



P.O. Box 3160 • Omaha, Nebraska 68103-C160

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 | Relationship | Date of Birth | | | Age | Soc. Sec. No. |
| Address | | No. and Street | | | Mo. | Day | Yr. | | |
| 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 | | Total Premium | | \$ | |
| | | | | <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000 | | | | | |

- Will there be any other health insurance in force on the policy date? Yes No *If yes, a policy cannot be issued.*
- 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.*
- 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.*
- 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.*
- 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.*
- 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:

- The policy date will be the date the application is received in the Home Office, or, if later, the requested date of _____.
- 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 | Date Received | |
| _____ | _____ | |
| Home Office Corrections | Amount Received \$ _____ | |
| _____ | _____ | |



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Agent #121056

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 | | |
|--|-----|----------------------|--------|---------|
| | | Deductible | | |
| | | \$250 | \$500 | \$1,000 |
| 18-24 | M | 80.74 | 54.59 | 45.49 |
| | F | 105.58 | 70.52 | 56.86 |
| 25-29 | M | 96.26 | 63.71 | 50.03 |
| | F | 114.89 | 75.08 | 61.40 |
| 30-34 | M | 108.65 | 72.80 | 56.86 |
| | F | 139.73 | 93.26 | 72.80 |
| 35-39 | M | 136.62 | 90.99 | 72.80 |
| | F | 164.59 | 109.21 | 86.44 |
| 40-44 | M | 167.68 | 109.21 | 88.72 |
| | F | 186.30 | 122.84 | 97.81 |
| 45-49 | M | 204.97 | 134.21 | 109.21 |
| | F | 220.45 | 145.58 | 116.03 |
| 50-54 | M | 296.41 | 196.20 | 159.56 |
| | F | 296.41 | 196.20 | 156.98 |
| 55-59 | M | 399.93 | 264.23 | 217.13 |
| | F | 349.95 | 230.20 | 185.73 |
| 60-64 | M | 544.01 | 360.31 | 305.72 |
| | F | 406.15 | 267.53 | 218.38 |
| <u>Dependent Child</u> | | | | |
| Ages 0-17 | | 62.11 | 40.95 | 34.12 |
| <u>R2192-MO - Chemical Dependency & Psychiatric Services Benefit Rider</u> | | | | |
| All Ages | | 53.99 | 35.16 | 28.58 |

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

Credit Card Payment Request

I authorize World Insurance Company to bill my:

Visa MasterCard – account for \$ _____

(dollar amount) for Short-Term Medical insurance.

Credit Card number: _____

Expiration Date: _____

Signature of Cardholder _____ Date _____

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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 800-733-5454.