$ _____ paid with the attached insurance application to World Insurance Company.

Conditions – World Insurance Company agrees to insure those proposed for insurance if:

1. The payment received with the application is equal to the full first modal premium, including all application fees, for this certificate,
2. All medical or lab tests, if required, have been completed and no adverse medical condition(s) have been detected which would result in the declination or amendment of the certificate; and
3. All those proposed for insurance are insurable on the date of application without special exception and at standard or preferred rates under the Company's regular underwriting rules and practices for the certificate applied for.

Terms of Conditional Insurance:

1. This conditional receipt is governed by the terms of the certificate applied for.
2. This conditional receipt terminates 45 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. The effective date will be the earlier of a) underwriting approval date or b) specified future effective date (no sooner than 10 days after application date).

No Representative of the Company is authorized to modify this Conditional Receipt

Signature of Applicant _____ Signature of Agent/Broker _____

Date _____ Agent # _____

PERSONAL PROFILE INTERVIEW

Please call 800-846-9981 for your Personal Profile Interview. The hours available to complete your Interview are Monday thru Friday 7 a.m. to 9 p.m. and Saturday 9 a.m. to 3 p.m.

Make checks payable to World Insurance Company

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

Completing Your Personal Profile Interview

Thank you for choosing World Insurance Company to provide insurance protection for you and your family. As part of World's process for issuing your coverage, every adult applying for coverage will be asked to participate in a telephone interview to complete a personal profile of information important to the application process.

How To Complete Your Personal Profile Interview

Use the space below to capture information for ready reference.

1. Gather the names, addresses and phone numbers of all health care providers (physicians, specialists, chiropractors, etc.) you or any applicants for coverage have consulted in the past 10 years. Please include information about hospitals, outpatient surgical facilities and medical tests.
2. Gather information about the medications you or any applicant are currently taking or have taken in the past.
3. Select a convenient time to call and a private location, as some of the questions will explore the details of your health history. Please set aside approximately 20-30 minutes for the interview. All adults applying for coverage will need to be available to be interviewed.
4. Call 800-846-9981, Monday through Friday between 7 a.m. and 9 p.m., Central Time, or Saturday, between 9 a.m. and 3 p.m. to complete your Personal Profile Interview.

Personal Information

Please use this space to record your healthcare provider information and your medical history for your personal interview.

Healthcare Providers

Name	Address	Phone	Dates Visited/Reason

Medications – Past and Present

Name	Dosage and Frequency	Dates Taken





P.O. Box 3160
Omaha, NE 68103-0160
(402) 496-8000

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.

You have a right to know how your medical information is used and shared by us. PLEASE READ THIS NOTICE. It explains how we use information about you and when we can share that information with others. This Notice applies to current and former insureds, as well as covered dependents. Whenever we use the word “you” and “your”, it applies to everyone covered under your policy/certificate.

Protected Health Information (“PHI”) means information that is about you or identifies you. It includes demographic information, as well as information about your past, present or future physical or mental health or condition, the provision of your health care or the past, present or future payment of your health care. It does not include employment records or educational records covered by the Family Educational rights and Privacy Act.

We are legally required to keep your PHI confidential and private. We must also provide you with this notice which explains our legal duties and privacy practices and abide by it. We reserve the right to change our privacy practices which will apply to all PHI we maintain. If we make material changes to our privacy practices, we will provide you a copy of our revised Notice of Privacy Practices. At least every three years, we will let you know how you can access our Notice of Privacy Practices. If two or more insureds are named on your insurance contract, we will send only one notice to the insureds.

Confidentiality and Security – We view the security of your confidential and private information as a top priority and we strive to maintain appropriate physical, electronic and procedural safeguards to protect it. Only employees who need your information to perform their jobs can access your information. Additionally, we train our work force on protecting your PHI.

USES AND DISCLOSURES OF PHI – We do not use or share your PHI without your valid authorization unless permitted or required by law. Your authorization must be in writing and we have a form available for your use. You may contact our Customer Service Department at the address listed at the bottom of this notice to obtain a valid authorization form.

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

- To you, the subject of the PHI.

- To the U.S. Department of Health and Human Services for purposes of compliance with federal privacy rules.
- For your treatment, payment and/or health care operations. Examples of sharing for **treatment** purposes may be to provide a doctor or healthcare facility involved in your care information they request to assist in your care. Examples of **payment** purposes may be to collect premiums, determine eligibility for coverage, subrogation, billing activities, claims management, or disclosure to consumer reporting agencies. Examples of **health care operations** might include general administrative and business functions necessary for us to perform business such as underwriting, premium rating and other activities needed to issue, renew or replace an insurance policy/certificate.
- Persons assisting in your care and/or payment for care. If you are available and do not object, we may share your information with a family member, friend or someone involved with your care or payment for care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interest, we may share limited information without your approval.
- Required by law. We may use and/or share your information to the extent required to comply with the law.
- Public health activities. We may share your PHI with a public health authority that collects or receives information such as required reporting of disease, injury, birth or death and for required public health investigations.
- Reporting about victims of abuse, neglect or domestic violence. We may share PHI with a public health authority, governmental entity or agency if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect or domestic violence.
- Health oversight activities. We may use and/or share PHI for audits, investigations and inspections to government agencies that oversee the healthcare system, government programs, and civil rights laws.
- Judicial and administrative proceedings. We may use and/or share your PHI in the course of a judicial or administrative proceeding, order or a court or administrative tribunal and in response to a subpoena, discovery request or other lawful purposes.
- Law enforcement purposes. We may use and/or share your PHI for (1) lawful processes and otherwise required by law; (2) concerning crime victims; (3) suspicious deaths; (4) crimes on our premises; (5) reporting crimes in

Please leave with Proposed Insured in all cases

- emergencies; and (6) for the purposes of identifying or locating a suspect or other person.
- Information about decedents. We may use and/or share PHI with coroners and medical examiners to identify a deceased person, determine a cause of death, or as authorized by law. We may use and/or share PHI with funeral directors as necessary to carry out their duties.
 - Organ, eye or tissue donation purposes. We may use and/or share PHI with organ procurement organizations or other entities associated with the banking or transplantation of organs, eyes or tissues.
 - Avert a serious threat to health or safety. We may use and/or share PHI to prevent or lessen a serious and imminent threat to the health or safety of you or the public.
 - Specialized government functions. We may use and/or share PHI for military and veteran activities, national security and intelligence activities, protective services to the President or other authorized persons.
 - Workers' compensation. We may use and/or share PHI as necessary to comply with workers' compensation laws.

OTHER LAWS – If there is a law applicable to you that provides greater protection or greater rights regarding your PHI, we will comply with that law.

OTHER DISCLOSURES – We may disclose PHI to our business associates who help us conduct our business. They may not use or reuse your PHI except for providing the services we have contracted with them to perform on our behalf. Our business associates are also contractually obligated to maintain appropriate safeguards to protect PHI. Also, we may communicate directly with you about contract benefits or other covered products to enhance your current benefits.

Other disclosures require your valid authorization. Specific authorizations may be required for the release of psychotherapy notes and marketing with certain exceptions. You may revoke in writing any authorization you provide us.

YOUR RIGHTS

- You have the **right to request restrictions** on the use and disclosure of PHI in writing to carry out your treatment, payment or health care operations. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** Restriction forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to request confidential communications** from us by alternative means or at alternative locations. This request must be in writing. We will accommodate reasonable requests. Confidential Communication forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to inspect and copy your PHI** we maintain about you in our designated record set, with some exceptions, as defined by law. All requests must be made in writing and signed by you or your personal representative. Access request forms are available from our Customer Service Department at the address listed below.

- You have the **right to request an amendment** to certain components of your PHI to correct inaccuracies. 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 personal representative, and must state the reasons for the requested amendment. Amendment request forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to receive an accounting of certain disclosures** made by us after April 14, 2003 of your personal health information. Please note that we are not required to provide you with an accounting of the information that was collected prior to April 14, 2003; used or disclosed for treatment, payment, and/or healthcare operations; disclosed to you or pursuant to your authorization; incidental to a use or disclosure otherwise permitted by law; disclosed for a facility's directory or to a person involved in your care or other notification purposes; disclosed for national security or intelligence purposes; disclosed to correctional institutions, law enforcement officials or health oversight agencies; used or disclosed as part of a limited data set for research, public health or health care purposes.

Your request must be made in writing and you can obtain an accounting request form from our Customer Service Department at the address listed below. The first accounting in any 12-month period is free of charge; however, a fee will be charged for any subsequent request for an accounting during that same time period.

- You have the **right to obtain a copy of this notice** upon request at any time. We are required to abide by the terms of this notice. We reserve the right to change our privacy practices and the terms of this notice at any time and to make the new notice effective for all protected health information we maintain. If we do revise this notice, a copy will be sent to you at the time of the change.

COMPLAINTS – You may file a written complaint if you believe your privacy rights have been violated by submitting your complaint to our Customer Service Department at the address listed below. You may also file your complaint directly to the Secretary of the U.S. Department of Health and Human Services. If you file a complaint, we will not retaliate against you for that action.

CONTACT INFORMATION – If you have any questions regarding this notice, please contact us at:
World Insurance Company
P.O. Box 3160
Omaha, NE 68103-0160
800-786-7557 (Monday through Friday 7:30 a.m. to 5:00 p.m., Central Time)

EFFECTIVE DATE – This notice is effective as of April 14, 2003 and thereafter until amended or revised by us.



P.O. Box 3160
Omaha, NE 68103-0160
(402) 496-8000

Notice of Privacy Policy and Insurance Information Practices

Your privacy is important to us. This notice is being provided to you pursuant to the requirements of federal and state laws and/or regulations addressing the privacy of nonpublic personal consumer information, which may include financial and health information. This notice details the privacy policy and insurance information practices of World Insurance Company, as it relates to your nonpublic personal information.

Information Collected – We may collect nonpublic personal information about you to provide and administer products and services. We collect information about you from a variety of sources, such as:

- Information we receive from you or through our affiliates or subsidiaries, producers or other individuals, on applications, forms or interviews, such as salary information or health history. We may also collect identifying information such as name, address, social security number and age.
- Information about your transactions with us, our affiliates, or others, such as information about insurance premium payments, coverage selections, and claims history.
- Information received from a third party or consumer reporting agency, such as creditworthiness and credit history, or motor vehicle driving record report.
- Information received from medical providers regarding treatment of health conditions and payment for that treatment.

Disclosure Policy – We may disclose the personal information we collect to service, process or administer business operations, as permitted by law. Examples of how we may disclose your information are as follows:

- To process your applications and issue your coverage.
- To pay your claims.
- To provide service, perform policy maintenance or make any coverage changes you may request.
- To offer products or services that may be of interest to you.

We may 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. The agreements prohibit the third party from disclosing or using the information other than to carry out the function on our behalf for which the information was collected or disclosed.

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

Financial information – We do not disclose nonpublic personal financial information about you to nonaffiliated third parties, except as permitted or required by law.

Health Information – We do not disclose nonpublic personal health information, other than as permitted or required by law, unless you specifically authorize us in writing in advance to release such information.

Fair Credit Reporting Act – We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law.

Confidentiality and Security – We restrict access to nonpublic personal information about you to those employees who need to know that information for a business purpose in order to provide products and services to you. We maintain physical, electronic, and procedural safeguards that comply with requirements to protect your nonpublic personal information. Additionally, we maintain policies about the proper physical security of workplaces and records.

Former Customers – We do not disclose nonpublic personal information about former customers except as permitted or required by law.

If you have any questions regarding this notice, please contact us at World Insurance Company, (800) 786-7557.

We reserve the right to change the privacy practices of World Insurance Company. If we do so, we will communicate any material changes to you as required by law.

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.

