Dental, Vision & Hearing Plan

Insurance Agency:

Agent Name:

Agent Phone Number:

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 Client Services 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.

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 outline. Please read the Producer Instructions to ensure a smooth application process.

Remove pages i through 4 from the booklet once the forms in the booklet have been completed.

The remainder of the booklet must be left with the applicant(s).

IMPORTANT - PLEASE NOTE THE FOLLOWING

1. Use only a blue or black pen when filling out the application booklet.

2. 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.

3. **If this coverage will replace any existing insurance, you will need to go to the MIC website at mic.gomedico.com and print off two copies of the Replacement Form MI9F-1060.** Go to the "My Agency" tab and click on "Forms." The form must be signed by the producer and the applicant and submitted with the application if the replacement question is answered, "Yes." Leave one signed copy with the applicant.

4. **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 4.

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

Please submit this form with ALL new business applications.

Distributor Instructions

Please complete a separate transmittal form for each distributor number and include it with your application(s). Multiple applications can be included on one transmittal form. **If you are submitting applications that qualify for a Household Discount or a Family Discount, please submit them on the same New Business Transmittal. You must indicate this discount and/or an Association Group Discount on this New Business Transmittal.**

The "Policy/Certificate 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. **Do not send any money if you are faxing the application or uploading the application from the MIC website.** However, you must include this New Business Transmittal form and a completed Bank Withdrawal Authorization form MI21F-074. See below for the available premium billing modes. Initial premium will be deducted on approval of the application. Faxed applications must use automatic bank withdrawal.

The "Premium Collected Including Fees" includes any premium and policy fee, if applicable, received with the application(s). For applications submitted with no money (using the automatic bank withdrawal method of payment), 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____________
Distributor Name Distributor Number

Policy Number (if applicable)	Applicant's Name	Policy/Certificate Form	Mode	Writing Number	Premium Collected (including fees)
					$.
					$.
					$.
					$.
					$.
					$.

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

☐ Household Discount
☐ Association Group Discount
Association Name____________________

Make sure all checks are payable to Medico.

Total Premium submitted
$.

Billing Modes:
Bank Withdrawal — Monthly, Bi-Monthly or Quarterly
Direct Bill — Bi-Monthly, Quarterly, Semi-Annually or Annually
List Bill — Use Monthly Bank Withdrawal Mode. A list can be sent to a billing source or bank withdrawal can be used.

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

Questions? Call New Business at 1-866-520-6653.

For Distributor Use Only

1515 South 75th Street
Omaha, Nebraska 68124

www.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?	❒	❒	❒	❒
If "Yes," provide details: Applicant: ______________________________ Co-Applicant: ______________________________				
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?	❒	❒	❒	❒
If "Yes," provide details: Applicant: ______________________________ Co-Applicant: ______________________________				
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?	❒	❒	❒	❒

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?	❒	❒	❒	❒
If "Yes," provide type of contract or policy number, and name of company: Applicant: ______________________________ Co-Applicant: ______________________________				
(c) If replacement is involved, have you received a replacement form (in states where required by law)?	❒	❒	❒	❒

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

Information regarding usual and customary fee determination is available from Medico Insurance Company upon request.

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

www.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.

Co-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.

1515 South 75th Street
Omaha, Nebraska 68124

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

RECEIPT

Applicant

The applicant has applied for the MI-DVA18 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-DVA18 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: Client Services at 1-800-228-6080

E-mail: clientservices@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 www.gomedico.com/products.

1515 South 75th Street
Omaha, Nebraska 68124

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

www.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. If you answer "yes" to Part B, question 3(c) on the application, the policy will not pay benefits for the purchase of hearing aids during the first Policy Year. In such case, an Elimination Rider will be issued with the policy confirming the exclusion.

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

www.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. If you answer "yes" to Part B, question 3(c) on the application, the policy will not pay benefits for the purchase of hearing aids during the first Policy Year. In such case, an Elimination Rider will be issued with the policy confirming the exclusion.

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® 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 and to make the new Notice effective for all PHI that we maintain. 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, even if you have consented to receive the Notice electronically. 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, telephone: 1-800-228-6080.

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 and to make the new Notice effective for all PHI that we maintain. 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, even if you have consented to receive the Notice electronically. 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, telephone: 1-800-228-6080.

EFFECTIVE DATE

This Notice is effective April 14, 2003.

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 www.gomedico.com.

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