



Omaha, Nebraska

Proprietary Application Packet

CP G4600 Pkt

06 133 4600 060109 US

06 133 2708 0609 US

SBA Association Membership Application

This insurance plan requires that applicants are members of the association who sponsor this coverage.

Agent Instructions: Please have your customer complete the following application for association membership. If applying for insurance with World Insurance Company, the association membership must be completed, in addition to the insurance application.

- Application for Association Membership** – *Complete the application and submit to World Insurance Company with the insurance application.*
- Description of Benefits** – *Leave with applicant. These are the benefits available to association members.*

SBA Membership Application • Please Print

Applicant First Name _____ MI _____ Last _____
 Residence Address _____
 City _____ State _____ ZIP _____
 Home Tel. (____) _____ Bus. Tel. (____) _____
 Age _____ Sex _____ Birthday ____ - ____ - ____ Social Security # _____ - _____ - _____
 Spouse First Name _____ MI _____ Last _____
 Age _____ Sex _____ Birthday ____ - ____ - ____ Social Security # _____ - _____ - _____
 Dependent #1 First Name _____ MI _____ Last _____
 Age _____ Sex _____ Birthday ____ - ____ - ____ Social Security # _____ - _____ - _____
 Dependent #2 First Name _____ MI _____ Last _____
 Age _____ Sex _____ Birthday ____ - ____ - ____ Social Security # _____ - _____ - _____
 Dependent #3 First Name _____ MI _____ Last _____
 Age _____ Sex _____ Birthday ____ - ____ - ____ Social Security # _____ - _____ - _____
 Applicant's Signature _____ Date _____

For Completion by Agent

SBA Enroller's Name (Please Print) _____
 Agent # _____ Date _____ SBA Enroller's Signature _____

Pre-Authorization Check (PAC) Payment Plan Request

Please print all of the information below. A voided blank check must be attached.

Authorization to Honor Checks Drawn by World Insurance Company – As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to **World Insurance Company**, provided there are sufficient collected funds in my account to pay such checks, upon presentation. I agree that your rights in respect to each check shall be the same as if it were a check signed personally by me. This authority is to remain in effect until revoked by me in writing and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check.

Please Print information about the bank account to be charged.

Depositor's Name as shown on Bank Account _____
 Bank Name _____ Bank Address _____
 Routing Number _____ Account Number _____
 Signature X _____ Date _____
 Second Signature if joint account X _____





Founded to promote the common interests of small businesses and their employees, the SBA offers its members a wide variety of cost saving programs ranging from business to personal lifestyle. Through membership in **The Small Business Association**, members reap the benefits of the negotiating efforts of the **SBA**.

BUSINESS

- **Alamo, Avis, Hertz & National** – Special member discount rates on car rentals nationwide.
- **Powernet Global** – *4.5 cents per minute* on long distance calls, state to state, anytime.
- **Customized Web Sites** – *20% Discount* on full service web site development and maintenance.
- **Internet Access Services** – Discounts on *Unlimited Dial-Up Access* to the internet.
- **Lease Now** – *Save 1%* of the cost of *Office Equipment* financing and get up to *\$500 in cash rebates*.
- **Association Travel Club** – *Tour and cruise discounts*.
- **Crisp Publications** – *40% Discount* off the cost of any quality educational book or video/book training program.
- **Grayhawk Administrative Services** – Simplifies *Payroll Processing* and prepares payrolls for less.
- **File Solutions** – Step-by-step filing systems for home, business and special needs at a *15% Discount*.
- **Pre-Employment Background Reports and Investigative Services** – *15% Off* investigative services. Free consultation.
- **Penny Wise** – *Save up to 36%* off already discounted brand name office supplies and furniture.
- **Quest Hotel Discount Program** – Quest card provides *Savings of 50%* on accommodations at approximately 5,000 hotels.

PRESCRIP DISCOUNT PRESCRIPTION PROGRAM

- **Prescription Drugs Discount Program** – This program provides *On-The-Spot Discounts* on *Prescription Drugs*. More than *35,000* chain and independent *Pharmacies* participate in this program. The SBA Prescription Savings Program is honored at over *99% of all Pharmacies Nationwide*. The SBA Prescription Savings Program is not insurance. It is a Discount Savings Program provided for active members of the SBA

LIFESTYLE

- **Child ID Card** – You can't be with your children all the time – especially when they go to school – but you can provide additional protection for those times when they're not with you. By registering your children with a *UBR Child ID Card*, authorities will be able to provide faster, more complete help to your child should he/she be missing or abducted. *Registration of your first two children is free* as part of your association membership. Registration of additional children is available for a nominal fee.
- **Hop-The-Shops.com** – Up to *50% Discount* on brand name

merchandise through premium on-line shopping mall.

- **Floral Discounts** – *40-60% Savings* from what most retail florists charge.
- **Emergency Roadside Assistance** – *24-Hour Nationwide Discounted Service*, includes towing, mechanical assistance, tire changing, fuel delivery, etc.
- **Savers Club Book** – Featuring savings on . . .
 - Hotels, Motels, Condos and Bed & Breakfasts
 - Movie Theater Tickets
 - Theme Park Admissions
 - And Much More!
- **Discount Magazines** – Up to *85% Off* popular titles.
- **North American Van Lines Moving Discounts** – Substantial savings on *Interstate*, competitive pricing on *Intrastate* and *Local* as well.
- **Discount Dining** – *Quarterly Rebates on Dining* and other services.

HEALTH

- **Accidental Injury Excess Coverage** – *\$250 Deductible* with benefits up to *\$5,000 Per Accidental Injury* per covered member.
 - Benefits include both *Medical and Dental*
 - *Ambulance Service*
 - Plus *Accidental Death & Dismemberment* benefits included.

See Certificate of Coverage for complete details, exclusions and waiting periods.
- **Emergency Travel Assistance Plan** – Receive the following benefits when *Traveling more than 100 miles* from your home.
 - *Emergency Evacuation/Repatriation* – If member cannot be treated by a local medical facility, the member will be transported by the most appropriate means to the nearest hospital able to provide treatment.
 - *Transportation of Escort* – Spouse or companion is free to accompany injured or ill member if transportation is provided by air whether air ambulance or commercial airline.
 - *Minor Children Return*
 - *Medical Referral* – Assistance in locating a local medical provider.
 - *Transportation of Remains*
 - *Vehicle Return*
 - *Lost Document Service*

Health Benefits continue on next page

This application at the left is submitted for consideration of membership in The Small Business Association of America also known as SBA. At the discretion of SBA, benefits may be changed periodically.

HEALTH (cont'd.)

- Legal Assistance
- Emergency Prescription Delivery
- Emergency Cash Transfer & Advances
- **Medical Emergency Data Card** – Wallet size card provides Personal Medical Profile in case of emergency.
- **The Hearing Aid Service** – Up to 60% Discount on Quality Hearing Aids on a no-risk, 100% Satisfaction-Guaranteed basis.
- **Lenscrafters Vision Club and Retail Eye wear Discounts** – 20% Discount on Purchases.
- **Med Script Mail Order Prescription Drug Program** – Members can Save Up to 50% on Prescription Drugs . . . plus, have them delivered right to your front door!
- **24-Hour Nurse Helpline** – Members have unlimited access to registered nurses via a toll-free number 24 hours a day, 365 days a year. These nurses are specially trained to offer prompt, confidential medical counseling to help members make informed decisions about their health and the medical care they receive. However, our nurses do not diagnose or provide treatment.
 - Toll-free, Confidential Availability to registered nurses 24-hours a day.
 - Access to a library of Audio Tapes on over 700 Health Topics found in the Nurse Helpline Booklet.
 - Information About Self-Care techniques for common symptoms.
 - Explanations on what to expect during a medical test.
 - Help from a Registered Nurse who can answer questions regarding:

*diagnostic and surgical procedures
a recently diagnosed medical condition
prescription and over-the-counter medication
information.*

- **GlobalFit Fitness Benefit** – To help improve member health and well-being, we have arranged for association members to take advantage of GlobalFit, with access to over 1,800 fitness clubs nationwide, including select Bally Total Fitness, World Gym and Ladies Workout Express locations.
 - Guaranteed Lowest Rates – Up to 60% savings on monthly dues
 - Month-to-Month Memberships with no long-term contracts
 - Ability to freeze your membership at most clubs
 - Flexibility to Transfer to Any Club in GlobalFit's growing fitness club network
 - Full-Service Web Site and toll-free customer service line
- **Accudiet.com** – As an association member you and your family receive special pricing at accudiet.com, the all-in-one interactive toolkit for the personalized diet and exercise program made to fit just one person – you.
 - Personalized Meal Plans tailored to your needs and goals
 - Interactive Program to keep your diet on track
 - Smart Weekly Shopping Lists
 - Convenient at-a-glance calorie, fat, carb and protein totals
 - Customized Workouts match your fitness level
 - Access-Anywhere online workout calendar and log

Receipt for SBA Initial _____ Months Dues

Received from _____ Check # _____

In the Amount of \$ _____ Dollars for payment of SBA Enrollment and Initial Dues.

Enroller's Signature _____

Agent # _____ Date _____

Cancellation and Refund Provision

SBA will accept cancellations in writing only. You may cancel your benefits at any time, however you will not receive a refund for any month in which your membership was in force. To cancel your monthly bank draft we must be notified 15 days in advance of the draft.

If you need to write us, please send correspondence to:

The Small Business Association of America
16476 Chesterfield Airport Road, 2nd Floor
Chesterfield, MO 63017

Important New Member Information

Your Small Business Association of America Membership Kit will arrive in about four weeks. This package will include your Member's Guide to Benefits and Discounts as well as your Association Member Benefits Card. If you have any questions about your new membership call:

The Small Business Association of America • **1.800.992.8044**

Application for Health Insurance

Agent Instructions: The information in this section will be used to determine the applicant's eligibility for health insurance and to specify which payment method is requested. Applications must be submitted on behalf of the customer by the agent. Please include the following completed forms with the application.

- Association Application**
- Software Proposal** – Please attach an accurate proposal. This will identify which plan/PPO network/options are being applied for. (If applying for Dental Coverage under Master Policy AM3200, please include on the proposal. Please include correct premium for Dental Coverage.)
- Arbitration Form (M1074)** – Applicable only in AL.
- Application for Insurance** – Applicant must answer all questions. Applicant and agent signature is required.
- HIPAA Compliant Authorization to Obtain Information** – Applicant must read and sign form.
- Agent Certification** – Agent completes and signs form.
- Authorization to Charge Credit Card OR Automatic Payment Plan** – Applicant completes if electing to pay with credit card or automatic payment plan. Must include a voided check if electing automatic payment plan.
- Initial Premium** – Including any fees.
- State Mandated Forms** – If applicable.

Utilize the following materials on www.worldsells.com:

- Limited Benefit Product Underwriting Guide – W1308

Have any questions about completing the application? Call your General Agent or our toll-free number at 800-733-5454. Product and Marketing questions should be directed to your General Agent or our Marketing Hot Line at 800-995-9010.

A. General Information (please print)

1. a. Member's Name (First, Middle, Last)					2. Phone Number					Best time to call	
b. Address (Number, Street)					a. Home ()						
c. City, State & ZIP • Within city limits? <input type="checkbox"/> Yes <input type="checkbox"/> No					4. Spouse's Name (First, Middle, Last)						
3. a. Proposed Insured's Employer					5. a. Spouse's Employer					Address	
Address					b. Occupation/Title/Duties						
b. Occupation/Title/Duties											
6. Persons proposed for insurance. List first, MI, and last names.		Relationship to proposed member	Ht. ft., in.	Wt. lbs.	Birthdate Mo./Day/Yr.	Birth state	Sex	Tobacco use in the past 2 yrs. Yes No	Social Security Number	Driver's License Number/State	
								<input type="checkbox"/> <input type="checkbox"/>			
								<input type="checkbox"/> <input type="checkbox"/>			
								<input type="checkbox"/> <input type="checkbox"/>			
								<input type="checkbox"/> <input type="checkbox"/>			
								<input type="checkbox"/> <input type="checkbox"/>			
								<input type="checkbox"/> <input type="checkbox"/>			
7. a. Parent/Guardian (if child-only coverage)			b. Address (No., Street, City, State and ZIP)					c. Phone #		d. Social Security #	
8. a. Payor (if different from above)			b. Address (No., Street, City, State and ZIP)					c. Phone #		d. Social Security #	
9. Provide details under Additional Remarks in Section E for any questions answered "No".										Yes	No
a. Is each person to be covered a U.S. citizen?.....										<input type="checkbox"/>	<input type="checkbox"/>
b. Are all persons to be covered living at the same residence?.....										<input type="checkbox"/>	<input type="checkbox"/>
c. Do all persons to be covered live or plan to live only in the U.S. or Canada?.....										<input type="checkbox"/>	<input type="checkbox"/>

B. Type of Coverage Requested

1. **Proposal Required:** Submit with application – the proposal indicates the type of coverage requested.

2. **Please check your choice of Effective Date of Coverage:** Underwriting Approval Date Specified Future Date _____ (1st - 28th)

3. **Payment Mode: Direct Bill:** Annual Semiannual Quarterly **Monthly:** Bank Draft Credit Card
 List Bill (If requesting a new list bill [if allowed in your state], the current list bill form is required. Submit only application fee, if any, for initial premiums on list bill. Application Fees are non-refundable unless required by state law.)
 Other _____

Payment for Initial Premium: Check Credit Card (available only for Monthly Modes) \$_____ Total amount submitted with application (The first full premium by mode, association dues, and the application fee must be submitted with this application.)

4. **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 #	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. If "Yes" to any of the following, complete and submit any required replacement forms.

a. Is there any medical insurance in force or pending?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Is replacement or change of existing medical insurance in this company or elsewhere involved in this application?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Was any person proposed for insurance coverage under a health benefit plan within 90 days of the requested effective date of this certificate?.....	<input type="checkbox"/>	<input type="checkbox"/>

Name	Name of Insurance Company	Address & Phone Number for Insurance Carrier	Plan/Certificate #	Start Date	End Date

Administrative Use Only

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

C. Health Statement

Proposed Insured or Spouse must answer all questions in full. Your representative does not have the authority to waive or omit any information from your application.

If any questions are answered "Yes", give details in #5 and #6.

	Yes	No
1. Are you and all persons proposed for insurance now in good health and without physical or mental defect or deformity?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you or any persons proposed for insurance own or operate a motorcycle or trail bike; engage in weight lifting; underwater diving; auto or vehicle racing; rodeo activities or any other hazardous work or sport activity?	<input type="checkbox"/>	<input type="checkbox"/>
<i>If yes, please provide name: _____</i>		
<i>What sport activity? _____</i>		
3. Has any person proposed for insurance:		
a. been evaluated for alcoholism/chemical dependency or frequently used alcoholic beverages to intoxication or excess or been advised to modify drinking or other habits for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
b. used sedatives, tranquilizers, cocaine, marijuana, hallucinogens, other narcotic drugs or controlled substance, or received treatment for drug abuse or chemical dependency?	<input type="checkbox"/>	<input type="checkbox"/>
c. been in a hospital, clinic, or other medical facility in the past 10 years for treatment, confinement or observation?	<input type="checkbox"/>	<input type="checkbox"/>
d. had surgery or had diagnostic testing, treatment, or surgery recommended or scheduled that has not been completed?	<input type="checkbox"/>	<input type="checkbox"/>
e. ever had, been diagnosed with 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?	<input type="checkbox"/>	<input type="checkbox"/>
f. taken medication of any kind or had any medication prescribed within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
g. does any person have any fixation/prosthetic devices present including, but not limited to, plates, screws, pins, implants including breast implants, pacemakers, valve replacements or transplants?	<input type="checkbox"/>	<input type="checkbox"/>
4. To the best of your knowledge and belief, has <u>any</u> person proposed for insurance in the past 10 years had any indication, diagnosis or treatment of:		
a. blood or lymph disorders including but not limited to anemia or lymphadenopathy?	<input type="checkbox"/>	<input type="checkbox"/>
b. congenital disorder, birth defects or developmental disorders including but not limited to:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Down's Syndrome <input type="checkbox"/> mental retardation <input type="checkbox"/> autism <input type="checkbox"/> cleft palate <input type="checkbox"/> club foot		
<input type="checkbox"/> congenital heart defects		
c. the respiratory system, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> allergies <input type="checkbox"/> asthma <input type="checkbox"/> pneumonia <input type="checkbox"/> emphysema <input type="checkbox"/> bronchitis		
<input type="checkbox"/> shortness of breath <input type="checkbox"/> chronic cough <input type="checkbox"/> apnea <input type="checkbox"/> sinusitis <input type="checkbox"/> tuberculosis		
<input type="checkbox"/> Cystic Fibrosis <input type="checkbox"/> other _____		
d. the circulatory system including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> heart disease <input type="checkbox"/> heart defect <input type="checkbox"/> heart condition <input type="checkbox"/> high blood pressure (hypertension)		
<input type="checkbox"/> heart attack <input type="checkbox"/> chest pain <input type="checkbox"/> varicose veins <input type="checkbox"/> mitral valve prolapse		
<input type="checkbox"/> phlebitis <input type="checkbox"/> murmur <input type="checkbox"/> aneurysm <input type="checkbox"/> elevated cholesterol		
<input type="checkbox"/> Raynaud's <input type="checkbox"/> palpitations/irregular heartbeat <input type="checkbox"/> stroke, TIA		
e. the digestive system, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ulcer <input type="checkbox"/> esophagus <input type="checkbox"/> colitis <input type="checkbox"/> hepatitis, jaundice, or cirrhosis		
<input type="checkbox"/> pancreas <input type="checkbox"/> gall bladder <input type="checkbox"/> bowel <input type="checkbox"/> diverticulitis, diverticulosis		
<input type="checkbox"/> gastritis <input type="checkbox"/> stomach <input type="checkbox"/> rectum <input type="checkbox"/> disorder of pancreas, spleen, liver		
<input type="checkbox"/> spleen <input type="checkbox"/> hernia <input type="checkbox"/> intestinal disorder <input type="checkbox"/> hemorrhoids		
<input type="checkbox"/> polyps <input type="checkbox"/> other _____		
f. the nervous system, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> epilepsy <input type="checkbox"/> seizure <input type="checkbox"/> headaches <input type="checkbox"/> Alzheimers <input type="checkbox"/> Parkinson's disease		
<input type="checkbox"/> dizziness <input type="checkbox"/> fainting spells <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> Multiple Sclerosis		
<input type="checkbox"/> convulsions <input type="checkbox"/> paralysis <input type="checkbox"/> dementia <input type="checkbox"/> other _____		
g. a mental or nervous disorder, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> anxiety <input type="checkbox"/> learning/behavior disorder <input type="checkbox"/> A.D.D./A.D.H.D. <input type="checkbox"/> eating disorder		
<input type="checkbox"/> psychiatric treatment or counseling <input type="checkbox"/> depression <input type="checkbox"/> other _____		
h. the genitourinary system including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> prostate <input type="checkbox"/> kidney disorder or stones urinary incontinence <input type="checkbox"/> urinary tract infection <input type="checkbox"/> bladder		
<input type="checkbox"/> other _____		
i. any disease or disorder of female/male reproductive systems or genitalia, including:	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> ovaries <input type="checkbox"/> impotency <input type="checkbox"/> reproductive organ <input type="checkbox"/> irregular menstruation		
<input type="checkbox"/> infertility <input type="checkbox"/> uterus/cervix <input type="checkbox"/> premenstrual syndrome (PMS)		
<input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> other _____		
1. Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?	<input type="checkbox"/>	<input type="checkbox"/>
Expected delivery date: _____		
If i(1) is answered Yes, medical coverage cannot be issued. Questions (2)-(4) for female applicants only.		
2. Any complications of pregnancy, including but not limited to caesarean section delivery or miscarriage?	<input type="checkbox"/>	<input type="checkbox"/>
3. Date of last pap smear _____ Results _____		
4. 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?	<input type="checkbox"/>	<input type="checkbox"/>

- | | | |
|--|--------------------------|--------------------------|
| j. the endocrine system, including:..... | Yes | No |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> glandular disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> goiter | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> pituitary disorder | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> thyroid gland | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> high or low blood sugar | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| k. the musculoskeletal system, including:..... | Yes | No |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> subluxation | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> the back, spine, or muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> gout | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> physical handicap | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> TMJ/jaw problems | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> lupus erythematosus | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> rheumatism | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> loss of limb | <input type="checkbox"/> | <input type="checkbox"/> |
| l. cancer, tumors, cysts, growths or breast disorders: (For cancer, provide location, type of cancer and treatment received.)? | <input type="checkbox"/> | <input type="checkbox"/> |
| m. skin disorder/problems, such as cancer, psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, acne, etc.? | <input type="checkbox"/> | <input type="checkbox"/> |
| n. the eyes, ears, nose, or throat, including cataracts, glaucoma, speech or hearing impairment, otitis media, ear tubes? | <input type="checkbox"/> | <input type="checkbox"/> |

5. Remarks – If any questions were answered “Yes”, give full details below, and details of any other ailments about which any physician was consulted **in the last 10 years** by you or any dependent listed above. If none, state “None”. **List all hospital confinements or outpatient surgeries in last 10 years (routine confinements, without complications, for childbirth need not be listed).**

Name of Person	Nature of Illness or Injury – Date(s)	Names and Addresses of Doctor(s) and Hospitals	Recovery Completed?
----------------	---------------------------------------	--	---------------------

6. List all prescriptions currently being taken by the:

Applicant: _____
 Spouse: _____
 Children: _____

D. Additional Remarks

E. 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 application, 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 provi-

sions, 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 association 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.

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 Parent or Legal Guardian (if other than Member) for child-only coverage _____ Date Signed _____

Signature of Dependent (If 18 or older) _____ Date Signed _____

Signature of Dependent (If 18 or older) _____ Date Signed _____

Signature of Agent _____ Agent Code _____ Date Signed _____

Printed Name of Agent _____

Agent Certification

Check Box 1 or 2.

- 1. I certify that during an in-person interview with the Member, I saw each person proposed for coverage, I have truly and accurately recorded in this application all the information supplied and have witnessed the signatures of the proposed insured(s).
- 2. If other than #1 above, explain in detail how the completion of the application differed from #1 and the reasons for the differences.

	Yes	No
3. Do you have any knowledge or reason to believe that replacement or duplication of existing insurance might be involved?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you reviewed the entire application for corrections or omissions?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you aware of any information, not recorded on the application, which might have a bearing on the insurability of any person proposed for insurance. (If yes, please list details below.).....	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you given the member the attached Fair Credit and M.I.B. notices?	<input type="checkbox"/>	<input type="checkbox"/>

Special requests, remarks and instructions: _____

Agent Name — Please Print _____ Agent Code _____ Date _____

Agent Phone No. _____ Agent Cell Phone No. _____ Agent Fax No. _____

Agent e-mail Address _____ Agent Signature _____

Register @ www.worldsells.com to receive e-mail notification from World.

If you are not registered at www.worldsells.com, please do so today. Registration on World's Virtual Home Office is quick and easy. You can also log on to update your e-mail address if you are already registered.

HIPAA Authorization

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to World Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; or the Medical Information Bureau (MIB).

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.

- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it.
- I have the right to ask for and obtain a copy of any consumer report made about me to the Company.

I agree that a copy of this Authorization is as valid as the original.

Date

_____ **X**

Your Name (Please Print) Your Signature

_____ **X**

Your Spouse's Name (if applying) (Please Print) Your Spouse's Signature (if applying)

_____ **X**

Your Child's Name (if 18 or older) Your Child's Signature (if 18 or older)

_____ **X**

Your Child's Name (if 18 or older) Your Child's Signature (if 18 or older)

Your Child(ren)'s Name(s) if younger than 18 (Please Print)

1. _____ 3. _____

2. _____ 4. _____

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Person(s) to be Insured (Please Print)

My relationship to applicant(s) (Please Print)

X _____
Personal Representative

Authorization to Disclose Information

I authorize World Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention. I understand that I do not have to authorize this disclosure to MIB.

Issuance of coverage will not be conditioned on me signing this authorization. Yes No

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and

must send my written request to: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Date

_____ **X**

Your Name (Please Print) Your Signature

_____ **X**

Your Spouse's Name (if applying) (Please Print) Your Spouse's Signature (if applying)

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Person(s) to be Insured (Please Print)

My relationship to applicant(s) (Please Print)

X _____
Personal Representative

Disclosure Forms for Applicant

The information in this section must be left with the applicant.

Agent Instructions: The following forms should be left with your customer.

- Disclosure** – Agent Signature is required on the Conditional Receipt, if *FULL* premium, and all applicable fees are submitted with application.
- Completing Your Personal Profile Interview** – This form describes the process for the telephone interview required for all applicants.
- Notice of Privacy Policy and Insurance Information Practices**
- Notice of Privacy Practices – Medical**

WORLD INSURANCE COMPANY • P.O. Box 3160, Omaha, NE 68103-0160

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 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 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901.

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.

X Signature of Applicant _____

Signature of Agent/Broker _____

Date _____ Agent # _____

ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a policy/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 (where applicable), 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 not be completed.

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 (where applicable), for this policy/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 policy/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 policy/certificate applied for.
2. This conditional receipt terminates 45 days after the application date, when the policy/certificate applied for is declined or withdrawn, or when the policy/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

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. (Central Time).

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. We will call you as close as possible to the time/day you specified on the application. You will want to set aside approximately 20-30 minutes in a setting where you are able to discuss confidential health information. If it is more convenient for you to call us, you may do so at 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.

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



Notice of Privacy Practices for AmericanEnterprise Group Companies FINANCIAL

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.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, World Insurance Company, and World Corp Insurance Company (“Company”) we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records (“non-public personal information”). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- to process your application and issue your policy.
- to pay your claims.
- to make any policy changes you may request.
- to offer you additional opportunities to improve your financial security.

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

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

Questions?

**If you have any questions, please call
our toll-free Customer Service line.**

1-800-247-2190

Notice of Privacy Practices for AmericanEnterprise Group Companies 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.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, World Insurance Company, and World Corp Insurance Company, (“Company”) we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about “information” or “health information” in this notice we mean individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Individually identifiable health information is health information that:

- Is created or received by the Company’s designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

How We Use or Share Information

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

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs.

- To use or disclose your information to provide you with information about health related benefits and services that you may be interested in.
- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

There are also state and federal laws that may require or permit us to release your information to others without your authorization.

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services and the Iowa Division of Insurance.
- To share information for public health activities. For example, we may report information to government authorities conducting public health investigations.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law. For example audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding. For example pursuant to a valid court order or subpoena.
- To report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information to a funeral director as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes, or tissue.

- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law.

If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information.** If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Service Center. Contact information for our Customer Service Center is located at the end of this Notice.

- **You have the right to ask us to restrict** how we use or disclose your information for payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care and uses and disclosures for disaster relief purposes. Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions.
- **You have the right to request confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain.** All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Service Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission.** 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 representative, and must

state the reasons for the requested amendment. Amendment request forms are available from our Customer Service Center at the address below.

- **You have the right to receive an accounting** of certain disclosures of your information. Please note that we are not required to:
 - Any information collected prior to April 14, 2003.
 - Information disclosed or used for treatment, payment, and/or health care operations purposes.
 - Information disclosed to you or pursuant to your authorization.
 - Information that is incidental to a use or disclosure otherwise permitted.
 - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
 - Information disclosed for national security or intelligence purposes.
 - Information disclosed to correctional institutions, law enforcement officials or health oversight agencies.
 - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Accounting requests forms are available from our Customer Service Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period.

Exercising Your Rights

- You have a right to receive a copy of this notice upon request at any time. You can also view a copy of this notice on our website at www.americanenterprise.com. We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail and post it on our website.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Service Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint.**

Contact Information

If you have any questions or complaints, please contact us at:

**Notice of Privacy Practices
American Enterprise Group Companies,
Customer Service Center
P.O. Box 9371, Des Moines, IA 50306-9371**

You can call us at: **1-800-247-2190.**

www.americanenterprise.com



P.O. Box 3160
Omaha, NE 68103-0160