



P.O. Box 3160 • Omaha, Nebraska 68103-0160

# Application for Short-Term Medical Policy

Applicant Name (Print First, Middle, Last)		Sex M <input type="checkbox"/> F <input type="checkbox"/>	Persons Proposed for Coverage	Relation- tship	Date of Birth			Age	Soc. Sec. No.
Address No. and Street		Applicant			XXX	Mo.	Day		
City State ZIP Code								- -	
Work Phone ( ) Home Phone ( )								- -	
Policy Term Payment in Full (Check One) Month(s) <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6								- -	
		Deductible <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000	Total Premium		\$ _____				

1. Will there be any other health insurance in force on the policy date?  Yes  No *If yes, a policy cannot be issued.*
2. Is the applicant, spouse, or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?  Yes  No *If yes, a policy cannot be issued.*
3. Has any person proposed for coverage ever had a stroke, been diagnosed or aware of heart disease or disorder, or had heart surgery?  Yes  No *If yes, a policy cannot be issued.*
4. Within the past five (5) years, have you been aware of, diagnosed, treated by a member of the medical profession, or taken medication for cancer, COPD (chronic obstructive pulmonary disease), emphysema, diabetes, rheumatoid arthritis, osteoarthritis or degenerative joint disease of the knees, degenerative spinal disc disease or disc herniation/bulge, or liver disorder?  Yes  No *If yes, a policy cannot be issued.*
5. Have you been diagnosed or treated for AIDS, AIDS-related complex, or any other immune system disorder?  Yes  No *If yes, a policy cannot be issued.*
6. Have you been a legal resident of the United States for last twelve (12) consecutive months?  Yes  No *If no, a policy cannot be issued.*

I understand that:

1. The policy date will be the date the application is received in the Home Office, or, if later, the requested date of \_\_\_\_\_ .
2. The policy will not cover pre-existing conditions.

I acknowledge that I have received a copy of the Outline of Coverage.

I authorize my licensed doctor, practitioner of the healing arts, hospital, clinic, health-related facility, pharmacy, government agency, Social Security Administration, insurance company, group policyholder, employee or benefit plan administrator having information as to the care, advice, treatment, diagnosis, or prognosis of any physical, mental, drug and/or alcohol condition or the employment status, of the proposed applicants, to provide this information to **WORLD INSURANCE COMPANY** or any agent or independent administrator acting on its behalf.

I understand that I have the right to receive a copy of this authorization upon request.

A copy of this shall be as valid as the original. This authorization is valid for twelve months from the date signed.

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.

Date Signed	Dated At	Signature of Applicant	
Agent Signature and Number			
Home Office Corrections		Date Received	
		Amount Received \$	_____

**TO CALCULATE YOUR PREMIUM, SIMPLY:**

1. Add each applicant's monthly base premium (based on age, sex and deductible) found on the chart below.	Applicant + _____ Spouse + _____ Children (per child) + _____	Subtotal 1 = \$ _____
2. Chemical Dependency & Psychiatric Services Rider (per person based on deductible - see chart below)	Rate (from chart below) x _____ number of dependents	Subtotal 2 = \$ _____
3. Add Subtotal 1 and Subtotal 2.		Subtotal 3 = \$ _____
4. Multiply by the number of months of coverage.	Subtotal 3 x _____ months	Subtotal 4 = \$ _____
5. Multiply by your ZIP Code area factor (found on chart below).	Subtotal 4 x _____ Area Factor	Subtotal 5 = \$ _____
6. Add one-time administrative fee.	One month policy: \$20.00 2-6 month policy: \$40.00	
7. Add one-time application fee.	One month policy: \$5.00 2-6 month policy: \$10.00	
8. Enclose the full premium and fees with your application.	Add Subtotal 5 to items 6 and 7	Total = \$ _____

Age	Sex	Monthly Base Premium		
		\$250	\$500	\$1,000
<b>Deductible</b>				
18-24	M	73.07	49.40	41.17
	F	95.55	63.82	51.46
25-29	M	87.11	57.66	45.28
	F	103.97	67.95	55.57
30-34	M	98.33	65.88	51.46
	F	126.45	84.40	65.88
35-39	M	123.64	82.34	65.88
	F	148.95	98.83	78.23
40-44	M	151.75	98.83	80.29
	F	168.60	111.17	88.52
45-49	M	185.49	121.46	98.83
	F	199.50	131.75	105.00
50-54	M	268.24	177.56	144.40
	F	268.24	177.56	142.06
55-59	M	361.93	239.12	196.50
	F	316.70	208.33	168.08
60-64	M	492.32	326.07	276.67
	F	367.56	242.11	197.63
<u>Dependent Child</u>				
Ages 0-17		56.21	37.06	30.88
<u>R2192-MO - Chemical Dependency &amp; Psychiatric Services Benefit Rider</u>				
All Ages		48.86	31.82	25.86

State	ZIP	Area Factor
Missouri	630-633, 640-641, 652 .....	1.90
	All Others .....	1.50

*Rates effective Oct. 15, 2005.*

Credit Card Payment Request	
I authorize World Insurance Company to bill my:	
<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard – account for \$ _____	
(dollar amount) for Short-Term Medical insurance.	
Credit Card number:	_____
Expiration Date:	_____
Signature of Cardholder	_____
	Date _____

Please note: Children age 18-23 will be charged the 18-24 rate based on the gender of the child. When applying for dependent child-only coverage, the premium for children ages 0-17 is the male 18-24 rate for the first child and the child rate for each additional child. If you have any questions, ask your World agent or call our Marketing Division at 800-600-7760.