MEDICO® CORP
LIFE INSURANCE COMPANY

Medico® Corp Medicare Supplement Insurance

APPLICATION BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

- ☐ Application for Medicare Supplement Insurance Policy
- ☐ Bank Draft and/or Credit Card Authorization (if applicable)
- ☐ Additional forms which may be required. See forms marked Complete and Send with Application. All other forms should be left with the applicant.

Outline of Coverage and Rates

To provide an Outline of Coverage and Rates to the applicant at the time of application. You may:

1. Print and/or download from the MIC website; or
2. Order on the MIC website or call Agent Sales Support at the number shown below.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller
Electronic Application Submission Tool
Website: mic.GoMedico.com

Mail
Medico Corp Life Insurance Company
Administrative Services
PO Box 10482 • Des Moines, IA 50306

Fax
1-844-850-2550

If you have any questions, please call 1-800-547-2401-Option 3.

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MEDICO® CORP
LIFE INSURANCE COMPANY

Corporate Office – Omaha, NE
Administrative Services – PO Box 10482
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-822-9993
Fax: Toll Free 1-844-850-2550

Application for Medicare Supplement Insurance

Requested Effective Date of New Policy (optional)

_____

Requested Effective Date must be after the Application Date.
If no Effective Date is requested, the Effective Date will be the day the Application is approved by our Underwriting Department.

Policy Delivery Options

Upon approval of this Application, the policy will be mailed to:

❒ Applicant ❒ Producer

Part A General Information (Please Print)

First Name | M.I. | Last Name | Suffix

Date of Birth (MM/DD/YY) | Age | Gender | Social Security Number

Address

City | State | ZIP Code

Phone Number | Alternate Phone Number | Email Address

Are you eligible for Open Enrollment? ❒ Yes ❒ No

If "Yes", skip Parts C, D and E.

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. Please enter your Medicare Claim number .....
2. (a) Are you within 6 months of your 65th birthday? ❒ Yes ❒ No
   (b) Did you enroll in Medicare Part B in the last 6 months? ❒ Yes ❒ No
   (c) What is your Part B effective date? MM/DD/YYYY
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. (If you are still covered under the policy, leave **"End"** blank.)

Start	End
MM/DD/YYYY	MM/DD/YYYY

   (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", please indicate company and plan.

Company	Plan

   (c) If so, do you intend to replace your current Medicare supplement policy with this policy? ❒ Yes ❒ No

Producer: If replacing another Medicare plan or a Medicare Supplement, please complete and submit NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE.

6. Are you eligible for Guaranteed Issue? ❒ Yes ❒ No
   If "Yes", please provide documentation and skip Parts C, D and E.
7. 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", please indicate company and kind of policy.

Company	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
MM/DD/YYYY	MM/DD/YYYY

8. If you have lost or are losing other health insurance coverage, did you receive notice from that insurance company stating you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy a policy? If you answered, "Yes," and you are unable to provide a termination notice please complete all sections of this form ❒ Yes ❒ No
   If "No," Please provide an explanation.

Part C General Health Information

Note: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a Guaranteed Issue.

Please indicate your current height and weight.

Height		Weight	

QUALIFYING INFORMATION

(If any answer to questions 1 through 4 is "Yes," you are not eligible for coverage.)

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

1. Within the past 5 years, have you:
   (a) had or been treated for or diagnosed as having diabetes requiring insulin or with complications? ❒ Yes ❒ No
   (b) had or been treated for or advised to have a bone marrow or organ transplant? ❒ Yes ❒ No
   (c) had or been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? ❒ Yes ❒ No
2. Within the past 2 years have you:
   (a) had or been treated for or diagnosed as having internal cancer, leukemia, melanoma, Hodgkin's Disease or lymphoma? ❒ Yes ❒ No
   (b) had or been treated for or diagnosed as having Amyotrophic Lateral Sclerosis (ALS), Parkinson's or Multiple or Lateral Sclerosis? ❒ Yes ❒ No
   (c) had or been treated for or diagnosed as having cirrhosis of the liver, Hepatitis C, chronic renal failure, kidney failure or had dialysis? ❒ Yes ❒ No
   (d) had or been treated for or diagnosed as having had a stroke or Transient Ischemic Attack (TIA)? ❒ Yes ❒ No
   (e) had heart surgery, including bypass, angioplasty or stent placement? ❒ Yes ❒ No
   (f) had or been treated for or diagnosed as having peripheral vascular disease (poor circulation in your extremities), had angioplasty or stent placement of any vessel, congestive heart failure or a heart attack? ❒ Yes ❒ No
   (g) had or been treated for or diagnosed as having emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disease? ❒ Yes ❒ No
   (h) had or been treated for or diagnosed as having connective tissue disease, (for example, lupus), degenerative bone disease or disabling or rheumatoid arthritis? ❒ Yes ❒ No
   (i) had fractures due to osteoporosis or amputation due to disease? ❒ Yes ❒ No

Part C General Health Information (continued)

(j) been or are you now bedridden or confined to a wheelchair? ❒ Yes ❒ No

(k) had or been treated for or diagnosed as having schizophrenia or bipolar disease? ❒ Yes ❒ No

(l) been hospitalized for a mental or nervous condition? ❒ Yes ❒ No

(m)been treated for or diagnosed as having alcohol or drug abuse? ❒ Yes ❒ No

3. Do you have, or have you been told by a medical professional, that you have Alzheimer's Disease, senile dementia or organic brain disorder? ❒ Yes ❒ No

4. Are you currently using oxygen? ❒ Yes ❒ No

Part D Medical Health 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 the following questions, please provide details in the space allotted following question D. If you need additional space, attach a separate page that you have signed and dated.

A. Do you require assistance or supervision to perform any of the following everyday living activities; dressing, eating, bathing, toileting (including use of a catheter), or walking (including use of cane, walker, motorized scooter or wheelchair)? ❒ Yes ❒ No

B. Has a member of the medical profession recommended that you have medical tests, treatment or therapy, or surgery, including cataract surgery or joint replacement, that has not yet been performed? ❒ Yes ❒ No

C. Have you been, or has a member of the medical profession recommended that you be hospitalized or confined to a nursing facility within the last 60 days, or have you been hospitalized 3 or more times within the past 2 years? ❒ Yes ❒ No

D. Have you had a seizure within the last 2 years? ❒ Yes ❒ No

Question (list A, B, C, or D)	Details

Have you taken any medication in the last 12 months? ❒ Yes ❒ No

If "Yes", please provide the name and diagnosis or condition for which they were prescribed.

Medication	Diagnosis/Condition

Please provide the date and reason for your last visit to a physician.

Your Physician's Name

Date of Last Visit	Reason for Last Visit
MM/DD/YYYY	

Part E Preferred Rate Information

Note: These questions 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 any form in the past 2 years? ❒ Yes ❒ No

Part F Notices

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 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.

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 G Benefit Options

Choose Your Plan:

- ❒ Policy Form MSM70A – Plan A
- ❒ Policy Form MSM70F – Plan F
- ❒ Policy Form MSM70G– Plan G
- ❒ Policy Form MSM70N– Plan N

Household Discount – When the Applicant lives in the same household with another person over 18 years of age, regardless of whether both sign up for coverage with Medico Corp Life Insurance Company, a discount is applied to the premium rates.

Do you live in the same household with another person who is over the age of 18?..... ❒ Yes ❒ No

First Name M.I. Last Name

Method of Payment: **Frequency of Payment:**

❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Amount Received with Application $ Renewal Premium $

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

Part H Application Agreement

I hereby apply to Medico Corp Life Insurance Company (the Company) for a **Medicare Supplement Insurance Policy** to be issued solely and entirely in reliance on my answers to the questions. This Application will become a part of any policy to which this form is attached. 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 General Health Information Part above. I also may not have a right to have this policy issued to me if I have answered "Yes" to any of questions A through D in the Medical Health Information Part if I am not applying during "Open Enrollment" or not eligible for a Guaranteed Issue. I have read, or had read to me, the complete Application.

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a policy is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an immediate family member), either directly, or through wage adjustments or other means of reimbursement.

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 Applicant's 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.

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.

NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

I acknowledge that in states where it is required, the Producer 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 Medicare Supplement Insurance Policy.

X _____

Applicant's Signature Date (MM/DD/YYYY)

Part I Producer's Section

Have you personally sold any other health insurance policies to the proposed insured that are still in force OR sold any policies no longer in force in the past 5 years? ..... ❒ Yes ❒ No

If "Yes", please list policies.

Policy Type and Policy Number	In Force?
	❒ Yes ❒ No
	❒ Yes ❒ No

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

Producer's Certification: I certify the information in this Application was provided by the Applicant and correctly recorded. I have no information to add that could affect the acceptance or rejection of the risk. Any intention to replace coverage is reflected in the Application. I have provided the Applicant a link to the Medicare Buyer's Guide at GoMedico.com or a hard copy of it.

_____ _____

Producer's Printed Name Producer's Number

X _____

Producer's Signature Date (MM/DD/YYYY)

BANK DRAFT INFORMATION

STOP! Complete this section *only* if you have chosen the monthly automatic payment option.

A. If you requested the "Bank Draft" option, what is to be included?

☐ Only the Coverage Applied for Today ☐ All Coverage (New and Existing)

B. Initial Premium

Authorization to Bank or Other Financial Institution

☐ Checking ☐ Savings

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

C. Ongoing Premium ***(Complete C only if different from Initial Premium information)***

Authorization to Bank or Other Financial Institution

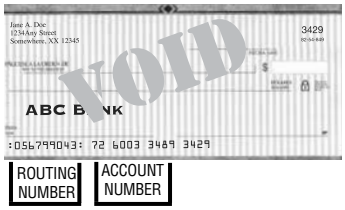
☐ Checking ☐ Savings

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

D. Please read: By providing my account information here and signing the application for insurance coverage, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Medico Insurance Company and/or Medico Corp Life Insurance Company for insurance premiums. I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



CREDIT CARD AUTHORIZATION

STOP! Complete this section *only* if you are paying by credit card.

By providing this information and signing the application for insurance coverage, you authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to bill your MasterCard/Visa account for the initial premium.

A. If you requested the "Credit Card" option, what is to be included?

☐ Only the Coverage Applied for Today ☐ All Coverage (New and Existing)

B. Initial Premium

Credit Card Information: ☐ MasterCard ☐ Visa

Credit Card Number | Card Security Code (3 digits) | Expiration Date MM / YYYY

Billing Address:

Billing information must be entered exactly as it appears on the credit card statement. Please check the statement for accuracy to avoid delays in processing.

First Name | M.I. | Last Name

Billing Address | City | State | Zip Code

C. Ongoing Premium ***(Complete C only if different than Initial Premium Information)***

Credit Card Information: ☐ MasterCard ☐ Visa

Credit Card Number | Card Security Code (3 digits) | Expiration Date MM / YYYY

Billing Address:

Billing information must be entered exactly as it appears on the credit card statement. Please check the statement for accuracy to avoid delays in processing.

First Name | M.I. | Last Name

Billing Address | City | State | Zip Code

HIPAA and MIB Authorization

HIPAA AUTHORIZATION

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

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

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

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

I authorize the Company or it's reinsurers to make a brief report of my personal health information to the MIB.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P. O. Box 10482, Des Moines, Iowa 50306-0482.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it. (180 days for confidential HIV-related information).
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

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

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

AUTHORIZATION TO DISCLOSE INFORMATION (MIB)

I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB.

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

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

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P. O. Box 10482, Des Moines, Iowa 50306-0482.

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

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

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

If you are signing as a personal representative for an individual to be insured, read and sign below

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

Personal Representative (Please print)

Personal Representative Signature

X

Person(s) to be Insured
(Please print)

1.

2.

My relationship to applicant(s)
(Please print)

1.

2.

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Administrative Services – PO Box 10482
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-822-9993

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 Corp Life 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.

_____

☐ 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

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RECEIPT

Medicare Supplement Policy Receipt

The applicant has applied for Medicare Supplement Policy: ❒ M70A ❒ M70F ❒ M70G ❒ M70N

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 CORP LIFE 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 the following methods:

Write to:
Medico Corp Life Insurance Company
P.O. Box 10482 • Des Moines, Iowa 50306

Call:
Customer Service at 1-800-822-9993

E-mail:
customerservice@GoMedico.com

_____ _____
Producer's Printed Name Date

_____
Producer's Signature

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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.

_____

☐ 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

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Senior Counseling Notice

Counseling services are available in the State of Nebraska that offer seniors advice concerning the purchase of Medicare Supplement and/or Long-Term Care insurance.

This free senior counseling program is administered by:

Nebraska Department of Insurance
Nebraska Senior Health Insurance Information Program (SHIIP)
941 "O" Street, Suite 400
Lincoln, NE 68508

The Senior Health Insurance Information Program (SHIIP) offers a toll-free hotline for residents of Nebraska. Any person eligible for Medicare, concerned relatives or friends can call the SHIIP hotline for answers to insurance questions or to arrange a meeting with a SHIIP staff member or volunteer: **1-800-234-7119.**

TTY: 1-800-833-7352

The Nebraska Senior Health Insurance Information Program (SHIIP) provides information and counseling to older Nebraskans and persons with disabilities regarding Medicare, Medicaid and health insurance.

Notes

about the company

Your Medico Corp team has a long tradition of offering quality health and life insurance products for Americans nationwide, and we are proud to continue a tradition of service to our policyholders.

We are located in the heart of the United States. When you call our number, the people who answer the phone understand your problems and want to help you find solutions.

For more information about Medico Corp Life Insurance Company visit www.GoMedico.com.

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Medico Corp Life Insurance Company

Corporate Office – Omaha, NE
Administrative Services – PO Box 10482, Des Moines, IA 50306

www.GoMedico.com
1.800.822.9993