Insurance Agency:

Agent Name:

Agent Phone Number:

Dental, Vision & Hearing Plan

application booklet

MEDICO™
INSURANCE COMPANY
A Member of Medico Group

Welcome!

Thank you for choosing Medico™ Insurance Company, a member of Medico Group, as your provider of Dental, Vision and Hearing Insurance.

You have made a wise decision, and we know that as time passes, you'll see that your choice was one of the best healthcare decisions you have ever made.

Over 75 years of experience in the insurance business has molded our program — we understand the value of offering fast, accurate claims handling and exceptional personal service.

We're old-fashioned enough to have real people, not recorded menus, answer phone calls from policyholders, but modern enough to use the latest technologies. You can contact us using the method most comfortable and convenient for you; either by phone, mail, email, or Internet. Regardless of how we communicate, your personal information will be protected — safe and secure.

As you'll discover, we strive to make the application process convenient and hassle-free for you.

Policyholders tell us they appreciate our efficiency in handling claims and the integrity with which we extend our personal service. Medico stands ready to put our years of experience to work for you and we look forward to serving you, our valued policyholder.

The Staff of Medico Insurance Company

If you have any questions, please speak with your knowledgeable insurance agent for assistance or contact one of our trained Customer Service Representatives toll-free at **1.800.228.6080** Monday through Thursday from 7:30 a.m. to 4:45 p.m. and on Friday from 7:30 a.m. to 11:30 a.m., Central Time.

Producer Instructions

Thank you for choosing Medico Insurance Company as your carrier for Dental, Vision and Hearing Insurance.

Getting Started…

This application booklet contains all of the forms needed to write and submit an application, including the brochure and outline. Please read the Producer Instructions to ensure a smooth application process. **Remove pages i through 12 from the booklet once the forms in the booklet have been completed.** The remainder of the booklet must be left with the applicant(s).

Please use only a blue or black pen when filling out the application booklet.

- Any Medicare-eligible applicant(s) must receive a copy of the Medicare Buyers Guide. Applicant(s) can choose to accept an electronic version of the Medicare Buyers Guide. The Internet link is provided on the bottom of the receipt.
- MI9F-1060 – Replacement Notice – Complete the notice if the replacement question on the application is answered "Yes."
- Duplicates of MI9F-1060 and MI9F-4218 are used when a co-applicant is applying with the applicant.

When you are ready to submit the application, please complete the New Business Transmittal form on page ii and use it as the cover page for submitting the front of each page, 1 through 12.

For questions on how to use this application booklet or for more information on our products, please visit mic.gomedico.com or call Agent Services at 1.800.547.2401.

For Producer Use Only

MEDICO™ GROUP

Medico™ Insurance Company
1515 South 75th Street
Omaha, Nebraska 68124

New Business Transmittal

www.gomedico.com

Producer Instructions

Please complete a separate transmittal form for each manager number and include it with your application(s). Multiple applications can be included on one transmittal form.

The "Policy Form" for submitting new business can be found in the application.

The "Mode" can be found in the rate guide or outline. Applications are accepted without initial premium when an automatic bank withdrawal mode is requested. Initial premium will be deducted on approval of the application. Faxed applications must use automatic bank withdrawal.

The "Premium Collected Including Fees" includes cash received with the application(s). For automatic bank withdrawal, list $0.

Submit applications to the Home Office either by:

Mail: **Medico Group**
1515 South 75th Street
Omaha, NE 68124

or **Fax: 1.888.363.3420** or **File Upload: mic.gomedico.com**

Visit mic.gomedico.com for up-to-date information on pending applications.

______________________________ #________________ Date________________

General Agent (GA) Name GA Number

Policy Number if applicable	Applicant's Name	Policy Form	Mode	Producer Number	Premium Collected including fees
					$.
					$.
					$.
					$.
					$.
					$.
					$.
					$.
					$.
					$.

Each application submitted for issue must be listed on this form.

Make sure all checks are payable to Medico.

Total Premium submitted
$.

We do not accept trial applications.

Use a separate sheet for Additional Premium, Balance of Modes or Reinstatement business.
Please include the respective policy numbers for these types of business.

For Producer Use Only

MEDICO™ INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

gomedico.com
Toll-Free 1-800-228-6080

Application for Dental, Vision and Hearing Insurance

Part A: General Information – Please Print

Applicant Information

Name ______________________ ____________ Date of Birth (Mo./Day/Yr.) ______ Age ______ Sex

Address ______________________ Street Address City State Zip

Social Security # ______________________

Phone # ______________________ E-mail Address ______________________

Beneficiary ______________ Relationship ______________ Address ______________

Co-Applicant Information

Name ______________________ ____________ Date of Birth (Mo./Day/Yr.) ______ Age ______ Sex

Social Security # ______________________ E-mail Address ______________________

Beneficiary ______________ Relationship ______________ Address ______________

Part B: Medical Information

	Applicant Yes	Applicant No	Co-Applicant Yes	Co-Applicant No
1. (a) Do you currently wear dentures?	❒	❒	❒	❒
(b) Have you been advised to have any dental work which has not been completed?	❒	❒	❒	❒
2. (a) Do you currently wear eyeglasses or contact lenses?	❒	❒	❒	❒
(b) Have you received advice or treatment within the past nine months for correction of a vision problem?	❒	❒	❒	❒
3. (a) Do you currently wear a hearing aid?	❒	❒	❒	❒
(b) Have you been treated for hearing loss within the past nine months?	❒	❒	❒	❒
(c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	❒	❒	❒	❒

1. (b) If "Yes," provide details:
Applicant: ______________________
Co-Applicant: ______________________

2. (b) If "Yes," provide details:
Applicant: ______________________
Co-Applicant: ______________________

Part C: Applicant Information

	Applicant Yes	Applicant No	Co-Applicant Yes	Co-Applicant No
1. (a) Do you have any dental, vision or hearing insurance currently in force?	❒	❒	❒	❒
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company?	❒	❒	❒	❒
(c) If replacement is involved, have you received a replacement form (in states where required by law)?	❒	❒	❒	❒

1. (b) If "Yes," provide type of contract or policy number, and name of company:
Applicant: ______________________
Co-Applicant: ______________________

Part D: Benefit Option

Applicant: Check the Benefit you prefer:

Policy Year Maximum: ❒ $1,000 ❒ $1,500

Co-Applicant: Check the Benefit you prefer:

Policy Year Maximum: ❒ $1,000 ❒ $1,500

Part E: Payment Options

Applicant: Provide the following information:

Make all checks payable to: Medico™ Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment: ❒ Automatic Bank Withdrawal ❒ Direct Bill

Frequency of Payment: ❒ Monthly* ❒ Bi-Monthly ❒ Quarterly ❒ Semi-Annually ❒ Annually
*Monthly is not a payment option for Direct Bill.

Amount Received with Application $________________ Renewal Premium $________________

Requested Effective Date of Policy (optional) ________________
(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Co-Applicant: Provide the following information:

Make all checks payable to: Medico™ Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment: ❒ Automatic Bank Withdrawal ❒ Direct Bill

Frequency of Payment: ❒ Monthly* ❒ Bi-Monthly ❒ Quarterly ❒ Semi-Annually ❒ Annually
*Monthly is not a payment option for Direct Bill.

Amount Received with Application $________________ Renewal Premium $________________

Requested Effective Date of Policy (optional) ________________
(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part F: Application Agreement

I hereby apply to Medico™ Insurance Company for a **Dental, Vision and Hearing Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, or prescription/pharmaceutical database that has any record or knowledge of me or my health, to give to Medico™ Insurance Company any such information. I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for 24 months unless revoked by me in writing to the Home Office of Medico™ Insurance Company.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if you are eligible for Medicare and "A Guide to Health Insurance for People With Medicare" is required in your state:

Applicant	Co-Applicant	
❒	❒	1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products.
❒	❒	2. I have received a hard copy of the Medicare Buyers Guide.
❒	❒	3. I am not eligible for Medicare.

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I acknowledge that in states where it is required, the producer met with me on this date, made the necessary inquiries concerning my insurance needs and proposed a program of insurance which is suitable for my needs. I am applying for this Dental, Vision and Hearing insurance.

Applicant's Signature ________________ Date ________________

Co-Applicant's Signature ________________ Dated at ________________
City State

Producer's Name ________________
(Please print)

Producer's Signature ________________ Date ________________

1515 South 75th Street
Omaha, Nebraska 68124

gomedico.com
Toll-Free 1-800-228-6080

Bank Withdrawal Authorization

(For New Applications)

Name____

Address ____

Street Address City State Zip

By signing the authorization below and attaching a voided check (if a checking account is selected for the withdrawal) for proper encoding of your personal account number, we will start you on your Bank Draft service. **Remember to attach a voided check.**

❒ Checking Account ❒ Savings Account

Routing #									

Account #																		

Date for premiums to be withdrawn (select a date from the 1st to the 28th of the month) ___________________

I (We) give permission to my (our) financial institution to automatically make payments to Medico™ Insurance Company in Omaha, Nebraska. This authorization will remain in force unless I (we) cancel it, or unless the insurance policy/certificate is cancelled or my (our) bank account is closed.

Applicant's Signature ____________________________________ Date ______________
(As it appears on bank records)

Signature ____ Date ______________
(If a joint account)

If payment is not received with this application, the first premium will be withdrawn from your bank account upon approval of your application.

If this is a dual application and the Co-Applicant's premium payments are to be withdrawn from a separate bank account, please complete the next page of this form with the Co-Applicant's bank information.

Bank Withdrawal Authorization

(For Co-Applicant's New Application – Complete this portion only if Co-Applicant's premium payments are to be withdrawn from a separate bank account)

Name____

Address ____

Street Address   City   State   Zip

By signing the authorization below and attaching a voided check (if a checking account is selected for the withdrawal) for proper encoding of your personal account number, we will start you on your Bank Draft service. **Remember to attach a voided check.**

❒ Checking Account   ❒ Savings Account

Routing #

Account #

Date for premiums to be withdrawn (select a date from the 1st to the 28th of the month) __________________

I (We) give permission to my (our) financial institution to automatically make payments to Medico™ Insurance Company in Omaha, Nebraska. This authorization will remain in force unless I (we) cancel it, or unless the insurance policy/certificate is cancelled or my (our) bank account is closed.

Applicant's Signature ____ Date ______________
(As it appears on bank records)

Signature ____ Date ______________
(If a joint account)

If payment is not received with this application, the first premium will be withdrawn from your bank account upon approval of your application.

MEDICO™ INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico™ Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still 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/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

____
(Date)

____
(Applicant’s Signature)

____
(Agent’s Signature)

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico™ Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico™ Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE

The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Medico™ Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION

This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Medico™ Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy/certificate.

COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

I have received the Notice of Privacy Practices

____
Printed Name of Applicant/Insured

____ ____
Signature of Applicant/Insured Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

____ ____
Printed Name of Personal Representative Description of Personal Representative's Authority

____ ____
Signature of Personal Representative Date

MEDICO™ INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico™ Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still 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/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

____
(Date)

____
(Applicant’s Signature)

____
(Agent’s Signature)

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico™ Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico™ Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

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I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy/certificate.

COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

I have received the Notice of Privacy Practices

____
Printed Name of Applicant/Insured

__________________________________	__________________________________
Signature of Applicant/Insured	Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

__________________________________	__________________________________
Printed Name of Personal Representative	Description of Personal Representative's Authority
__________________________________	__________________________________
Signature of Personal Representative	Date

OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

____

(Agent or Insurance Company Representative)

____

(Address)

Completed this questionnaire on ______________________________

describing ______________________________
(Policy Name, Form Number)

an individual health insurance policy providing coverage for ______________________

____

This policy is underwritten by ______________________________
(Insurance Company)

____

(Address)

NOTICE

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

Are You Considering Replacing Your Current Coverage? Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are You Considering Adding to Your Current Coverage?

> **Review Your Coverage.** Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.
>
> **Which Coverage Will Pay?** If coverage under the offered policy duplicates coverage under your current policy, the offered policy _____ will ____ will not pay if your current policy also pays. (NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

Questions? Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

Read Your Policy! If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill Out Your Application Carefully! Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, the insurer may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

____
(Agent or Insurance Company Representative)

____
(Address)

Completed this questionnaire on ______________________________

describing ______________________________________
(Policy Name, Form Number)

an individual health insurance policy providing coverage for ____________________

____

This policy is underwritten by ______________________________
(Insurance Company)

____
(Address)

NOTICE

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Are You Considering Adding to Your Current Coverage?

Review Your Coverage. Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Which Coverage Will Pay? If coverage under the offered policy duplicates coverage under your current policy, the offered policy _____ will ____ will not pay if your current policy also pays. (NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

Questions? Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

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Fill Out Your Application Carefully! Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, the insurer may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

1515 South 75th Street
Omaha, Nebraska 68124

gomedico.com
Toll-Free 1-800-228-6080

RECEIPT

Applicant

The applicant has applied for the MI-MSA18 Dental, Vision and Hearing Insurance Policy with a Policy Year Maximum Benefit in the amount of: ❒ $1,000 ❒ $1,500

Received of ____
(Applicant's Name)

an application for insurance as shown above and $______________________ Dollars.
(includes policy fee, if any)

Co-Applicant

The co-applicant has applied for the MI-MSA18 Dental, Vision and Hearing Insurance Policy with a Policy Year Maximum Benefit in the amount of: ❒ $1,000 ❒ $1,500

Received of ____
(Co-Applicant's Name)

an application for insurance as shown above and $______________________ Dollars.
(includes policy fee, if any)

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO MEDICO INSURANCE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not receive your policy within 30 days, please contact us by one of the following methods:

Write to: Medico Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

Call: Customer Service at 1-800-228-6080

E-mail: customerservice@gomedico.com

______________________________ Date ______________________
Producer Signature

____
Producer Name

The Medicare Buyers Guide, "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," can be found on our website at gomedico.com/products.

1515 South 75th Street
Omaha, Nebraska 68124

gomedico.com
Toll-Free 1-800-228-6080

LIMITED BENEFIT POLICY
DENTAL, VISION AND HEARING COVERAGE

RETAIN THIS OUTLINE FOR YOUR RECORDS
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract. Only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY**.

Limited Benefit Coverage: Policies of this type are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

BENEFITS PROVIDED BY THE POLICY

Policy Year Maximum Benefit: The maximum benefit we will pay during any one Policy Year. You may choose from:

❒ $1,000 ❒ $1,500

Policy Year Deductible: You are responsible for the first $100 of Covered Expenses during each Policy Year.

After satisfaction of the $100 Policy Year Deductible, the policy will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit based on the Policy Year:

60% – First Policy Year
70% – Second Policy Year
80% – Third Policy Year and thereafter

Covered Expenses, subject to the limitations described in the Exceptions and Limitations Section, are:

(1) Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

(2) Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one Policy Year.

(3) Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

After the policy has been in force three months, the policy will pay 100% of the cost of one dental cleaning up to a maximum benefit of $50 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

Reasonable and Customary Charges are the normal and prevailing charges, fees or expenses for the service rendered or for the material furnished in the geographic area where rendered or furnished.

EXCEPTIONS AND LIMITATIONS

Benefits will not be payable for the following items and/or services **during the first six months following the Policy Date:**

(1) Root canals; or

(2) Existing eyeglasses or contact lenses (including the renewal or changing of prescriptions).

Benefits will not be payable for the following items and/or services **during the first Policy Year:**

(1) Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions or fluoride treatments; or

(2) Existing hearing aids.

Benefits will not be paid under this policy for: (1) any loss resulting from war, declared or undeclared; (2) any intentionally self-inflicted Injury; (3) any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation; (4) any expense for which payment is provided under Medicare; (5) any services that are not recommended by a Physician, as defined by the policy; (6) any Experimental or Investigational procedure or treatment; (7) orthodontic treatment; (8) any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; (9) expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts); (10) charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; (11) prescription drugs; (12) charges in excess of Reasonable and Customary Charges; (13) treatment or diagnosis received while outside the territorial limits of the United States; (14) services for which you are not liable or for which no charge normally is made in the absence of insurance; and (15) loss that occurs while the policy is not in force.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR DENTAL, VISION AND HEARING NEEDS.

RENEWABILITY AND PREMIUM CHANGES

Renewability – Guaranteed Renewable – This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums before the end of the grace period.

Terms Under Which We May Change Premiums – We can change premiums only if we do the same to all policies of this form issued to persons of your class in your state, and we notify you in advance of the due date. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under the policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PREMIUMS

MONTHLY BANK DRAFT	QUARTERLY	SEMI-ANNUALLY	ANNUALLY

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay your premium. Your policy stays in force during your grace period.

1515 South 75th Street
Omaha, Nebraska 68124

Outline of Coverage for MI-DVA18
Dental, Vision and Hearing Policy

gomedico.com
Toll-Free 1-800-228-6080

LIMITED BENEFIT POLICY
DENTAL, VISION AND HEARING COVERAGE

RETAIN THIS OUTLINE FOR YOUR RECORDS
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract. Only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY**.

Limited Benefit Coverage: Policies of this type are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

BENEFITS PROVIDED BY THE POLICY

Policy Year Maximum Benefit: The maximum benefit we will pay during any one Policy Year. You may choose from:

❒ $1,000 ❒ $1,500

Policy Year Deductible: You are responsible for the first $100 of Covered Expenses during each Policy Year.

After satisfaction of the $100 Policy Year Deductible, the policy will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit based on the Policy Year:

60% – First Policy Year
70% – Second Policy Year
80% – Third Policy Year and thereafter

Covered Expenses, subject to the limitations described in the Exceptions and Limitations Section, are:

(1) Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.

(2) Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of $150 in any one Policy Year.

(3) Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

After the policy has been in force three months, the policy will pay 100% of the cost of one dental cleaning up to a maximum benefit of $50 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

Reasonable and Customary Charges are the normal and prevailing charges, fees or expenses for the service rendered or for the material furnished in the geographic area where rendered or furnished.

EXCEPTIONS AND LIMITATIONS

Benefits will not be payable for the following items and/or services **during the first six months following the Policy Date:**

(1) Root canals; or

(2) Existing eyeglasses or contact lenses (including the renewal or changing of prescriptions).

Benefits will not be payable for the following items and/or services **during the first Policy Year:**

(1) Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, “full mouth” extractions or fluoride treatments; or

(2) Existing hearing aids.

Benefits will not be paid under this policy for: (1) any loss resulting from war, declared or undeclared; (2) any intentionally self-inflicted Injury; (3) any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation; (4) any expense for which payment is provided under Medicare; (5) any services that are not recommended by a Physician, as defined by the policy; (6) any Experimental or Investigational procedure or treatment; (7) orthodontic treatment; (8) any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; (9) expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts); (10) charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; (11) prescription drugs; (12) charges in excess of Reasonable and Customary Charges; (13) treatment or diagnosis received while outside the territorial limits of the United States; (14) services for which you are not liable or for which no charge normally is made in the absence of insurance; and (15) loss that occurs while the policy is not in force.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR DENTAL, VISION AND HEARING NEEDS.

RENEWABILITY AND PREMIUM CHANGES

Renewability – Guaranteed Renewable – This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums before the end of the grace period.

Terms Under Which We May Change Premiums – We can change premiums only if we do the same to all policies of this form issued to persons of your class in your state, and we notify you in advance of the due date. “Class” means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under the policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PREMIUMS

MONTHLY BANK DRAFT	QUARTERLY	SEMI-ANNUALLY	ANNUALLY

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay your premium. Your policy stays in force during your grace period.

MEDICO™ INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico™ Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still 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/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____
(Date)

____
(Applicant's Signature)

____
(Agent's Signature)

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico™ Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico™ Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

POTENTIAL FOR REDISCLOSURE

The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

REFUSAL TO SIGN

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Medico™ Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

EXPIRATION AND REVOCATION

This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Medico™ Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy/certificate.

COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

I have received the Notice of Privacy Practices

____
Printed Name of Applicant/Insured

______________________________________ ______________________________________
Signature of Applicant/Insured Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

______________________________________ ______________________________________
Printed Name of Personal Representative Description of Personal Representative's Authority

______________________________________ ______________________________________
Signature of Personal Representative Date

MEDICO™ INSURANCE COMPANY
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico™ Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3) If, after due consideration, you still 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/health history. FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above “Notice to Applicant” was delivered to me on:

____
(Date)

____
(Applicant’s Signature)

____
(Agent’s Signature)

MEDICO™ GROUP

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION

MEANING OF TERMS

Health Care Provider means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

Personal Information means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

AUTHORIZATION TO DISCLOSE

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico™ Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

AUTHORIZATION TO USE

I authorize Medico™ Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

PURPOSES OF DISCLOSURE

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

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COPY OF THIS AUTHORIZATION

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

NAMES AND SIGNATURES

I have received the Notice of Privacy Practices

____
Printed Name of Applicant/Insured

________________________________ ________________________________
Signature of Applicant/Insured Date

If applicable: I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

________________________________ ________________________________
Printed Name of Personal Representative Description of Personal Representative's Authority

________________________________ ________________________________
Signature of Personal Representative Date

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

____
(Agent or Insurance Company Representative)

____
(Address)

Completed this questionnaire on ______________________________________

describing ____
(Policy Name, Form Number)

an individual health insurance policy providing coverage for ____________________

____

This policy is underwritten by ______________________________________
(Insurance Company)

____
(Address)

NOTICE

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

Are You Considering Replacing Your Current Coverage? Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are You Considering Adding to Your Current Coverage?

Review Your Coverage. Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Which Coverage Will Pay? If coverage under the offered policy duplicates coverage under your current policy, the offered policy _____ will ____ will not pay if your current policy also pays. (NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

Questions? Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

Read Your Policy! If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill Out Your Application Carefully! Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, the insurer may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.

1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com
Toll-Free 1-800-228-6080

OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

____
(Agent or Insurance Company Representative)

____
(Address)

Completed this questionnaire on ______________________________

describing ______________________________________
(Policy Name, Form Number)

an individual health insurance policy providing coverage for ____________________

____

This policy is underwritten by ______________________________
(Insurance Company)

____
(Address)

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MEDICO™ GROUP

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices explains our policy with regard to your Protected Health Information (PHI). It describes how we may use and disclose this information. This Notice also describes your rights with respect to your PHI and how you can exercise those rights. Protected Health Information (PHI) refers to individually identifiable health information which relates to your past, present or future health, treatment or payment for health care services.

We are required by law to maintain the privacy of PHI, to provide this Notice to you and to abide by its terms. We reserve the right to change the terms of this Notice as necessary. If a change is made to this Notice, a copy of any revised Notice will be mailed to all policyholders/certificateholders then covered by our health plans. Copies of our current Notice may be obtained by contacting us at the address below, or on our Website at www.gomedico.com.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization – Except as outlined below, we will not use or disclose PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing, except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance.

For Payment – We may use and disclose PHI as necessary for payment purposes. For example, we may use information regarding your medical procedures and treatment to process and pay claims. We may also disclose your PHI to pay a health care provider or a health plan.

For Health Care Operations – We may use and disclose PHI as necessary for our health care operations. This includes activities relating to the creation, renewal or replacement of your health coverage. We may also disclose your PHI to reinsurers.

Where Required by Law or for Public Health Activities – We may disclose PHI when required by federal, state or local law. This includes reporting disease, injury, birth and death; for public health investigations; and to a government oversight agency. We may also release PHI to coroners, medical examiners and/or funeral directors.

To Avoid Serious Threats to Health or Safety – We may disclose PHI to the proper authorities to avoid a serious threat to someone's health or safety, such as abuse, neglect or domestic violence. We may also disclose PHI to federal, state or local agencies for assistance in disaster relief.

For Law Enforcement or Specific Government Functions – We may disclose PHI to respond to a court order, subpoena or discovery request. We may also disclose PHI if required by armed forces services or for other specialized government functions, such as national security or intelligence activities.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends or others who are involved in your care. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

over, please

Business Associates – At times, we use outside persons or organizations to help us provide you with the benefits of your coverage. An example is an organization that helps us process your claims. It may be necessary for us to provide some of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use your PHI to tell you about our health insurance products that could substitute for your existing coverage or add value to your coverage.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Inspect and Copy – In most cases, you have the right to inspect and obtain a copy of your PHI. To inspect and copy your PHI, you must submit a written request. In some situations, the writing must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Please send your request to our Privacy Officer at the address below. We may charge you a fee for copying and postage.

Amendments – You have the right to request amendments to PHI that we maintain about you. We are not required to make all requested amendments, but we will give each request careful consideration. To be considered, you must submit a signed written request (signed by you or your representative), and you must state the reasons for the request. Amendment requests should be sent to our Privacy Officer at the address below.

List of Disclosures – You have the right to receive a list of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your request must be in writing and signed by you or your representative. A request for a list of disclosures should be sent to our Privacy Officer 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 within the same 12-month period.

Restrictions on Use and Disclosure – You have the right to request restrictions on certain uses and disclosures of your PHI for insurance payment or health care operations. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request, but we will attempt to accommodate reasonable requests. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate, and we notify you of the termination. You also have the right to terminate any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Copy of the Notice – You have the right to a paper copy of this Notice upon request. Please contact us at the address below.

Complaints – If you believe your privacy rights have been violated, you may file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. We will not penalize you for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our Privacy Office by writing to: Privacy Officer, Medico™ Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

MEDICO™ GROUP

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

NOTICE OF PRIVACY PRACTICES

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.

This Notice of Privacy Practices explains our policy with regard to your Protected Health Information (PHI). It describes how we may use and disclose this information. This Notice also describes your rights with respect to your PHI and how you can exercise those rights. Protected Health Information (PHI) refers to individually identifiable health information which relates to your past, present or future health, treatment or payment for health care services.

We are required by law to maintain the privacy of PHI, to provide this Notice to you and to abide by its terms. We reserve the right to change the terms of this Notice as necessary. If a change is made to this Notice, a copy of any revised Notice will be mailed to all policyholders/certificateholders then covered by our health plans. Copies of our current Notice may be obtained by contacting us at the address below, or on our Website at www.gomedico.com.

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Your Authorization – Except as outlined below, we will not use or disclose PHI unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing, except to the extent that we have taken action in reliance upon the authorization or that the authorization was obtained as a condition of obtaining insurance.

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For Health Care Operations – We may use and disclose PHI as necessary for our health care operations. This includes activities relating to the creation, renewal or replacement of your health coverage. We may also disclose your PHI to reinsurers.

Where Required by Law or for Public Health Activities – We may disclose PHI when required by federal, state or local law. This includes reporting disease, injury, birth and death; for public health investigations; and to a government oversight agency. We may also release PHI to coroners, medical examiners and/or funeral directors.

To Avoid Serious Threats to Health or Safety – We may disclose PHI to the proper authorities to avoid a serious threat to someone's health or safety, such as abuse, neglect or domestic violence. We may also disclose PHI to federal, state or local agencies for assistance in disaster relief.

For Law Enforcement or Specific Government Functions – We may disclose PHI to respond to a court order, subpoena or discovery request. We may also disclose PHI if required by armed forces services or for other specialized government functions, such as national security or intelligence activities.

Family and Friends Involved in Your Care – If you are available and do not object, we may disclose your PHI to your family, friends or others who are involved in your care. If you are unavailable or incapacitated and we determine that a limited disclosure is in your best interest, we may share PHI with such individuals. For example, we may use our professional judgment to disclose PHI to your spouse concerning the processing of a claim.

over, please

Business Associates – At times, we use outside persons or organizations to help us provide you with the benefits of your coverage. An example is an organization that helps us process your claims. It may be necessary for us to provide some of your PHI to one or more of these outside persons or organizations.

Other Products and Services – We may contact you to provide information about other health-related products and services that may be of interest to you. For example, we may use your PHI to tell you about our health insurance products that could substitute for your existing coverage or add value to your coverage.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Inspect and Copy – In most cases, you have the right to inspect and obtain a copy of your PHI. To inspect and copy your PHI, you must submit a written request. In some situations, the writing must be signed by you or your representative (e.g., requests for medical records provided to us directly from your health care provider). Please send your request to our Privacy Officer at the address below. We may charge you a fee for copying and postage.

Amendments – You have the right to request amendments to PHI that we maintain about you. We are not required to make all requested amendments, but we will give each request careful consideration. To be considered, you must submit a signed written request (signed by you or your representative), and you must state the reasons for the request. Amendment requests should be sent to our Privacy Officer at the address below.

List of Disclosures – You have the right to receive a list of certain disclosures made by us of your PHI. Examples of disclosures that we are required to account for include those to state insurance departments, pursuant to valid legal process, or for law enforcement purposes. To be considered, your request must be in writing and signed by you or your representative. A request for a list of disclosures should be sent to our Privacy Officer 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 within the same 12-month period.

Restrictions on Use and Disclosure – You have the right to request restrictions on certain uses and disclosures of your PHI for insurance payment or health care operations. For example, you may request that we not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. We are not required to agree to your request, but we will attempt to accommodate reasonable requests. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate, and we notify you of the termination. You also have the right to terminate any agreed-to restriction. You may make a request for a restriction (or termination of an existing restriction) by contacting us at the address below.

Request for Confidential Communications – You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. We are required to accommodate reasonable requests if you inform us that disclosure of all or part of your information could place you in danger. Requests for confidential communications must be in writing, signed by you or your representative, and sent to us at the address below.

Copy of the Notice – You have the right to a paper copy of this Notice upon request. Please contact us at the address below.

Complaints – If you believe your privacy rights have been violated, you may file a complaint with us in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C. We will not penalize you for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact our Privacy Office by writing to: Privacy Officer, Medico™ Insurance Company, 1515 South 75th St., Omaha NE 68124-1655.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

PRIVACY NOTICE TO MEDICO™ INSURANCE COMPANY POLICYHOLDERS/CERTIFICATEHOLDERS

Your privacy is our concern**.* Certain laws regulate the collection, use and disclosure of a consumer or customer's nonpublic information. Medico™ Insurance Company does not sell or otherwise disclose any nonpublic personal information about our customers or former customers to anyone outside the Medico™ Group Family, except as permitted by law. ***You don't need to take any action to prevent disclosure; this notice is solely for your information.

General Privacy Information: It is the policy of Medico™ Insurance Company, their independent agents and those companies whose policies/certificates we administer together with ours to:

- Collect only information necessary or relevant to our business.
- Make a reasonable effort to ensure that information we act upon is accurate, relevant, timely and complete.
- Use only legitimate means to collect information.
- Make personal information available externally only to respond to legitimate business needs, to regulatory or other government authorities or as otherwise permitted by law.
- Limit employees' access to those who need to and are trained in the proper handling of personal information.
- Require anyone outside our corporate family (nonaffiliates) who perform services for us to conform to our privacy standards. We also require them not to use your nonpublic personal information for any other purpose.
- Not to disclose your nonpublic personal information to others for their own marketing purposes.
- Not to reveal your health, character, personal habits or reputation to anyone for marketing purposes.

The following summary explains the kinds of information that Medico™ Insurance Company or their agents may collect, what is done with the information and how you can find out about information, if any, we have about you in our records.

What kind of information do we collect about you and from whom? Most of our information comes directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage from outside sources, such as medical records, credit reports, court records or other public records. We also might obtain information from third parties, such as other insurance companies or financial institutions that you have notified us of.

What do we do with the information collected about you? The information is kept with your application/policy or certificate records. We review it in evaluating your request for insurance coverage and in determining your rates. We will also refer to and use information in our policy/certificate records for purposes related to issuing and servicing insurance policies/certificates and settling claims. Your agent may use information about you in his/her files for insurance marketing purposes or to help you with your overall insurance program.

To whom do we disclose information about you? We will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, we are also permitted to share some or all of your nonpublic personal information with affiliates or nonaffiliates without prior permission under certain circumstances to certain persons and organizations such as:

- Our affiliated insurance companies.
- Your agent or broker.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Businesses that conduct actuarial or underwriting studies.
- Affiliates or nonaffiliates that market our products. The parties we may share nonpublic personal information with include life and health insurers, insurance agents and marketing firms.
- Other insurance companies, agents or consumer reporting agencies as reasonably necessary in connection with any application, policy/certificate or claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes or fraudulent claims.
- Insurance regulatory or law-enforcement agencies in connection with the regulation of our business.

Should you cease to be one of our policyholders/certificateholders or after your claim is settled, it is our policy to archive our information for a period of 5 years.

How do we protect the confidentiality of information about you? We restrict access to nonpublic information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information. Confidentiality agreements are obtained from third-party vendors where services they perform for us in connection with our normal business operation may give them access to nonpublic information. Finally, Medico™ Insurance Company educates their employees regarding privacy so that they know about its importance.

How can you find out about information we have about you? You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and receive a copy. Write to us if you have questions about information that you would like to receive. When you write us, please provide your complete name, address, type of policy/certificate and policy/certificate number that was issued or applied for with us and identify the information you seek.

Medico™ Insurance Company
Attn: Policyholder Services
1515 South 75th Street
Omaha, NE 68124

Medico™ Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

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- Collect only information necessary or relevant to our business.
- Make a reasonable effort to ensure that information we act upon is accurate, relevant, timely and complete.
- Use only legitimate means to collect information.
- Make personal information available externally only to respond to legitimate business needs, to regulatory or other government authorities or as otherwise permitted by law.
- Limit employees' access to those who need to and are trained in the proper handling of personal information.
- Require anyone outside our corporate family (nonaffiliates) who perform services for us to conform to our privacy standards. We also require them not to use your nonpublic personal information for any other purpose.
- Not to disclose your nonpublic personal information to others for their own marketing purposes.
- Not to reveal your health, character, personal habits or reputation to anyone for marketing purposes.

The following summary explains the kinds of information that Medico™ Insurance Company or their agents may collect, what is done with the information and how you can find out about information, if any, we have about you in our records.

What kind of information do we collect about you and from whom? Most of our information comes directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage from outside sources, such as medical records, credit reports, court records or other public records. We also might obtain information from third parties, such as other insurance companies or financial institutions that you have notified us of.

What do we do with the information collected about you? The information is kept with your application/policy or certificate records. We review it in evaluating your request for insurance coverage and in determining your rates. We will also refer to and use information in our policy/certificate records for purposes related to issuing and servicing insurance policies/certificates and settling claims. Your agent may use information about you in his/her files for insurance marketing purposes or to help you with your overall insurance program.

To whom do we disclose information about you? We will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, we are also permitted to share some or all of your nonpublic personal information with affiliates or nonaffiliates without prior permission under certain circumstances to certain persons and organizations such as:

- Our affiliated insurance companies.
- Your agent or broker.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Businesses that conduct actuarial or underwriting studies.
- Affiliates or nonaffiliates that market our products. The parties we may share nonpublic personal information with include life and health insurers, insurance agents and marketing firms.
- Other insurance companies, agents or consumer reporting agencies as reasonably necessary in connection with any application, policy/certificate or claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes or fraudulent claims.
- Insurance regulatory or law-enforcement agencies in connection with the regulation of our business.

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How do we protect the confidentiality of information about you? We restrict access to nonpublic information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information. Confidentiality agreements are obtained from third-party vendors where services they perform for us in connection with our normal business operation may give them access to nonpublic information. Finally, Medico™ Insurance Company educates their employees regarding privacy so that they know about its importance.

How can you find out about information we have about you? You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and receive a copy. Write to us if you have questions about information that you would like to receive. When you write us, please provide your complete name, address, type of policy/certificate and policy/certificate number that was issued or applied for with us and identify the information you seek.

Medico™ Insurance Company
Attn: Policyholder Services
1515 South 75th Street
Omaha, NE 68124

Notes

about the company

Medico Insurance Company began operations in 1930. We offer quality health and life insurance products for Americans nationwide.

Today Medico Insurance Company continues a proud tradition of service to our policyholders.

Located in the heart of the United States, all of our work is done in Nebraska. When you call our number, people answer the phone, people who understand your problems and are anxious to help you find solutions.

For more information about Medico Insurance Company and Medico Group, visit gomedico.com.

MEDICO™
INSURANCE COMPANY

Medico Insurance Company
1515 S. 75th St.
Omaha, NE 68124
gomedico.com
1.800.228.6080