

## **World Insurance Application Check List**

- All Medical questions must be answered, if any are answered yes, please give complete details, including Physicians name and address.
- Make sure that all applications are signed and dated. (especially on the back side of application)
- If paying via monthly Bank Draft, please also complete Bank Authorization, and attach a voided check.

**You can fax your completed Application back to (803)781-7750**

Or Mail to the following address:

**Health Benefits ABC**  
Attn: David Greenhalgh  
PO Box 186  
Ballentine, SC 29002  
  
FAX: (803) 781-7750

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**Please feel Free to call us at any time with additional questions  
(800) 861-3834**



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
Address
b. Occupation/Title/Duties
4. Spouse's Name (First, Middle, Last)
5. a. Spouse's Employer
Address
b. Occupation/Title/Duties

Table with 10 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 (check one): FreedomCare 100, FreedomCare 80, FreedomCare 70, FreedomCare 50, Other
2. Deductible (check one): \$1,000, \$2,000, \$2,500, \$3,000, \$5,000, \$7,500, \$10,000, Other
3. Name of PPO Selected:
4. Optional Benefits: Maximum Benefit, Life Benefit for Covered Member, Life Benefit for Covered Spouse, Other
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:
5. Please check your choice of effective date of coverage: Underwriting Approval Date, Specified Future Date
6. 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.
7. Payment Mode: Annual, Semiannual, Quarterly, Check-O-Matic, List Bill
\$ 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, Check

Administrative Use Only



8. 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?
- | 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?    
 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 proposed insured 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**

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 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?







- 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.

*For New Mexico residents only:* 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.

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 SCU 13 Date Signed  
Agent Code

**David Greenhalgh**  
\_\_\_\_\_  
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.

**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/certificate 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.

**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

**T**hank 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 8 a.m. and 9 p.m., Central Standard Time, or Saturday, between 10 a.m. and 2 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

