Medicare Supplement

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 Medicare Supplement 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.

Producer Instructions

Thank you for choosing Medico Insurance Company as your carrier for Medicare Supplement Insurance.

Getting Started…

This application booklet contains all of the forms needed to write and submit an application. Please read the Producer Instructions and Underwriting Guidelines to ensure a smooth application process.

Remove pages i through 9 from the booklet once the forms in the booklet have been completed.

The remainder of the booklet must be left with the applicant.

IMPORTANT - PLEASE NOTE THE FOLLOWING

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

2. MI9F-4368 – Replacement Notice – Complete the notice if the replacement question on the application is answered "Yes."

3. MI9F-4372 – Comparison Statement – Complete the comparison statement if the replacement question on the application is answered "Yes."

4. Applicant must receive a copy of the Medicare Buyers Guide. Applicant can choose to accept an electronic version of the Medicare Buyers Guide. The Internet link is provided on the bottom of the receipt.

5. Outline of Coverage – A copy of the outline must be left with the applicant.

6. **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 pages 1 through 9.

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. 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 or Quarterly
Direct Bill — 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

Underwriting Guidelines

An applicant would not be eligible for coverage:

- If not covered by Part A & B of Medicare.
- If covered by Medicaid.
- If they answer "yes" to any question 1-4 (Part C) of the application.

If the applicant answers all of the questions 1-4 (Part C) "no," but we determine from the Personal Health Interview (PHI) or any other source that one of the questions should have been answered "yes," he/she is not eligible for coverage.

In the following cases an applicant does not have to answer the health questions and is guaranteed coverage:

- If the application is made during "open enrollment" (6 months prior or 6 months following the first day of the first month in which he/she is both 65 and enrolled for benefits under Medicare Part B).
- If the application is made during a guarantee issue period because of other health care coverage that changes in some way, such as when someone loses or drops the other health care coverage.

Underwriting Requirements:

- A Personal Health Interview (PHI) will be required for all underwritten cases. Mid-America Agency Services (MAAS) can conduct the Personal Health Interview.*
  - You can call from the applicant's home for the interview.
  - You can have the applicant call MAAS at their convenience.
  - We can request the interview when we receive the application, but this adds unnecessary delays to the processing time.
  - Call Toll-Free 1-888-318-9436 Monday through Thursday, 8:00 a.m. to 9:00 p.m. (Central Time) and Friday, 8:00 a.m. to 5:00 p.m. (Central Time).
- A Prescription Drug Screen will be required for all underwritten cases. This screen is requested by the Underwriting Department through Milliman Intelliscript. This has proven to be a very effective underwriting tool used by many life and health insurance companies.
- We will not routinely request an Attending Physician's Statement (APS). An APS could be requested:
  - to clarify conflicting information between the application and another source.
  - to clarify the diagnosis for a high-risk medication.
  - to determine the reason the applicant was declined for coverage in the past.

* *While MAAS will conduct the PHI, the folks at the Underwriting Hotline (1-800-626-2068) are still available to help with risk selection questions.*

NOTE: This form is not required to be submitted with the application.

For Producer Use Only

Rate Structure

There are standard and preferred rates. If insurable, an applicant qualifies for preferred rates if he/she has not used tobacco in the last 12 months. There are also male/female rates. The premiums are area rated by zip code.

Application Dates

Applications can be written as indicated below:

- Open Enrollment – up to six months prior to the month the applicant turns age 65.
- Guarantee Issue Period – up to 60 days prior to the termination date of the prior coverage.
- Underwritten cases – up to 60 days prior to the requested coverage effective date.

Coverage Effective Dates

Coverage will be made effective as indicated below:

- Between age 64 ½ and 65 – the first of the month the individual turns age 65.
- All others – the day following the application date.

NOTE: This form is not required to be submitted with the application.

For Producer Use Only

MEDICO® INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

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

Application for Medicare Supplement Insurance

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Part A: General Information – Please Print

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

Address ______________________ Street Address City State Zip

Phone # ____________________ E-mail Address ____________________

Social Security # ____________________ Medicare Claim # ____________________

Beneficiary (Optional) ____________________ Relationship ____________________

Beneficiary's Address ______________________ Street Address City State Zip

Best time to call for Personal Health Interview __________
Not applicable if you apply during Open Enrollment or if you are eligible for a guaranteed issue.

Are you eligible for Open Enrollment? ☐ Yes ☐ No If "Yes," we will need documentation, unless you are turning 65.

Part B: Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer the following questions to the best of your knowledge.

1. (a) Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
   (b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
   (c) If "Yes," what is the effective date? ____________________
2. Are you insured under Parts A and B of Medicare? (If "No," you are not eligible for coverage) ☐ Yes ☐ No
3. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.) ☐ Yes ☐ No
   If "Yes," (a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐ Yes ☐ No
4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
   START ____________________ END ____________________
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No

Part B: Insurance Information (continued)

5. (a) Do you have another Medicare supplement policy in force? ❒ Yes ❒ No
   (b) If "Yes," with which company? ____________________
   what plan? ____________________
   (c) If so, do you intend to replace your current Medicare supplement policy with this policy? ❒ Yes ❒ No

PRODUCER: If the answer to this question is yes, please complete and submit NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE.

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.) ❒ Yes ❒ No
   (a) If "Yes," with which company? ____________________
   what kind of policy? ____________________
   (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)
   START ____________________ END ____________________
7. If you have lost or are losing other health insurance coverage, have you provided a copy of the notice from your prior insurer? ❒ Yes ❒ No
   If "No," please provide an explanation. ____________________
8. If you are eligible for Medicare due to a disability, please provide the reason you are on disability. ____________________

Producer shall list any other health insurance policies he/she has sold to the applicant.

1) List policies you sold to the applicant that are still in force (If none, indicate "None"): ❒ None

Name of Insurer	Type	Policy #

2) List policies you sold to the applicant in the past five (5) years that are no longer in force (If none, indicate "None"): ❒ None

Name of Insurer	Type	Policy #

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ❒ Yes ❒ No

Part C: Medical Information

NOTE: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue. If you answer "Yes," to any of questions 1 through 4 you are not eligible for coverage.

Height: ____________ Weight: ____________

1. Have you ever:
   (a) had any fractures due to osteoporosis or amputation due to disease? ❒ Yes ❒ No

Part C: Medical Information (continued)

(b) had kidney disease requiring dialysis; diabetes requiring insulin; Parkinson's disease; liver disease; or multiple or lateral sclerosis? ❒ Yes ❒ No

(c) been diagnosed with emphysema; chronic obstructive pulmonary disorder (COPD); or any other chronic pulmonary disorder? ❒ Yes ❒ No

(d) been treated for Alzheimer's disease; senile dementia; or organic brain disorder? ❒ Yes ❒ No

(e) had an organ transplant or been advised by a physician to have an organ transplant? ❒ Yes ❒ No

(f) had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? ❒ Yes ❒ No

2. Within the past 24 months have you:

(a) been hospitalized 3 or more times? ❒ Yes ❒ No

(b) had a stroke or transient ischemic attack (TIA)? ❒ Yes ❒ No

(c) been treated for or been diagnosed as having internal cancer; leukemia; or malignant melanoma? ❒ Yes ❒ No

(d) had heart trouble or disease that required treatment by a physician (not including high blood pressure)? Taking prescription medication is not considered treatment. ❒ Yes ❒ No

(e) been treated for alcohol or drug abuse; degenerative bone disease; crippling or rheumatoid arthritis; or been advised by a physician to have a joint replacement? ❒ Yes ❒ No

3. Within the past 12 months have you been advised that surgery for cataracts may be required? ❒ Yes ❒ No

4. Currently:

(a) are you bedridden; confined (or has any doctor recommended that you be confined) to a hospital or nursing facility; or do you need the assistance of a walker or wheelchair? ❒ Yes ❒ No

(b) do you have surgery pending or have you been advised to have surgery? ❒ Yes ❒ No

5. List all medications taken within the past 12 months (if none, indicate none).

Please provide the following information:

Medication				
Date originally prescribed				
Frequency and dosage				
Diagnosis/condition				

Part D: Preferred Rate Information

NOTE: This question should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue.

To qualify for preferred rates you must be able to answer "No" to the following question:

Have you used tobacco in the past 12 months? ❒ Yes ❒ No

Part E: Statements Regarding Medicare Supplement Policies

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Part E: Statements Regarding Medicare Supplement Policies (continued)

If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Part F: Benefit Options – Check the Plan you prefer:

❒ Policy Form MSA20A – Plan A ❒ Policy Form MSA20D – Plan D ❒ Policy Form MSA20F – Plan F

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

Note: If you select the Automatic Bank Withdrawal method of payment and we receive no money with your application, your first premium will be withdrawn from your account on the day we issue your policy.

Method of Payment:	**Frequency of Payment:**		
❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly	
❒ Direct Bill	❒ Quarterly	❒ Semi-Annually	❒ Annually

Amount Received with Application $__________ **Renewal Premium $**__________

Effective Date of Policy ____________________
(Day after applicant signs the application or expiration date of current policy)

If you currently have health insurance in force, on what date does it end?____________________

Part G: Application Agreement

I hereby apply for insurance to be issued solely and entirely upon the answers and statements in the Parts above that I adopt as my own and represent to be true, full and complete to the best of my knowledge and belief. I understand and agree that no insurance will be in force until coverage has been issued. If I am not applying during “Open Enrollment” or not eligible for a guaranteed issue, I do not have a right to have this policy issued to me if I have answered “Yes” to any of questions 1 through 4 in the Medical Information Part above. I have read, or had read to me, the complete application.

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

Check one of the following if “A Guide to Health Insurance for People With Medicare” is required in the applicants’ state:

❒ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at www.gomedico.com/products.

❒ 2. I have received a hard copy of the Medicare Buyers Guide.

I understand that it may be necessary to phone me to verify the answers to the questions in this application.

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.

Applicant’s Signature ____________________ Date __________

Dated at ____________________
City State

Producer’s Name ____________________
(Please print)

Producer’s Signature ____________________ Date __________

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 producer, 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.

REVOCATION AND EXPIRATION

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.

In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits, this authorization may not exceed 24 months from the date I sign the authorization.

In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization may not exceed the term of coverage of my insurance policy.

COPY OF THIS AUTHORIZATION

I understand that I, or my authorized representative, is entitled to receive a copy of the authorization form. 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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

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

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. (Check One):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment below.
- ☐ Other. (please specify)

____

____

____

If 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 and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

______________________________	______________________________
Signature of Producer	Typed Name and Address of Issuer or Producer
______________________________	______________________________
Applicant's Signature	Date

1515 South 75th Street
Omaha, Nebraska 68124

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

Comparison Statement

KENTUCKY MEDICARE SUPPLEMENT COMPARISON STATEMENT

Current Insurance ______________________________ Annual Premium ____________
(Insurer Name)

Proposed Insurance Medico® Insurance Company ______________ Annual Premium ____________
(Insurer Name)

MEDICARE (PART A): HOSPITAL INSURANCE – COVERED SERVICES PER BENEFIT PERIOD (1)				PRIVATE INSURANCE CHECKLIST	
Services	Benefit	Medicare Pays*	You Pay*	Current Insurance Pays (Plan ____)**	Proposed Insurance Pays (Plan ____)
HOSPITALIZATION Semiprivate room and board, general nursing and miscellaneous hospital services and supplies.	First 60 days.	All but $1,100.	$1,100.		
	61st to 90th day.	All but $275 a day.	$275 a day.		
	91st to 150th day.***	All but $550 a day.	$550 a day.		
	Beyond 150 days.	Nothing.	All costs.		
POSTHOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare. You must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge (2).	First 20 days.	100% of approved amount.	Nothing.		
	Additional 80 days.	All but $137.50 a day.	$137.50 a day.		
	Beyond 100 days.	Nothing.	All costs.		
HOME HEALTH CARE	Visits limited to medically necessary skilled care.	Full cost of services; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.		
HOSPICE CARE Available to terminally ill.	Up to ____ days if doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.		
BLOOD	Blood.	All but first 3 pints.	For first 3 pints.****		
FOREIGN TRAVEL	Medically necessary emergency care in a foreign country.	Emergency hospital services in qualified Mexican or Canadian hospitals.*****	All costs not covered by Medicare.		

* These figures are for 2010 and are subject to change each year.
** If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.
*** 60 reserve days may be used only once; days used are not renewable.
**** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.
***** Please refer to your Medicare Handbook for more information.
(1) A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.
(2) Medicare and private Medicare supplement insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): HOSPITAL INSURANCE – COVERED SERVICES PER CALENDAR PERIOD				PRIVATE INSURANCE CHECKLIST	
Services	Benefit	Medicare Pays	You Pay	Current Insurance Pays (Plan ____)*	Proposed Insurance Pays (Plan ____)
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital.	80% of approved amount (after $155 deductible).	$155 Deductible** plus 20% of balance of approved amount (plus up to 15% above approved charge).***		
HOME HEALTH CARE	Visits limited to medically necessary skilled care.	Full cost of services; 80% of approved amount for durable medical equipment (after $155 deductible).	Nothing for services; 20% of approved amount for durable medical equipment (after $155 deductible).		
AT-HOME RECOVERY BENEFIT	Short-term at-home assistance with activities of daily living.****	Nothing.	All costs.		
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary.	80% of approved amount (after $155 deductible).	Subject to deductible plus 20% of approved amount.		
BLOOD	Blood.	80% of approved amount (after $155 deductible and starting with the 4th pint).	First 3 pints plus 20% of approved amount (after $155 deductible).*****		
PREVENTIVE CARE-PATIENT EDUCATION	Annual physical exam, preventive testing, influenza vaccines.	Screening pap smears once every 3 years; screening mammograms every 24 months.	All costs not covered by Medicare.		
OUTPATIENT PRESCRIPTION DRUGS	Outpatient prescription drugs.	Nothing.	All costs.		
FOREIGN TRAVEL	Medically necessary emergency care in foreign country.	Doctor and ambulance service in Canada and Mexico if in connection with covered inpatient.	All costs not covered by Medicare.		
OTHER******					

* If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.

** Once you have had $155 of expense for covered services in 2010, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

*** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

**** At-home recovery benefits must be received in conjunction with Medicare approved home health care benefits.

***** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

****** Use this area to compare pre-standardization and/or innovative benefits.

NOTICE TO APPLICANT:
Do not sign this form unless it has been explained to you.

Applicant: ______________________ Date: __________ Producer: ____________________ Date: __________

NOTICE TO PRODUCER/INSURER:
This form is to be retained by the replacing insurer and attached to the replacement policy.

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.

1515 South 75th Street
Omaha, Nebraska 68124

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

RECEIPT

The applicant has applied for Medicare Supplement Policy: ☐ A20A ☐ A20D ☐ A20F

Received of ____
(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

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

Replacement Notice

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

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

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. (Check One):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment below.

☐ Other. (please specify)

____

____

____

If 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 and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

________________________	________________________
Signature of Producer	Typed Name and Address of Issuer or Producer
________________________	________________________
Applicant's Signature	Date

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 producer, 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.

REVOCATION AND EXPIRATION

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.

In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy, a policy reinstatement, or a request for change in policy benefits, this authorization may not exceed 24 months from the date I sign the authorization.

In the case of authorizations signed for the purpose of collecting information in connection with a claim for benefits under an insurance policy, this authorization may not exceed the term of coverage of my insurance policy.

COPY OF THIS AUTHORIZATION

I understand that I, or my authorized representative, is entitled to receive a copy of the authorization form. 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® 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

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.

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. We may share some or all of your nonpublic personal information with affiliates or nonaffiliates without prior permission as allowed by law. This may include disclosures of your nonpublic personal information, including your name and contact information, to life and health insurers, insurance agents and marketing firms for marketing of our products.

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: Client 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 nationwide for Americans over the age of 50.

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