Omaha, Nebraska

Broker

Colorado

Application Packet

CB G1200-CO Pkt

Colorado

Colorado does not require association membership.

WORLD INSURANCE
Omaha, Nebraska

Application for Health Insurance

State: Colorado

Instructions: The information in this application will be used to determine the applicant's eligibility for health insurance and allows selection of payment method. Applications must be submitted by or on behalf of the customer. If additional space is needed, please have applicant include a separate sheet and sign, date and attach to this application.

Please include the following completed forms with the application.

- ❑ **Software Proposal – An accurate proposal is required.** 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.)
- ❑ **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.
- ❑ **Authorization to Charge Credit Card OR Bank Draft –** Applicant completes if electing to pay with credit card or Bank Draft. Must include a voided check if electing Bank Draft.
- ❑ **Initial Premium –** Including any fees, if applicable.
- ❑ **State Mandated Forms –** If applicable.

Utilize the following materials on www.worldsells.com:

- Health Underwriting Guide – W1282

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.

Application to World Insurance Company
(herein called the Company) for Health Coverage
P.O. Box 3160 • Omaha, NE 68103-0160

To be completed by Agent
Agent #

Complete & Submit
Home Office Use Only
Application #

A. General Information *(please print)*

1. Your Information

Name *(First, Middle, Last)*

Address *(Street, City, State, ZIP)*

Home Phone Number | Cell Phone Number

Best Time to Call: ☐AM ☐PM ☐Home ☐Work ☐Cell

Email Address *(It may be used to send you important notices.)*

Employer *(Name, Street, City, State, ZIP)*

Occupation/Duties | Work Phone Number

If unemployed or employed part-time, are you seeking full-time employment? ☐Yes ☐No

Driver's License Number/State ____________________

2. Your Spouse's Information *(where different)*

Name *(First, Middle, Last)*

Address *(Street, City, State, ZIP)*

Home Phone Number | Cell Phone Number

Best Time to Call: ☐AM ☐PM ☐Home ☐Work ☐Cell

Email Address *(It may be used to send you important notices.)*

Employer *(Name, Street, City, State, ZIP)*

Occupation/Duties | Work Phone Number

If unemployed or employed part-time, are you seeking full-time employment? ☐Yes ☐No

Driver's License Number/State ____________________

3. Persons proposed for insurance.

List first, MI, and last names.		Birthdate Mo./Day/Yr.	State of Birth	Ht. ft., in.	Wt. lbs.	Sex	Full-time Student	Social Security Number
You						☐M ☐F	☐Yes ☐No	
Spouse						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	

4. Residency Information

a. Do all people requesting coverage live in the same household? ☐Yes ☐No
b. Are all of you U.S. citizens, have established permanent resident status, and have been in the U.S. a minimum of two years? ☐Yes ☐No
If "No" to a. or b., explain: ____________________
c. Are any of you planning to live, work or attend school outside the U.S. for more than 60 consecutive days? ☐Yes ☐No
If "Yes" to c., explain: ____________________

5. Please complete if Life Benefit selected:

Beneficiary *(First, Middle Initial, Last)*	Address *(Street, City, State, ZIP Code)*	Social Security Number	Relationship

B. HIPAA Eligible Individual Determination

You may be eligible for guaranteed issue health coverage if you qualify under the rules of the Health Insurance Portability and Accountability Act (HIPAA). The information you provide in this section will help determine whether you qualify under HIPAA. Please answer the following questions for all applicants.

1. Was there any period of 63 days or more during the past 18 months when you were not continuously covered by group or individual health insurance, Medicare, Medicaid or any other health insurance? ☐Yes ☐No
2. If you answered "Yes" to question 1, were you offered coverage under COBRA or a similar state program, and
   a. refused coverage? ☐Yes ☐No
   b. were not covered through COBRA for the full allowable period of coverage available? ☐Yes ☐No
   c. are presently eligible for such coverage? ☐Yes ☐No
3. Are you presently eligible for, or will you be eligible for health coverage provided by an employer? ☐Yes ☐No
4. Was your most recent health insurance coverage terminated for non-payment of premium, misrepresentation or fraud? ☐Yes ☐No
5. Do you currently have health insurance in force? ☐Yes ☐No
6. Was your most recent health insurance coverage through an employer-sponsored group plan? ☐Yes ☐No

If you answered "No" to questions 1-5, and "Yes" to question 6, you meet the definition of an Eligible Individual.

☐ I elect to apply as a HIPAA Eligible Individual and understand the rates for this plan will be substantially higher than underwritten-plan rates.
☐ I am a HIPAA Eligible Individual, but elect to be underwritten and waive any available rights as an Eligible Individual. I understand I will be subject to pre-existing condition exclusions.

C. General Medical Overview

1. **Within the past 5 years,** have you or any applicant been treated for, been diagnosed as having, or had symptoms of any of the following medical conditions?
   - a. Heart attack, angina, congestive heart failure, heart surgery, bypass or angioplasty? ☐Yes ☐No
   - b. Rheumatoid arthritis, connective tissue disorders or psoriatic arthritis? ☐Yes ☐No
   - c. Addison's Disease, Cushing's Syndrome or pheochromocytoma (tumor of the adrenal gland)? ☐Yes ☐No
   - d. Diabetes, including hyperglycemia, insulin resistance or impaired glucose tolerance? ☐Yes ☐No
   - e. Inflammatory bowel disease including ulcerative colitis or Crohn's disease? ☐Yes ☐No
   - f. Chronic obstructive pulmonary disease (COPD) requiring oxygen, emphysema requiring oxygen or cystic fibrosis? ☐Yes ☐No
   - g. Schizophrenia, psychoses, Alzheimer's disease or dementias? ☐Yes ☐No
   - h. Stroke/TIA, Parkinson's disease? ☐Yes ☐No
   - i. Liver failure, kidney failure/dialysis? ☐Yes ☐No
   - j. Amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), muscular dystrophy (MD) or lupus (systemic)? ☐Yes ☐No
   - k. Major organ transplant, including heart, lung, kidney or liver? ☐Yes ☐No
   - l. Cancer including, but not limited to, cancer of any organ, melanoma, sarcoma, leukemia, Hodgkin's or other lymphoma, but excluding basal or squamous cell skin cancers? ☐Yes ☐No
2. Are any of you now pregnant, an expectant father, in the process of adopting a child, or planning to serve as a surrogate? ☐Yes ☐No
3. Are any of you eligible for Medicare due to a disability? ☐Yes ☐No
4. a. Have you or any applicant ever been diagnosed as having, or been treated by a member of the medical profession as having AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or any other disease or disorder of the immune system? ☐Yes ☐No
   b. Have you or any applicant ever tested positive for AIDS/HIV (limited to FDA licensed tests)? ☐Yes ☐No

Note: Applicant(s) who answers "Yes" to any questions in this section is not eligible for coverage. Please indicate individual(s): ______________________________

D. Comprehensive Medical and Additional History

Please indicate "YES" or "NO" for each category. If you answer "YES", check (✓) the applicable condition and provide details in the space provided in the Explanation of Health Section. Categories do not necessarily include all the conditions related to that category, so please indicate "Other" for any conditions not listed.

Within the last 10 years, have you or any applicant been treated for, diagnosed with or had symptoms of any of the following:

1. Ears/Eyes/Nose/Throat ☐Yes ☐No

☐ Ear infections/otitis ☐ Hearing loss ☐ Meniere's disease ☐ Ear tubes ☐ Enlarged tonsils/Adenoids ☐ Otosclerosis ☐ Cochlear implant ☐ Strabismus/lazy eye ☐ Cataracts ☐ Tonsillitis ☐ Double vision ☐ Loss of vision ☐ Macular degeneration ☐ Glaucoma/Increased eye pressure ☐ Retinal detachment ☐ Rhinitis ☐ Optic Neuritis ☐ Sinusitis ☐ Other ______________

2. Lungs and Respiratory ☐Yes ☐No

☐ Allergic rhinitis ☐ Allergic sinusitis ☐ Asthma ☐ Emphysema ☐ Reactive airway disease ☐ Bronchitis ☐ Pneumonia ☐ Chronic cough ☐ Chronic lung disease ☐ Tuberculosis ☐ Sleep apnea ☐ Chronic obstructive pulmonary disease ☐ Other ______________

3. Heart/Circulatory ☐Yes ☐No

☐ Chest pain ☐ Heart valve disorders ☐ Coronary artery disease ☐ Angina ☐ Heart attack ☐ Irregular heart beat ☐ Heart surgery (stent placement, coronary artery bypass, angioplasty, valve) ☐ Heart murmurs ☐ Peripheral vascular disease ☐ Edema ☐ High blood pressure/ hypertension ☐ Phlebitis ☐ Thrombophlebitis ☐ Varicose veins ☐ Aneurysm ☐ Claudication ☐ High lipid (cholesterol or triglycerides) ☐ Other ______________

4. Blood/Lymph/Anemia ☐Yes ☐No

☐ Anemia ☐ Hemophillia ☐ Thrombocytopenia ☐ Hyperglycemia (high blood sugar) ☐ Bleeding disorders ☐ Other ______________

5. Digestive ☐Yes ☐No

☐ Esophagitis ☐ Gastric reflux/GERD ☐ Hernia ☐ Irritable bowel ☐ Ulcers ☐ Gastritis ☐ Recurrent indigestion ☐ Diverticulosis ☐ Ulcerative colitis ☐ Crohn's disease ☐ Hemorrhoids ☐ Chronic diarrhea ☐ Rectal bleeding ☐ Other ______________

6. Liver/Gallbladder/Pancreas ☐Yes ☐No

☐ Cirrhosis ☐ Hepatitis ☐ Fatty liver ☐ Gallstones ☐ Pancreatitis ☐ Spleen/pancreas disease ☐ Other ______________

7. Urologic/Kidney/Bladder ☐Yes ☐No

☐ Bladder infections ☐ Incontinence ☐ Overactive bladder ☐ Kidney stones ☐ Interstitial cystitis ☐ Pyelonephritis ☐ Nephritis ☐ Other ______________

D. Comprehensive Medical and Additional History (Cont'd.)

8. Reproductive/Breast .... ☐Yes ☐No

- ☐ Prostate disorder
- ☐ Impotence
- ☐ Abnormal Prostate Specific Antigen (PSA)
- ☐ Abnormal PAP smear
- ☐ Uterine fibroids
- ☐ Ovarian disorders
- ☐ Infertility
- ☐ Sexually transmitted disease
- ☐ Complications of pregnancy
- ☐ Human papillomavirus (HPV)
- ☐ Mastitis
- ☐ Cesarean section delivery
- ☐ Breast cysts/lumps
- ☐ Abnormal mammogram
- ☐ Gynecomastia
- ☐ Endometriosis
- ☐ Menstrual disorders (painful, excessive or irregular bleeding
- ☐ Other ______________

9. Skin .... ☐Yes ☐No

- ☐ Acne/rosacea
- ☐ Hemangioma
- ☐ Eczema
- ☐ Psoriasis
- ☐ Shingles
- ☐ Herpes
- ☐ Keratosis
- ☐ Other ______________

10. Bone/Muscular/Connective Tissue .... ☐Yes ☐No

- ☐ Arthritis
- ☐ Gout
- ☐ Back/spine conditions
- ☐ Herniated, bulging or degenerative discs
- ☐ Osteoarthritis
- ☐ Joint replacement
- ☐ Back pain
- ☐ Scoliosis
- ☐ Degenerative joint disease
- ☐ Joint pain
- ☐ Curvature subluxation
- ☐ Osteopenia/osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Muscular pain
- ☐ Sciatica
- ☐ Fracture(s)
- ☐ Fibromyalgia
- ☐ Other ______________

11. Prosthetic Devices/Plates, Pins, Screws .... ☐Yes ☐No

- ☐ Plates, pins, screws
- ☐ Rods
- ☐ Artificial limb
- ☐ Pacemakers
- ☐ Shunts
- ☐ Valve/joint replacement
- ☐ Other ______________

12. Nervous System .... ☐Yes ☐No

- ☐ Dizziness/syncope
- ☐ Cerebral palsy
- ☐ Neuropathy
- ☐ Muscular weakness
- ☐ Restless leg syndrome
- ☐ Carpal tunnel syndrome
- ☐ Headaches/migraines
- ☐ Paralysis
- ☐ Seizures
- ☐ Epilepsy
- ☐ Tourette's syndrome
- ☐ Convulsions
- ☐ Other ______________

13. Endocrine/Thyroid .... ☐Yes ☐No

- ☐ Diabetes
- ☐ Goiter
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ High blood sugar
- ☐ Insulin resistance
- ☐ Impaired glucose tolerance
- ☐ Other ______________

14. Cancer/Tumors .... ☐Yes ☐No

- ☐ Of internal organ
- ☐ Leukemia
- ☐ Melanoma
- ☐ Hodgkin's disease
- ☐ Sarcoma
- ☐ Other lymphoma
- ☐ Adenoma
- ☐ Basal or squamous cell skin cancer
- ☐ Breast cancer
- ☐ Neoplasm
- ☐ Other ______________

15. Psychological .... ☐Yes ☐No

- ☐ Emotional disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Attention deficit disorder
- ☐ Eating disorder
- ☐ Chemical imbalance
- ☐ Bipolar (manic depression)
- ☐ Psychiatric treatment or counseling
- ☐ Obsessive compulsive disorder
- ☐ Other ______________

16. Congenital Disorders/Birth Defects/Developmental Disorders .... ☐Yes ☐No

- ☐ Down's syndrome
- ☐ Mental retardation
- ☐ Autism
- ☐ Club foot
- ☐ Cleft lip/palate
- ☐ Delayed development
- ☐ Speech impairment
- ☐ Other ______________

17. Other Conditions

a. In the past 10 years, have you or any applicant required an emergency room visit, hospital stay, surgery, or treatment?.... ☐Yes ☐No

b. In the past 10 years, have you or any applicant been recommended to have surgery or to receive treatment from a physician, chiropractor or other practitioner? .... ☐Yes ☐No

c. Do you or any applicant have any medical conditions/symptoms for which you have not seen a health care provider? ...... ☐Yes ☐No

d. Have you or any applicant had any tests or procedures recommended that have not yet been performed? .... ☐Yes ☐No

18. Medication Use

a. Have you or any applicant taken or been recommended to take any prescription medication in the last 2 years? .... ☐Yes ☐No

b. In the last two years have you or any applicant taken any herbal or over-the-counter medication more often than once a week? .... ☐Yes ☐No

19. Substance Abuse/Advice to Reduce or Eliminate Use

a. In the past 5 years, have you or any applicant 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? .... ☐Yes ☐No

b. In the past 5 years, have you or any applicant ever used non-prescribed sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency? .... ☐Yes ☐No

20. Tobacco Use

In the past 12 months, has anyone used cigarettes, cigars, pipes, oral tobacco or nicotine replacements? .... ☐Yes ☐No

If "YES", list name(s): ______________________________

21. High Risk Activities

In the past 2 years, has anyone participated in hazardous activities, including activities like hang-gliding, scuba diving, rodeoing or racing (including automobile, motorcycle, etc.)? .... ☐Yes ☐No

If "YES", list name(s): ______________________________

Activity: ______________________ Frequency: ______________________

D. Comprehensive Medical and Additional History (Cont'd.)

22. Driving Violations

In the past 2 years, has anyone been convicted of any driving violation, including DUI, DWI, license suspension or revocation, or 3 or more speeding violations? ☐Yes ☐No

Name: ________ Date: ________ Violation ________

Name: ________ Date: ________ Violation ________

23. Insurance Declination

In the past 5 years, has anyone's health insurance been declined, rescinded, rated or issued with waivers? ☐Yes ☐No

Name(s) ________

Insurance Company(ies) ________ Date(s) ________

Reason(s) ________ Details ________

24. Complete ONLY if applying for [Critical Illness/Cancer Care]

Has any applicant's biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age 55 with any of the following: diabetes, heart disease, stroke, kidney disease, internal cancer or MS, Alzheimer's, Parkinson's? ☐Yes ☐No

Name	Family member's relationship	Condition	Age at onset	Current age/ Age at death

Explanation of Health

Provide details for all questions 1 through 19 with "YES" answers. If you need additional space, please include a separate sheet and sign, date and attach to this application.

a. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

b. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

c. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

d. Name | Medical Condition | Date of Onset

Dates of Treatment | Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*

Physician's Name | Physician's Location (City/State) | Phone Number

Physician Information

	Name of Primary Physician	Location City/State	Phone Number	Date Last Seen	Reason for Visit	Results
Primary						
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						

Please add any additional information you feel will be helpful in evaluating your application on a separate sheet and sign, date and attach to this application.

E. Other Coverage

Statement: a) You normally do not require more than one policy; b) If you purchase this policy, you may want to evaluate your health coverage and decide if you need multiple coverages; c) You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplement policy; and d) If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the sate Medicaid program.

Questions: (If "Yes" for any proposed insured, please complete section below and submit any required replacement forms.) To the best of your knowledge:

1. Do you have another insurance policy or contract in force? .... ☐Yes ☐No
   If so, with which company? (Name and address) ____________________
   ____
   If so, do you intend to replace your current accident and sickness insurance with this policy (contract)? .... ☐Yes ☐No
2. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? .... ☐Yes ☐No
   If so, with which company? (Name and address) ____________________
   ____
   What kind of policy? ____________________
3. Are you covered for medical assistance through the state Medicaid program? .... ☐Yes ☐No
   As a Specified Low Income Medicare Beneficiary (SLMB)? .... ☐Yes ☐No
   As a Qualified Medicare Beneficiary (QMB)? .... ☐Yes ☐No
   For other Medicaid medical benefits? .... ☐Yes ☐No

F. Verification Information – Business Group of One

Self-Employed Business Group of One Determination (To be completed by all applicants.)

1. Are you either a self-employed person with no employees, or a sole proprietor who is not offering or sponsoring health care to your employees? .... ☐Yes ☐No
2. Have you carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage? .... ☐Yes ☐No
3. Do you have a gross income from your self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes from which you have derived a substantial part of your income from your business as a self-employed person or sole proprietor for one year out of the past three years? Note: Substantial part of your income means income derived from business activities of the Business Group of One that are sufficient to pay for the annual premiums for the Business Group of One's health benefit plan? .... ☐Yes ☐No
4. Do you work a minimum of 24 hours a week on a permanent basis? .... ☐Yes ☐No

Yes to all questions qualifies applicant as a Self-Employed Business Group of One.

For those meeting the definition of a Self-Employeed Business Group of One, please complete this section.

I acknowledge that I meet the definition of a self-employed business group of one. I understand that by purchasing an individual policy instead of a small group policy, I give up what would otherwise be my right to purchase, during open enrollment periods as specified by law, a business group of one Standard, Basic, or other small group health benefit plan from a small employer carried for a period of three years after the effective date of the individual health benefit plan for which I am applying. I understand that this will be the case unless a small employer carrier voluntarily permits me to purchase a small group policy within such three-year period.

I understand that the factors used to set new and renewal rates for the individual policy I want to purchase are plan design, attained age of insured, health related factors, utilization trends, number of individuals insured, policy duration from issue, and a factor that reflects the cost of care in the specific geographical area of where I live. By comparison, the rating factors that would apply if I purchased a small group business group of one policy are limited by plan design, my age, overall cost and utilization trends (index rate), my family size, and a factor that reflects the cost of care where I live.

I have been given a health plan benefit description form showing the benefits under Colorado's small group Standard Health Benefits Plans. I have also been given a Colorado Health Plan Description Form for the plan for which I am applying.

The state of Colorado requires that If a Business Group of One is applying for an individual medical plan, and is applying for family coverage, World Insurance Company must accept or reject the entire family, unless the proposed insured waives coverage for a family member who has other coverage in force.

I certify that the following family members have other health insurance coverage in force. (List the names of all your dependents, whether listed on the application or not.)

Name	Relationship	Type of Coverage and Name of Carrier	Effective Date

After consideration, it is my decision to waive coverage under the World Insurance Company Policy for the family member(s).

Please Read, Sign and Date

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a policy is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- Any false statement or misrepresentation may result in loss or reduction of coverage or an increase in premium.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- I must tell the Company if the health of any applicant changes prior to delivery of the policy.
- The policy, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the policy is issued.
- Health conditions present before the application is signed will be covered only if listed on this application and not excluded from coverage.
- I will be informed of the status of coverage within 90 days.

I represent 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 policy 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 policy, during the period the policy 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.

Please Note: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Signed at ______________________ this ________ day of ______________ , __________.
(City/State) *(Date)* *(Month)* *(Year)*

X ______________________
Your Signature

X ______________________
Your Spouse's Signature, if applying

X ______________________
Dependent's Signature, if 18 or older

X ______________________
Dependent's Signature, if 18 or older

X ______________________
Dependent's Signature, if 18 or older

Please Complete for Applicant Demographics

Business Name ______________________ Business Phone Number ______________________

Business Address *(Street, City, State, ZIP)* ______________________

Type of Business ______________________ Number of Employees ______________________

For Agent Use Only

I certify that the answers given to the foregoing questions in this application were provided by the applicant and accurately recorded. I have no information to add to the application that could affect the acceptance or rejection of the risk. I have provided the applicant with the Special Notice Federal Fair Credit Report Act and an outline of coverage where required.

Are you aware of any information, not recorded on the application, which might have a bearing on insurability of any person proposed for insurance? (If Yes, please list details below.) .... ☐Yes ☐No

____

X ______________________ ______________ **X** ______________________ ______________
Agent Name *Agent Number* *Agent Signature* *Date*

______________ ______________ ______________ ______________
Agent Phone Number *Agent Cell Phone Number* *Agent Fax Number* *Agent Email Address*

Administrative Details

1. **Proposal Required. Submit with application – the proposal documents the type of coverage requested.**
2. **Choice of Requested Date of Coverage***:* ☐Underwriting Approval Date ☐Specified Future Date *(1st - 28th)* ______________
3. **Health Savings Account Information:** ☐ Applicant requests HealthEquity open an HSA account according to the terms and conditions of the HealthEquity Service Agreement located at www.healthequity.com
4. **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 forms are required. Submit only application fee, if any, for initial premiums.)*
5. **Payment for Initial Premium:** ☐Check ☐Bank Draft ☐Credit Card
   $__________ Total Amount Submitted With Application *(The first full premium by mode and the application fee must be submitted with this application.)*

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

Authorization to Charge Credit Card for Premium

Not available in all states.

☐**VISA** ☐**MasterCard**

Credit Card Authorization: *I authorize World Insurance Company to bill my VISA/MASTERCARD account for full premium and application fee.*
NOTE: **We will debit your account for the application fee upon submission of the application. The premium will be debited upon policy approval which may not coincide with the effective date of the policy.**

Account Number					—				—				—					Exp. Date		/	

X____ Date ____________________________
Signature

Phone Number				—				—				

Authorization to Honor Checks Drawn by World Insurance Company

If you select the Bank Draft option, please complete the following:
I (we) hereby authorize World Insurance Company (World) to initiate debit entries to the account and depository (Depository) indicated below, to debit the same to such account. This authority is to remain in full force and effect until World and Depository have received written notification from me (or either of us) of its termination in such time and in such manner to afford World and Depository a reasonable opportunity to act on it. I understand that the withdrawal will be made on the effective date of the policy. ***NOTE:*** **We will debit your account for the application fee upon submission of the application. The premium will be debited upon policy approval which may not coincide with the effective date of the policy.**

Signature of Payor ____ *Date Signed* ____________________

☐ **To begin Bank Draft withdrawals:**
Withdrawal day will be effective day of policy.
Bank Name ______________________________
Address ______________________________
City ________________________ State ______

☐ **To add this policy to an existing Bank Draft:**
Policy Number____________________________

Jane Doe
2139 S. 33 St.
AnyTown, USA 12345
1234
Date ____________
____ $
____ Dollars
Bank Name
Memo ________________ ______________________
(Routing #) (Account #)

Routing *(9 digits)* ______________________________ Account # ____________________

You must either submit a voided check, or complete the routing and account information. Do not send a deposit slip. Please print clearly.

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 or the policy 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.

X ______________________
Personal Representative (Please Print)

Person(s) to be Insured (Please Print)	***My relationship to applicant(s) (Please Print)***

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.

X ______________________
Personal Representative (Please Print)

Person(s) to be Insured (Please Print)	***My relationship to applicant(s) (Please Print)***

WORLD® INSURANCE

Preferred Rating Guidelines/Questionnaire

Guidelines

To be eligible to apply for Preferred Rates, the proposed insured and/or proposed insured spouse*:

(a) must be between the ages of 18 and 60;

(b) must not have a health exclusion rider or health rate-up; and

(c) must answer "No" to questions 1-5 listed below.

Note: Information that is compiled during the application process concerning medical conditions, occupations, or medications you are taking may keep you from becoming eligible for Preferred Rates.

**Dependents are not eligible for Preferred Rates.*

Questionnaire

To be eligible for Preferred Rates, each proposed insured must answer the questions below and be within the Build Chart for Preferred Risks.

Question	Proposed Insured		Proposed Insured's Spouse	
1. Within the past 12 months, have you had a blood pressure reading that exceeded 140/90 (greater than 140 systolic and/or greater than 90 diastolic) or been treated for high blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No
2. Within the past 12 months, have you had total cholesterol readings that exceeded 220 or been treated for elevated cholesterol or triglycerides?	☐ Yes	☐ No	☐ Yes	☐ No
3. Within the past 2 years, have you had any DUI or DWI convictions or more than 2 moving violations?	☐ Yes	☐ No	☐ Yes	☐ No
4. Has it been more than 90 days since you had health coverage (group or individual) in force?	☐ Yes	☐ No	☐ Yes	☐ No
5. If you are over age 50, has it been more than 2 years since your last physical exam?	☐ Yes	☐ No	☐ Yes	☐ No

I understand and agree that this questionnaire, if completed, is part of the application for health insurance coverage with World Insurance Company.

X ______________________ ____________ X ______________________ ____________
Signature of the Proposed Insured *Date* *Signature of Spouse* *Date*

X ______________________ ____________ ______________________
Signature of Licensed Agent *Date* *Agent Number*

Build Chart for Preferred Risks

Male		Female	
Height	Weight (lbs.)	Height	Weight (lbs.)
4' 6"	80-131	4' 6"	79-126
4' 7"	83-134	4' 7"	82-129
4' 8"	86-138	4' 8"	83-132
4' 9"	89-142	4' 9"	87-135
4' 10"	92-145	4' 10"	90-138
4' 11"	95-149	4' 11"	92-140
5' 0"	98-152	5' 0"	94-143
5' 1"	101-155	5' 1"	96-146
5' 2"	103-159	5' 2"	98-150
5' 3"	105-162	5' 3"	101-153
5' 4"	107-166	5' 4"	104-158
5' 5"	110-171	5' 5"	107-163
5' 6"	112-175	5' 6"	109-168
5' 7"	115-181	5' 7"	112-173
5' 8"	118-186	5' 8"	115-178
5' 9"	121-191	5' 9"	117-185
5' 10"	124-197	5' 10"	119-192
5' 11"	126-203	5' 11"	122-197
6' 0"	129-208	6' 0"	123-202
6' 1"	132-215	6' 1"	126-207
6' 2"	135-220	6' 2"	130-212
6' 3"	139-226	6' 3"	134-217
6' 4"	143-232	6' 4"	138-222
6' 5"	146-240	6' 5"	142-227
6' 6"	149-246	6' 6"	146-232
6' 7"	153-252	6' 7"	150-237
6' 8"	156-258	6' 8"	154-242
6' 9"	160-264	6' 9"	158-247
6' 10"	163-270	6' 10"	162-252
6' 11"	167-276	6' 11"	166-257

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

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WORLD INSURANCE
Omaha, Nebraska

Complete & Submit

M1037-CO

Agent Instructions: Please have the applicant complete these forms if they are residents of the State of Colorado

- ❑ Submit the Home Office copy with the Application (page 2).
- ❑ Leave applicant's copy with them (page 3).

Complete and Submit

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

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by World Insurance Company. Your new policy will provide a 10-day free look period, within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:
I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other (please specify) ____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer ____

Name and Address of Producer ____

Applicant's Signature ____

Date _________________________

M1037-CO (7-01) (Rev. 8-05)

Notice to Agent: If applicable, have the proposed insured complete this page and the previous page. Please leave this page with Proposed Insured in all cases. Disregard completing this form if not applicable.

Submit with application for insurance.

Leave with Client

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

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by World Insurance Company. Your new policy will provide a 10-day free look period, within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:
I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other (please specify) ____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer ________________________________

Name and Address of Producer ____

Applicant's Signature ________________________________

Date ____________________

M1037-CO (7-01) (Rev. 8-05)

Notice to Agent: If applicable, have the proposed insured complete this page and the previous page. Please leave this page with Proposed Insured in all cases. Disregard completing this form if not applicable.

Leave with the proposed insured.

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

Omaha, Nebraska

Colorado Health Insurance Applicant and Agent Questionnaire

This form must be completed and signed by the applicant and the agent, and submitted to World Insurance Company with the application. A copy must be provided to the applicant.

To be completed by the Applicant:

The health insurance policy you are applying for should be considered an individual insurance policy exempt from the laws which regulate the small group market.

Please answer the following questions to determine whether or not the coverage you desire would be considered individual coverage or small group coverage.

1. Will any portion of the premium for this policy be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement? .... ☐Yes ☐No
2. Does any proposed insured intend to treat the policy as a health benefit plan under United States Internal Review code: Section 162 – Trade or Business Expenses, Section 125 – Cafeteria Plans, or Section 106 – Contributions by Employer to Accident and Health Plan? .... ☐Yes ☐No
3. Was this health coverage marketed through your employer's place of business? .... ☐Yes ☐No

If any of the above questions is answered yes, the coverage you desire would be considered small group coverage according to the Colorado Division of Insurance and you should request small group coverage from an authorized small group carrier.

_______________________________________ _______________________

Signature of Applicant *Date*

____

Signature of Spouse, if to be insured

To be completed by the Agent:

Was this policy marketed through any proposed insured's employer's place of business? .... ☐Yes ☐No

If yes, do NOT submit the application. Advise the applicant to seek group coverage from an authorized small group carrier.

_______________________________________ _______________________

Signature of Agent *Date*

WORLD INSURANCE
Omaha, Nebraska

[Leave with Client]

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.
- ❑ **Notice of Privacy Policy and Insurance Information Practices**
- ❑ **Notice of Privacy Practices – Medical**

Leave with Client

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 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.

ABREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a policycertificate, 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

X 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. (Central Time).

Make checks payable to World Insurance Company

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

Leave with Client

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 ("nonpublic 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

Leave with Client

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 communication**s 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

2008

COLORADO

Small Group
Health Plan Description Forms

Standard **Health Benefit Plans** *U1005-CO*	**Basic HSA** **Health Benefit Plans** *U1007-CO*
Basic Limited Mandate **Health Benefit Plans** *U1006-CO*	**Basic HSA Limited Mandate** **Health Benefit Plans** *U1008-CO*

Colorado Small Group Health Plan Description Form

All Colorado Small Group Health Insurance Companies
Name of Carrier

2008 Colorado Standard Health Benefit Plans: Indemnity, Preferred Provider, and HMO
Name of Plan

PART A: TYPE OF COVERAGE

	Standard Indemnity Plan	Standard Preferred Provider Plan	Standard HMO Plan
1. Type of Plan	Medical expense policy	Preferred provider plan	Health maintenance organization (HMO)
2. Out-of-Network Care Covered?[1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. Areas of Colorado where plan is available	Plan is available throughout Colorado	Varies by carrier.	Varies by HMO

PART B: Summary of Benefits ***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

	Standard Indemnity Plan	Standard Preferred Provider Plan		Standard HMO Plan
		In-Network	Out-Of-Network[2]	In-Network Only *(Out-of-Network care is not covered except as noted)*
4. Annual Deductible *(Deductibles do not apply to* benefits with flat dollar copays.) a) Individual b) Family	 $2,000 $6,000	 $1,500 $4,500	(Deductibles are separate from in-network deductibles) $3,000 $9,000	 No deductible No deductible
5. Out-of-Pocket Annual Maximum[3] *(Includes ded. and coinsurance. Copays apply for the HMO plan only. All copays for Rx drugs are excluded.)* a) Individual b) Family	 $4,000 $12,000	(Excludes flat-dollar copays) $3,500 $7,000	(Out-of-pocket amts. are separate from in-network out-of-pocket amts.) $7,000 $14,000	 $3,000 $6,000
5A. Coinsurance *(amount paid by carrier)* or Copay *(amount paid by insured/member)*	80% coinsurance	80% coinsurance	50% coinsurance	Depends on the service, see details below[4]
6. Lifetime or Benefit Maximum Paid by the Plan for all Care	$2 million	$5 million		No lifetime maximum.
7A. Covered Providers	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO
8. Medical Office Visits[5] • PCP • Specialist	 80% coinsurance 80% coinsurance	 $25 copay/visit $40 copay/visit	 50% coinsurance 50% coinurance	 $25 copay/visit $40 copay/visit
9. Preventive Care[6]	For all plans, only specified preventive services are covered.			
a) Children's services *(no deductible prior to application of coinsurance.)*	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit
b) Adults' services	80% coinsurance	$25 copay/visit	50% coinsurance	$25 copay/visit

	Standard Indemnity Plan	Standard Preferred Provider Plan		Standard HMO Plan
		In-Network	Out-Of-Network[2]	In-Network Only *(Out-of-Network care is not covered except as noted)*
10. Maternity[7]	80% coinsurance Deductible and coinsurance apply	80% coinsurance (A one-time $25 copay for all routine prenatal visits combined, then ded. and coinsurance for all oter charges)	50% coinsurance	A one-time $25 copay for all routine prenatal visits combined; then applicable copays for type of service[8]
11. Prescription Drugs[9] *(Copays do not apply to out-of-pocket maximums.)*	$10 copay preferred generic; $40 copay preferred brand name; $60 copay non-preferred[9a]	$10 copay preferred generic; $40 copay preferred brand name; $60 copay non-preferred[9a]	$10 copay preferred generic; $40 copay preferred brand name; $60 copay non-preferred[9a]	$10 copay preferred generic; $40 copay preferred brand name; $60 copay non-preferred[9a]
12. Inpatient Hospital	80% coinsurance	80% coinsurance	50% coinsurance	$250/day to a maximum of $1,000 per admission[10]
13. Outpatient/Ambulatory Surgery	80% coinsurance	80% coinsurance	50% coinsurance	$150 copay/visit[10a]
14. Diagnostics[11] a) Laboratory & X-ray	80% coinsurance	80% coinsurance If these services are delivered in conjunction with an office visit where a copay was charged, no additional copay or coinsurance requirement for lab & X-ray services applies.	50% coinsurance	No copay for physician-ordered services
b) MRI, Nuclear Medicine, CT, CTA, MRA, and PET Scans	80% coinsurance	80% coinsurance	50% coinsurance	$150 copay
15. Emergency Care[12,13]	80% coinsurance	$150 copay, then plan pays 80% coinsurance (No deductible)		$150 copay/visit[14] for in- and out-of-network emergency care.
16. Ambulance	80% coinsurance	80% coinsurance After satisfaction of in-nework deductible.		$100 copay
17. Urgent, Non-Routine, After-Hours Care	80% coinsurance	$75 copay/visit	50% coinsurance	$75 copay/visit. Out-of network urgent care covered only if temporarily traveling out of service area.
18. Biologically Based Mental Illness[15] Care	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. Other Mental Health Care[17] a) Inpatient Care[16]	50% coinsurance. Maximum 45 inpatient or 90 partial days/year	50% coinsurance Maximum 45 inpatient or 90 partial days/year		50% copay Maximum 45 inpatient or 90 partial days/year
b) Outpatient Care	50% coinsurance Plan/carrier pays maximum $1,500/year	50% coinsurance Plan/carrier pays maximum $1,500/year		50% copay Plans pay maximum 20 visits or $1,500/year
20. Alcohol and Substance Abuse	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18]	Acute detox: maximum 5 days per episode and 2 episodes per lifetime, 50% coinsurance.[18]		Diagnosis, medical treatment & referral services. 50% copay.[19]
21. Physical, Occupational & Speech Therapy[20]	80% coinsurance (Limited to 25 visits per therapy per year)	80% coinsurance (Limited to 25 visits per therapy per year combined in and out-of-network)	50% coinsurance	$25 copay (Limited to 25 visits per therapy per year)
22. Durable Medical Equipment[21]	80% coinsurance $2,000/year maximum	80% coinsurance $2,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	50% coinsurance	20% copay $2,000/year maximum
23. Oxygen	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)

	Standard Indemnity Plan	Standard Preferred Provider Plan		Standard HMO Plan
		In-Network	Out-Of-Network[2]	In-Network Only *(Out-of-Network care is not covered except as noted)*
24. Organ Transplants[22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	80% coinsurance	80% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness.
25. Home Health Care[22a]	80% coinsurance	80% coinsurance	50% coinsurance	No copay (100% covered)
26. Hospice Care[22a, 22b]	80% coinsurance per diem	80% coinsurance per diem	50% coinsurance per diem	No copay (100% covered)
27. Skilled Nursing Facility Care[23]	80% coinsurance (Not to exceed 100 days/year)	80% coinsurance (Not to exceed 100 days/ year)	50% coinsurance (Not to exceed 100 days/ year)	$50 copay/day (Not to exceed 100 days/year)
28. Dental Care	For all plans, not covered except for dental care needed as a result of an accident.			
29. Vision Care	No Coverage	No Coverage	No Coverage	No Coverage
30. Chiropractic Care	No [See 31(1)]	No [See 31(1)]	No [See 31(1)]	No [See 31(1)]
31. Significant Additional Services (List up to 5)				
(1) Spinal manipulation	80% coinsurance	80% coinsurance	50% coinsurance	$25 copay

PART C: LIMITATIONS AND EXCLUSIONS

	Standard Indemnity Plan	Standard Preferred Provider Plan		Standard HMO Plan
		In-Network	Out-Of-Network	
32. Period During Which Pre-Existing Conditions are not Covered[24,25]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 - 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
34. How Does the Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions
35. What Treatments and Conditions Are Excluded Under this Policy?	Standard exclusions, including benefits covered by an auto policy or employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents[25a] and anesthesia for dependent children as required by law; educational training problems; experimental and investigational procedure; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[26]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) then if they aren't used (i.e., go-out-of-network).

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

[3] "Out-of-pocket maximum". refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copayments, as specified. Copays or prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under the standard plans, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

[4] However, notwithstanding the copay amounts listed in this Standard HMO Plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured exceed 50% of charges for any single service.

[5] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically-based mental illnesses.

[6] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

[7] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

[8] The hospital copay applies to mother and well-baby together; there are not separate copays.

[9] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not subject to the deductible and the copays are not applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type.)

[9a] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[10] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

[10a] Copay includes all physician, facility services and supplies delivered during the visit.

[11] Includes low dose mammography screening not otherwise covered under the list of preventive care services, as mandated by Colorado law, § 10-16-104(4), C.R.S. Diagnostic services do not include therapeutic treatment.

[12] "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

[13] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred by the carrier or his/hers primary care physician to the emergency room for care. If emergency rooms are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

[14] Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

[15] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits; however, the copay amount paid by the insured/member shall not exceed 50% of the charge for any single office visit.

[16] The day cost of residential care must be less than or equal to the cost of a partial day of hospitalization. Each two days of residential or partial hospital care counts as one day of inpatient care.

[17] Pursuant to § 10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to § 10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of § 10-16-105(2), C.R.S., relating to such an exclusion.

[18] Carriers shall also offer alcoholism coverage pursuant to § 10-16-104(9), C.R.S., as may be amended.

[19] Federally-qualified HMOs shall comply with the alcohol and drug abuse benefit for federally qualified HMOs pursuant to 42 C.F.R., Section 417.101 (a)(5).

[20] Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of § 10-16-104, C.R.S., subsections (1.3) and (1.7)

[21] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this limitation. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the benefit cap; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

[22] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

[22a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[22b] Although the numbers of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Regulation 4-2-8.

[23] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

[24] Waiver of preexisting condition exclusions. State law requires carriers to waive some or all of the pre-existing condition exclusion period based on other coverage the insured/member recently may have had. The carrier or plan sponsor (e.g. employer) should provide details.

[25] The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

[25a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

[26] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

Colorado Small Group Health Plan Description Form

All Colorado Small Group Health Insurance Companies
Name of Carrier

2008 Colorado Basic Limited Mandate Health Benefit Plans: Indemnity, Preferred Provider, and HMO

Name of Plan

PART A: TYPE OF COVERAGE

	Basic Indemnity Plan	Basic Preferred Provider Plan	Basic HMO Plan
1. Type of Plan	Medical expense policy	Preferred provider plan	Health maintenance organization (HMO)
2. Out-of-Network Care Covered?[1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. Areas of Colorado where plan is available	Plan is available throughout Colorado	Varies by carrier.	Varies by HMO

PART B: Summary of Benefits ***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[2]	In-Network Only *(Out-of-Network care is not covered except as noted)*
4. Annual Deductible *(Deductibles do not apply to benefits with flat dollar copays.)* a) Individual b) Family	 $4,000 $12,000	 $4,000 $12,000	(Deductibles are separate from in-network deductibles) $8,000 $24,000	 No deductible No deductible
5. Out-of-Pocket Annual Maximum[3] *(Includes deductible and coinsurance. Copays apply for the HMO plan only. The prescription drug deductible and all prescription drug copays are excluded.)* a) Individual b) Family	 $12,000 $24,000	(Excludes flat-dollar copays.) $8,000 $12,000	(Out-of-pocket amounts are separate from in-network out-of-pocket amounts.) $16,000 $32,000	 $6,000 $12,000
5A. Coinsurance *(amount paid by carrier)* or Copay *(amount paid by insured/member)*	50% coinsurance	70% coinsurance	50% coinsurance	Depends on the service, see details below[4]
6. Lifetime or Benefit Maximum Paid by the Plan for all Care	$2 million	$5 million		No lifetime maximum.
7A. Covered Providers	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by insurance carrier.	Not applicable.	Answer varies by HMO
8. Medical Office Visits[5] • PCP • Specialist	 50% coinsurance 50% coinsurance	 $40 copay/visit $60 copay/visit	 50% coinsurance 50% coinsurance	 $40 copay/visit $60 copay/visit
9. Preventive Care[6]	For all plans, only specified preventive services are covered.			
a) Children's services *(no deductible prior to application of coinsurance.)*	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit
b) Adults' services[6a]	50% coinsurance	$40 copay/visit	50% coinsurance	$40 copay/visit

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	**Out-Of-Network**[2]	**In-Network Only** *(Out-of-Network care is not covered except as noted)*
10. Maternity[7]	50% coinsurance	70% coinsurance (A one-time $40 copay for all routine prenatal visits combined; then deductible and coinsurance for all other services)	50% coinsurance	A one-time $40 copay for all routine prenatal visits combined; then applicable copays for type of service[8]
11. Prescription Drugs[9] Deductible *(Must be satisfied prior to application of copays.)*	$100 annual deductible per per person	$100 annual deductible per person		$100 annual deductible per person (Not included in out-of-pocket maximum)
(Deductible and copays <u>do not</u> apply to out-of-pocket maximums)	$20 copay preferred generic; $50 copay preferred brand name $70 copay nonpreferred[9a]	$20 copay preferred generic $50 copay preferred brand name $70 copay non-preferred[9a]		$20 copay peferred generic $50 copay preferred brand name $70 copay non preferred[9a]
12. Inpatient Hospital	50% coinsurance	70% coinsurance	50% coinsurance	$500/day to $2,000 maximum per admission[10]
13. Outpatient/Ambulatory Surgery	50% coinsurance	70% coinsurance	50% coinsurance	$300 copay/visit[10a]
14. Diagnostics[11] a) Laboratory & X-ray	50% coinsurance	70% coinsurance If these services are delivered in conjunction with an office visit where a copay was charged, no additional copay or coinsurance requirement for lab & X-ray services applies.	50% coinsurance	No copay
b) MRI, Nuclear Medicine, CT, CTA, MRA and PET scans	50% coinsurance	70% coinsurance	50% coinsurance	$300 copay
15. Emergency Care[12,13]	50% coinsurance	$250 copay, then carrier pays 70% coinsurance (no deductible)		$250 copay/visit[14] for in- and out-of-network emergency care.
16. Ambulance	50% coinsurance	70% coinsurance After satisfaction of in-network deductible		$100 copay
17. Urgent, Non-Routine, After-Hours Care	50% coinsurance	$100 copay	50% coinsurance	$100 copay/visit. *Out-of network urgent care covered only if temporarily traveling out of service area.*
18. Biologically Based Mental Illness[15] Care	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. Other Mental Health Care a) Inpatient Care b) Outpatient Care	Excluded	Excluded		Excluded
20. Alcohol and Substance Abuse	Excluded	Excluded		Excluded
21. Physical, Occupational & Speech Therapy[16] per therapy per year)	50% coinsurance (Limited to 25 total visits per therapy per year)	70% coinsurance (Limited to 25 visits per theapy per year combined in and out-of-network)	50% coinsurance	$40 copay (Limited to 25 total visits per therapy per year)
22. Durable Medical Equipment[17]	50% coinsurance $1,000/year maximum	70% coinsurance $1,000/year maximum (In-network deductible applies to network providers and the out-of-network deductible applies to non-network providers. However, the maximum benefit is combined for in-network and out-of-network benefits.)	50% coinsurance	20% copay $1,000/year maximum
23. Oxygen	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[2]	In-Network Only *(Out-of-Network care is not covered except as noted)*
24. Organ Transplants[18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	50% coinsurance	70% coinsurance	50% coinsurance	Coverage is no less extensive than the coverage for any other physical illness
25. Home Health Care	50% coinsurance Limited to 60 visits per year	70% coinsurance Limited to 60 visits per year combined maximum	50% coinsurance	$20 copay per visit Limited to 60 visits per year
26. Hospice Care	50% coinsurance	70% coinsurance	50% coinsurance	$50 inpatient per diem copay $20 outpatient per diem copay
27 Skilled Nursing Facility	50% coinsurane (Not to exceed 100 days/year	70% coinsurance (Not to exced 100 days/ year)	50% coinsurance (Not to exceed 100 days/ year)	$50 copay/day (Not to exceed 100 days/year
28. Dental Care	For all plans, not covered except for dental care needed as a result of an accident.			
29. Vision Care	Excluded	Excluded	Excluded	Excluded
30. Chiropractic Care	Excluded	Excluded	Excluded	Excluded
31 Significant Additional Services (List up to 5)	None	None	None	None

PART C: LIMITATIONS AND EXCLUSIONS

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network	
32. Period During Which Pre-Existing Conditions are not Covered[20,21]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 - 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
34. How Does the Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions
35. What Treatments and Conditions Are Excluded Under this Policy?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents;[21a] educational training problems; experimental and investigational procedure; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[22]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

[2] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

[3] "Out-of-pocket maximum". refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, coinsurance and copays, as specified. The deductible and copays for prescription drugs, however, are not applied to the deductible or out-of-pocket maximum. Under this basic plan, copays for other than prescription drugs are applied to the out-of-pocket maximum on HMO plans only.

[4] However, notwithstanding the copay amounts listed in this Standard HMO Plan, under no circumstances, with the exception of the prescription drug benefit, shall the copay amount paid by the insured exceed 50% of charges for any single service.

[5] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically-based mental illnesses.

[6] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

[6a] Prostate cancer screening and routine mammograms are not covered.

[7] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

[8] The hospital copay applies to mother and well-baby together; there are not separate copays.

[9] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado. Additionally, as noted above in footnote 3, prescription drug benefits are not applied to the out-of-pocket maximums. Coverage levels for injectable drugs are based on place of service (e.g., office: included under office visit copay; pharmacy: covered at appropriate copay level based on drug type).

[9a] Prescription drugs otherwise excluded are not covered, regardless of whether preferred generic, preferred brand name, or non-preferred.

[10] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

[10a] Copay includes all physician, facility services and supplies delivered during the visit.

[11] Includes diagnostic low dose mammography. (Routine mammography screenings not covered.) Diagnostic services do not include therapeutic treatment.

[12] "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

[13] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by the carrier or his/her primary care physician. If emergency rooms are used by the plan for non-emergency after hours care, then urgent care coinsurance and copays apply.

[14] Emergency copay is waived if patient is admitted to hospital since hospital copay would apply.

[15] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

[16] Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

[17] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the annual maximum; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

[18] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

[18a] Covered services are defined in Colorado Insurance Regulation 4-2-8.

[18b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.

[19] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.

[20] "Waiver of preexisting condition exclusions." State law requires carriers to waive some or all of the preexisting condition exclusion period based on other coverage the insured/member recently may have had.

[21] The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.

[21a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.

[22] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

Colorado Small Group Health Plan Description Form

All Colorado Small Group Health Insurance Companies
Name of Carrier

2008 Colorado Basic HSA Health Benefit Plans: Indemnity, Preferred Provider, and HMO

Name of Plan

PART A: TYPE OF COVERAGE

	Basic Indemnity Plan	Basic Preferred Provider Plan	Basic HMO Plan
1. Type of Plan	Medical expense policy	Preferred provider plan	Health maintenance organization (HMO)
2. Out-of-Network Care Covered?[1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. Areas of Colorado where plan is available	Plan is available throughout Colorado	Varies by carrier.	Varies by HMO

PART B: Summary of Benefits ***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[1a]	In-Network Only *(Out-of-Network care is not covered except as noted)*
4. Annual Deductible[2] a) Single Coverage b) Non-Single Coverage (Employee + Spouse or Employee + Children or Employee, Spouse and Children)	 $4,000 $8,000	 $4,000 $8,000	 $8,000 $16,000 (Deductibles are separate from in-network deductibles)	 $4,000 $8,000
5. Out-of-Pocket Annual Maximum[3] *(Includes ded., coinsurance and copays)* a) Single Coverage b) Non-Single Coverage (Employee + Spouse or Employee + Children or Employee, Spouse and Children)	 $5,500 $11,000	 $5,500 $11,000	(Out-of-pocket amts. are separate from in-network out-of-pocket amts.) $11,000 $22,000	 $5,500 $11,000
5A. Coinsurance *(amount paid by carrier)* or Copay *(amount paid by insured/member)*	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
6. Lifetime or Benefit Maximum Paid by the Plan for all Care	$2 million	$5 million		No lifetime maximum.
7A. Covered Providers	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO
8. Medical Office Visits[4] • PCP or Specialist	50% coinsurance	70% coinsurance	50% coinsuance	30% copay
9. Preventive Care[5]	For all plans, only specified preventive services are covered.			
a) Children's services *(no ded.)* b) Adults' services *(no ded.)*	50% coinsurance 50% coinsurance	$40 copay/visit $40 copay/visit	50% coinsurance 50% coinsurance	$40 copay/visit $40 copay/visit

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[1a]	In-Network Only *(Out-of-Network care is not covered except as noted)*
10. Maternity[6] *(Ded., coinsurance and copay percentage apply to all services.)*	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
11. Prescription Drugs[7,8] *(Ded. and out-of-pocket maximums apply.)*	50% coinsurance	50% coinsurance	50% coinsurance	50% copay
12. Inpatient Hospital[9]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
13. Outpatient/Ambulatory Surgery	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
14. Diagnostics[10] a) Laboratory & X-ray b) MRI, Nuclear Medicine, CT, CTA, MRA and PET Scans	 50% coinsurance 50% coinsurance	 70% coinsurance 70% coinsurance	 50% coinsurance 50% coinsurance	 30% copay 30% copay
15. Emergency Care[11,12]	50% coinsurance	70% coinsurance *(In-network ded. applies regardless of where serivce is provided.)*		30% copay
16. Ambulance	50% coinsurance	70% coinsurance After satisfaction of in-network deductible		30% copay
17. Urgent, Non-Routine, After-Hours Care	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
18. Biologically Based Mental Illness[13] Care	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. Other Mental Health Care[14] a) Inpatient Care	50% coinsurance. Maximum 45 inpatient or 90 partial days/year.	50% coinsurance. Maximum 45 inpatient or 90 partial days/year.		50% copay. Maximum 45 inpatient or 90 partial days/year.
b) Outpatient Care	50% coinsurance. Plan/ insurer pays a maximum of $1,000/year	50% coinsurance. Plan/insurer pays a maximum of $1,000/year *(In-network ded. applies to network providers and out-of-network ded. applies to non-network providers. However, the max. benefit is combined for in-network and out-of-network benefits.)*		50% copay. Plan pays a maximum of $1,000/year.
20. Alcohol and Substance Abuse	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% coinsurance.	Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% coinssurance. *(In-network ded. applies to network providers and out-of-network ded. applies to non-network providers. However, the max. benefit is combined for in-network and out-of-network benefits.)*		Acute detox: maximum 5 days per episode and 2 episodes per lifetime. Covered at 50% copay.
21. Physical, Occupational & Speech Therapy[15]	50% coinsurance (Limited to 25 visits per therapy per year)	70% coinsurance (Limited to 25 visits per therapy per year combined in and out-of-network	50% coinsurance (Limited to 25 visits per therapy per year combined in and out-of-network)	30% copay (Limited to 25 visits per therapy per year.)
22. Durable Medical Equipment[16]	50% coinsurance $1,000/year maximum	70% coinsurance $1,000/year maximum *(In-network ded. applies to network providers and the out-of-network ded. applies to non-network providers. However,the maximum benefit is combined for in-network and out-of-network benefits.)*	50% coinsurance	30% copay $1,000/year maximum
23. Oxygen	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[2]	In-Network Only *(Out-of-Network care is not covered except as noted)*
24. Organ Transplants[17]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi-organ transplants, bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
25. Home Health Care[17a]	50% coinsurance Limited to 60 visits per year	70% coinsurance Limited to 60 visits per year combined maximum	50% coinsurance	30% copay Limited to 60 visits per year
26. Hospice Care[17a, 18]	50% coinsurance per diem	70% coinsurance per diem	50% coinsurance per diem	30% copay per diem
27 Skilled Nursing Facility [19]	50% coinsurane (Not to exceed 100 days/year	70% coinsurance (Not to exceed 100 days/ year)	50% coinsurance (Not to exceed 100 days/ year)	30% copay (Not to exceed 100 days/year
28. Dental Care	For all plans, not covered except for dental care needed as a result of an accident.			
29. Vision Care	Excluded	Excluded	Excluded	Excluded
30. Chiropractic Care	Excluded	Excluded	Excluded	Excluded
31 Significant Additional Services (List up to 5)	None	None	None	None

PART C: LIMITATIONS AND EXCLUSIONS

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[1a]	
32. Period During Which Pre-Existing Conditions are not Covered[20, 21]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 - 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
34. How Does the Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions
35. What Treatments and Conditions Are Excluded Under this Policy?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents;[21a] educational training problems; experimental and investigational procedure; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[22]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it pays more of the bill if their network providers are used (i.e., go in-network) then if they aren't used (i.e., go out-of-network).

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

[2] "Annual Deductible". The stated annual deductible **MUST** be met prior to any benefits being payable except as otherwise indicated.

[3] "Out-of-pocket maximum". refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

[4] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically-based mental illnesses.

[5] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

[6] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.
[7] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount rate in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado.
[8] Prescription drugs otherwise excluded are not covered.
[9] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.
[10] Includes diagnostic low dose mammography. Routine mammograms are covered. Diagnostic services do not include therapeutic treatment.
[11] "Emergency care" means services delivered by an emergency care facility that are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.
[12] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance applies.
[13] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.
[14] Pursuant to § 10-16-105(1), C.R.S., the following small employers may exclude mental health coverage from their plans: any small employer who has not provided group sickness and accident insurance to employees after July 1, 1989, and any small employer who has provided group sickness and accident from a person or entity licensed pursuant to § 10-3-903.5, C.R.S., that did not include mental health coverage after July 1, 1989. However, carriers allowing for such an exclusion must follow all the relevant provisions of § 10-16-105(2), C.R.S., relating to such an exclusion.
[15] Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).
[16] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the annual maximum; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.
[17] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.
[17a] Covered services are defined in Colorado Insurance Regulation 4-2-8.
[18] Although the numbers of days for this benefit is not limited, ancillary services, such as bereavement, shall be limited consistent with Colorado Regulation 4-2-8.
[19] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.
[20] "Waiver of preexisting condition exclusions." State law requires carriers to waive some or all of the preexisting condition exclusion period based on other coverage the insured/member recently may have had.
[21] The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.
[21a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.
[22] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

Colorado Small Group Health Plan Description Form

All Colorado Small Group Health Insurance Companies
Name of Carrier

2008 Colorado Basic HSA Limited Mandate Health Benefit Plans: Indemnity, Preferred Provider, and HMO

Name of Plan

PART A: TYPE OF COVERAGE

	Basic Indemnity Plan	Basic Preferred Provider Plan	Basic HMO Plan
1. Type of Plan	Medical expense policy	Preferred provider plan	Health maintenance organization (HMO)
2. Out-of-Network Care Covered?[1]	Yes, policy makes no distinction between in- and out-of-network care.	Yes, but patient pays more for out-of-network care.	Only for emergency and urgent care.
3. Areas of Colorado where plan is available	Plan is available throughout Colorado	Varies by carrier.	Varies by HMO

PART B: Summary of Benefits ***(Please note: all coinsurance percentages listed are what the carrier will pay for the service. For the HMO plan, the percentage copay listed is what the member will pay.)***

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[1a]	In-Network Only *(Out-of-Network care is not covered except as noted)*
4. Annual Deductible[2]	For all plans, deductible applies to all services unless specifically noted.			
a) Single Coverage b) Non-Single Coverage (Employee + Spouse or Employee + Children or Employee, Spouse and Children)	$4,000 $8,000	$4,000 $8,000	$8,000 $16,000 (Deductibles are separate from in-network deductibles)	$4,000 $8,000
5. Out-of-Pocket Annual Maximum[3] *(Includes ded., coinsurance and copays)* a) Single Coverage b) Non-Single Coverage (Employee + Spouse or Employee + Children or Employee, Spouse and Children)	$5,500 $11,000	$5,500 $11,000	(Out-of-pocket amts. are separate from in-network out-of-pocket amts.) $11,000 $22,000	$5,500 $11,000
5A. Coinsurance *(amount paid by carrier)* or Copay *(amount paid by insured/member)*	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
6. Lifetime or Benefit Maximum Paid by the Plan for all Care	$2 million	$5 million		No lifetime maximum.
7A. Covered Providers	All providers licensed or certified to provide benefits.	List of covered in-network providers varies by carrier.	All providers licensed or certified to provide benefits.	List of covered providers varies by HMO.
7B. With respect to network plans, are all the providers listed in 7A accessible to me through my primary care physician?	Not applicable. This is not a network plan.	Answer varies by carrier.	Not applicable.	Answer varies by HMO
8. Medical Office Visits[4] • PCP or Specialist	50% coinsurance	70% coinsurance	50% coinsuance	30% copay
9. Preventive Care[5]	For all plans, only specified preventive services are covered.			
a) Children's services *(no ded.)* b) Adults' services *(no ded.)*[5a]	50% coinsurance 50% coinsurance	$40 copay/visit $40 copay/visit	50% coinsurance 50% coinsurance	$40 copay/visit $40 copay/visit

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan In-Network Only *(Out-of-Network care is not covered except as noted)*
		In-Network	Out-Of-Network[1a]	
10. Maternity[6] *(Ded., coinsurance and copay percentage apply to all services.)*	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
11. Prescription Drugs[7,8] *(Ded. and out-of-pocket maximums apply.)*	50% coinsurance	50% coinsurance	50% coinsurance	50% copay
12. Inpatient Hospital[9]	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
13. Outpatient/Ambulatory Surgery	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
14. Diagnostics[10] a) Laboratory & X-ray b) MRI, Nuclear Medicinem, CT, CTA, MRA and PET scans	 50% coinsurance 50% coinsurance	 70% coinsurance 70% coinsurance	 50% coinsurance 50% coinsurance	 30% copay 30% copay
15. Emergency Care[11,12]	50% coinsurance	70% coinsurance *(In-network ded. applies regardless of where serivce is provided.)*		30% copay
16. Ambulance	50% coinsurance	70% coinsurance After satisfaction of in-network deductible		30% copay
17. Urgent, Non-Routine, After-Hours Care	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
18. Biologically Based Mental Illness[13] Care	For all plans, coverage is no less extensive than the coverage for any other physical illness under that plan.			
19. Other Mental Health Care a) Inpatient Care b) Outpatient Care	Excluded	Excluded		Excluded
20. Alcohol and Substance Abuse	Excluded	Excluded		Excluded
21. Physical, Occupational & Speech Therapy[14]	50% coinsurance (Limited to 25 visits per therapy per year)	70% coinsurance (Limited to 25 visits per therapy per year combined in and out-of-network)	50% coinsurance	30% copay (Limited to 25 visits per therapy per year)
22. Durable Medical Equipment[15]	50% coinsurance $1,000/year maximum	70% coinsurance $1,000/year maximum *(In-network ded. applies to network providers and the out-of-network ded. applies to non-network providers. However,the maximum benefit is combined for in-network and out-of-network benefits.)*	50% coinsurance	30% copay $1,000/year maximum
23. Oxygen	(Included under durable medical equipment)	(Included under durable medical equipment)		(Included under durable medical equipment)
24. Organ Transplants[16]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, other single and multi organ transplants and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	50% coinsurance	70% coinsurance	50% coinsurance	30% copay
25. Home Health Care[16a]	50% coinsurance Limited to 60 visits per year	70% coinsurance Limited to 60 visits per year combined maximum	50% coinsurance	30% copay Limited to 60 visits per year
26. Hospice Care[16a, 16b]	50% coinsurance per diem	70% coinsurance per diem	50% coinsurance per diem	30% copay per diem
27 Skilled Nursing Facility [19]	50% coinsurance (Not to exceed 100 days/year)	70% coinsurance (Not to exceed 100 days/ year)	50% coinsurance (Not to exceed 100 days/ year)	30% copay (Not to exceed 100 days/year
28. Dental Care	For all plans, not covered except for dental care needed as a result of an accident.			
29. Vision Care	Excluded	Excluded	Excluded	Excluded
30. Chiropractic Care	Excluded	Excluded	Excluded	Excluded
31 Significant Additional Services (List up to 5)	None	None	None	None

PART C: LIMITATIONS AND EXCLUSIONS

	Basic Indemnity Plan	Basic Preferred Provider Plan		Basic HMO Plan
		In-Network	Out-Of-Network[1a]	
32. Period During Which Pre-Existing Conditions are not Covered[18,19]	Business Groups of One: Up to 12 months for all pre-existing conditions Business Groups of 2 - 50: Up to 6 months for all pre-existing conditions			Not applicable; plan does not impose limitation periods for pre-existing conditions
33. Exclusionary Riders Can an individual's specific, pre-existing condition be entirely excluded from the policy?	No	No	No	No
34. How Does the Policy Define A "Pre-Existing Condition"?	A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last six months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that pre-existing condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn, other special enrollees, or for pregnancy.			Not applicable. Plan does not exclude coverage for pre-existing conditions
35. What Treatments and Conditions Are Excluded Under this Policy?	Standard exclusions, including benefits covered by employers liability laws; care that is not medically necessary; cosmetic care; custodial care; dental care except for accidents;[19a] educational training problems; experimental and investigational procedure; eye glasses and contact lenses; hearing aides and fitting; learning disorders; marital or social counseling; nursing home care except as specifically otherwise covered under this plan; sexual dysfunction, infertility treatment and counseling except as specifically otherwise covered under the policy requirements of this plan; TMJ; treatment for work-related illnesses and injuries except for those individuals who are not required to maintain or be covered by workers' compensation insurance as defined by workers' compensation laws[20]; transplants except for those listed above; charges related to the surgical treatment of obesity; and war.			

Endnotes

[1] "Network" refers to a specified group of physicians, hospitals, medical clinics and other health care providers that the plan may require the insured/member to use in order to get any coverage at all under the plan, or that the plan may encourage the insured/member to use because it may pay more of the bill if their network providers are used (i.e., go in-network) than if they aren't used (i.e., go out-of-network).

[1a] Out-of-network cost sharing (deductibles, coinsurance, and out-of-pocket maximums) levels apply ***ONLY IF*** plan has network providers for the covered benefit and insured goes out of the network. Otherwise, in-network-levels apply.

[2] "Annual Deductible". The stated annual deductible **MUST** be met prior to any benefits being payable except as otherwise indicated.

[3] "Out-of-pocket maximum". refers to the maximum amount the insured/member will have to pay for allowable covered expenses under a health plan, which includes the deductible, copays, and coinsurance.

[4] "Medical office visits" include physician, mid-level practitioner, and specialist visits, including the provision of injections of injectable drugs and outpatient psychotherapy visits for biologically-based mental illnesses.

[5] See Attachment 1 for list of covered preventive services. Immunizations for children up to age 13 shall be provided in accordance with Colorado Division of Insurance Bulletin 4.24.

[5a] Prostate cander screening and routine mammograms are not covered.

[6] Well-baby care includes an in-hospital newborn pediatric visit and newborn hearing screening. Well-baby charges incurred during the hospital stay are covered under the mother's deductible.

[7] Includes expendable medical supplies for the treatment of diabetes. Carriers are allowed to provide a mail order benefit or discount in the manner they do for their most frequently sold non-basic, non-standard group health plan in Colorado.

[8] Prescription drugs otherwise excluded are not covered.

[9] Inpatient care includes all physician, surgical, and other services delivered during a hospital stay.

[10] Includes diagnostic low dose mammography. (Routine mammograms are not covered.) Diagnostic services do not include therapeutic treatment.

[11] "Emergency care" means services delivered by an emergency care facility which are necessary to screen and stabilize a covered person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed than an emergency medical condition or life or limb threatening emergency existed.

[12] Non-emergency care delivered in an emergency room is covered only if the covered person receiving such care was referred to the emergency room by his/her carrier or primary care physician. If emergency departments are used by the plan for non-emergency after hours care, then urgent care coinsurance applies.

[13] "Biologically based mental illnesses" means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder. Outpatient psychotherapy visits for biologically based mental illnesses are covered at the same level as routine medical office visits.

[14] Coverage for medically necessary therapeutic treatment only – benefits will not be paid for maintenance therapy after maximum medical improvement achieved, except as required by law for children under 6 years of age. The services covered and the benefits provided for children under 6 years of age must be in accordance with the requirements of §10-16-104, C.R.S., subsections (1.3) and (1.7).

[15] Coverage for lesser of purchase or rental price for medically necessary durable medical equipment. DME includes, but is not limited to, home-administered oxygen, reusable equipment for the treatment of diabetes, and prostheses. Although the cost of prosthetic devices applies to the annual DME cap, benefits for prosthetic devices for arms or legs (or any part thereof) themselves are not subject to this maximum. The benefit level for prosthetic devices for arms or legs or parts thereof shall be as required by § 10-16-104(14), C.R.S. Repair or replacement of defective equipment is covered at no additional charge; repair and replacement needed because of normal usage is covered up to the annual maximum; and repair and replacement needed due to misuse/abuse by the insured is ***not*** covered.

[16] Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.
[16a] Covered services are defined in Colorado Insurance Regulation 4-2-8.
[16b] Although the number of days for this benefit is not limited, ancillary services, such as bereavement, shall be provided consistent with Colorado Insurance Regulation 4-2-8.
[17] Coverage for medically necessary skilled nursing facility care only. Benefits will not be paid for custodial care or maintenance care or when maximum medical improvement is achieved and no further significant measurable improvement can be anticipated.
[18] "Waiver of pre-existing condition exclusions." State law requires carriers to waive some or all of the preexisting condition exclusion period based on other coverage insured/member recently may have had.
[19] The plan shall waive any time period applicable to a pre-existing condition limitation period for the period of time an individual was covered by creditable coverage, if such creditable coverage was continuous to a date not more than ninety days prior to the effective date of the new coverage. Any waiting period before the effective date of the new coverage applied by the employer or the carrier shall not be considered a lapse of coverage and shall count toward satisfying any applicable pre-existing condition limitation.
[19a] Dental care related to accidental injury: treatment, supplies and appliances that are needed to restore the mouth, sound natural teeth or jaws to the condition they were in immediately prior to the accident. The first dental services must be performed within 60 days of the accident unless the patient's medical condition prohibits the initial dental care from being provided within that timeframe. Only services provided within 12 months of the accident are covered.
[20] Except that, if a workers' compensation policy is in place (although not required by state labor law), the workers' compensation policy, not this plan, is responsible for medical benefits for work-related illnesses and injuries. Also, if this plan is a federally qualified HMO plan, proof of workers' compensation coverage, if such coverage is required by law, may be required as a condition of coverage *if* such proof is required on the HMO's other small employer plans.

ATTACHMENT 1 FOR ALL PLANS

Covered Preventive Services[1]

All Persons
- 1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer.
- Chicken pox vaccination for all persons who have not had chicken pox.

Females
- Full cost of cervical cancer vaccine.[1a]

All Children
- Immunizations.
- Immunization deficient children are not bound by "recommended ages".

Age 0-12 months
- 1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery.
  6 well-child visits[2]
- 1 PKU

Age 13-35 months
- 3 well-child visits

Age 3-6
- 4 well-child visits

Age 7-12
- 4 well-child visits

Age 13-18
- 1 age appropriate health maintenance visit[3] every year
- 1 Td
- Females: screening pap smears not to exceed 1 per year.
- 1 hepatitis B vaccination if not given previously

Age 19-39
- 1 Td every ten years.
- 1 age appropriate health maintenance visit every three years.
- 1 fasting lipid panel.
- Females ages 35-39: 1 baseline screening mammogram and clinical breast exam. ***(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)***
- Females: screening pap smears not to exceed 1 per year.

Age 40-64
- 1 Td every ten years
- 1 fasting lipid panel every five years.
- Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75.
- 1 age appropriate health maintenance visit every 24 months.
- Females ages 40-49: 1 screening mammogram and clinical breast exam every two years (annually, if high risk) ***(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)***
- Females ages 50-64: 1 screening mammogram and clinical breast exam every 12 months. ***(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)***
- Females: screening pap smears not to exceed 1 per year.
- Males: prostate screening as specified in state law. ***(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)***

Age 65 and older
- 1 influenza immunization every year
- 1 pneumococcal vaccine at or after age 65
- Females: screening pap smears not to exceed 1 per year.
- 1 Td every ten years
- 1 age appropriate health maintenance visit every year.
- Females age 65-74: 1 screening mammogram and clinical breast exam every 12 months ***(Not covered under the Basic Limited Mandate Health Benefit Plans and the Basic HSA Limited Mandate Health Benefit Plans.)***
- Either annual fecal occult blood testing or 2 colorectal visualizations between ages 50 and 75
- Males: Prostate screening as specified in state law.

[1] Not all preventive services and screenings are specifically listed, but the list is considered to include all services and screenings deemed to be preventive by the Federal Department of the Treasury for HSA (health savings account) complaint plans.
[1a] Age limitations are recommended by the U.S. Department of Health and Human Services' Advisory Committee on Immunization Practices.
[2] "Well-child visit" means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling. Te schedule of these visits, through age 12, is based on the recommendations of he American Academy of Pediatrics.
[3] "Age appropriate health maintenance visit" means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).

WORLD INSURANCE
Omaha, Nebraska

Complete & Submit

M1037-CO

Agent Instructions: Please have the applicant complete these forms if they are residents of the State of Colorado

- ❑ Submit the Home Office copy with the Application (page 2).
- ❑ Leave applicant's copy with them (page 3).

Complete and Submit

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

Notice to Applicant Regarding Replacement of Accident and Sickness Insurance

According to your application the information furnished by you, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by World Insurance Company. Your new policy will provide a 10-day free look period, within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find the purchase of this accident and sickness coverage is a wise decision you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer or Producer:
I have reviewed your current accident and sickness insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits
- ☐ No change in benefits, but lower premiums
- ☐ Fewer benefits and lower premiums
- ☐ Other (please specify) ______________________________

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer ______________________________

Name and Address of Producer ______________________________

Applicant's Signature ______________________________

Date ____________________

M1037-CO (7-01) (Rev. 8-05)

Notice to Agent: If applicable, have the proposed insured complete this page and the previous page. Please leave this page with Proposed Insured in all cases. Disregard completing this form if not applicable.

Submit with application for insurance.

[Leave with Client]

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3. If you wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy has never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer ______________________________

Name and Address of Producer ______________________________

Applicant's Signature ______________________________

Date ____________________

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Leave with the proposed insured.

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