



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- ship XXX	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)		Deductible	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1000	Total Premium	Total Premium			\$
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	Monthly Billing <input type="checkbox"/>							

- 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.*
- Is any proposed insured currently eligible for Medicaid? Yes No *If yes, a policy cannot be issued.*
- Has any person proposed for coverage been declined for health insurance in the past 12 months? 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 (not applicable in Montana).

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 \$

G2300 (3-01)

***Monthly billing is not an option. Full premium & fees are due at application time.**

Rate revision 5-08

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. Multiply by the number of months of coverage.	Monthly base rate (Subtotal 1) x ___ months Subtotal 2 = \$ _____
3. Multiply by your ZIP Code area factor (found on chart below).	Subtotal 2 x _____ Area Factor Subtotal 3 = \$ _____
4. Add one-time administrative fee.	One month policy: \$20.00 2-6 month policy: \$40.00
5. Add one-time application fee.	One month policy: \$5.00 2-6 month policy: \$10.00
6. Enclose the full premium and fees with your application.	Add Subtotal 3 to items 4 and 5 Total = \$ _____

Age	Sex	Monthly Base Premium Deductible		
		\$250	\$500	\$1,000
18-24	M	77.53	52.41	43.68
	F	101.37	67.69	54.59
25-29	M	92.40	61.16	48.03
	F	110.31	72.08	58.96
30-34	M	104.32	69.88	54.59
	F	134.15	89.53	69.88
35-39	M	131.15	87.35	69.88
	F	158.00	104.82	83.00
40-44	M	160.97	104.82	85.17
	F	178.84	117.93	93.91
45-49	M	196.76	128.85	104.82
	F	211.63	139.77	111.37
50-54	M	284.55	188.37	153.18
	F	284.55	188.37	150.69
55-59	M	383.94	253.64	208.44
	F	335.95	221.01	178.30
60-64	M	522.23	345.92	293.49
	F	389.90	256.80	209.65
Each Child Ages 0-17		59.63	39.32	32.76

State	ZIP	Area Factor
Georgia	300-303	1.30
	All Others	1.10
Illinois	600-606	1.85
	All Others	1.20
Iowa	All	1.00
Nebraska	All	1.00
Wyoming	All	1.00

**Illinois rates effective June 1, 2008.
All other states, rates effective May 1, 2008.**

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 800-733-5454.