



MEDICO® CORP
LIFE INSURANCE COMPANY

Medicare Supplement Application Booklet

Insurance Agency:

Producer/Agent Name:

Producer/Agent Phone Number:

Welcome!

Thank you for choosing Medico® Corp Life Insurance Company 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. We understand that value of offering fast, accurate claims handling and exceptional personal service.

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.

If you have any questions, please speak with your knowledgeable insurance agent for assistance or contact one of our trained Customer Service Representatives toll-free at **1.800.822.9993** Monday through Friday from 7:30 a.m. to 4:45 p.m., Central Time.

The Staff of Medico Corp Life Insurance Company



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 _____

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?

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	Physician’s Phone Number
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 reinstated 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 reinstated 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 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:

Automatic Bank Withdrawal

Direct Bill

Credit/Debit Card

Frequency of Payment:

Monthly

Monthly

Quarterly

Quarterly

Quarterly

Semi-Annually

Semi-Annually

Semi-Annually

Annually

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 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?
	<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> 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 (9 digit Number)

X

Producer's Signature

Date (MM/DD/YYYY)

Page intentionally left blank.

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)

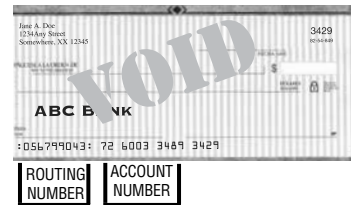
Bank or Financial Institution Name (including branch, if any)

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

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

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 its 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

Your Name (Please print)

Your Signature

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

Your Spouse's Signature (if applying)

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

Your Name (Please print)

Your Signature

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

Your Spouse's Signature (if applying)

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)

Person(s) to be Insured
(Please print)

Personal Representative Signature

My relationship to applicant(s)
(Please print)



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

Page intentionally left blank.



MEDICO® CORP
LIFE INSURANCE COMPANY

Corporate Office – Omaha, NE
Administrative Services – PO Box 10482
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-9993

RECEIPT

Medicare Supplement Policy Receipt

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

Received of _____
(Applicant's Name)

an application for insurance as shown above and \$ _____ Dollars.
(includes certificate 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

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.



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

Notice of Privacy Practices for AmericanEnterprise Group Companies

MEDICAL

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Lincoln Republic Insurance Company, Medico Insurance Company, and Medico Corp Life Insurance Company, (“Company”) we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about “information” or “health information” in this notice we mean individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Individually identifiable health information is health information that:

- Is created or received by the Company’s designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

How We Use or Share Information

Subject to state and federal laws, we are permitted to use and/or share your information without your authorization in certain circumstances, such as:

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs. We will not use or disclose genetic information, including family history, for underwriting purposes.
- To use or disclose your information to provide you with information about health related benefits and services that

you may be interested in. We will not share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates without your authorization.

- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

There are also state and federal laws that may require or permit us to release your information to others without your authorization.

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services and the Iowa Division of Insurance.
- To share information for public health activities. For example, we may report information to government authorities conducting public health investigations.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law. For example audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding. For example pursuant to a valid court order or subpoena.
- To report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information to a funeral director as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes, or tissue.

NOTICE OF PRIVACY PRACTICES—MEDICAL (continued)

- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law.

If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information.** In any case, we must obtain authorization for the use and disclosure of psychotherapy notes. If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Service Center. Contact information for our Customer Service Center is located at the end of this Notice.

- **You have the right to be notified** in the event there is a breach of your health information.
- **You have the right to ask us to restrict** how we use or disclose your information for payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care and uses and disclosures for disaster relief purposes. *Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions.*
- **You have the right to request confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain.** All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Service Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission.** We are not obligated to make all requested

amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment. Amendment request forms are available from our Customer Service Center at the address below.

- **You have the right to receive an accounting** of certain disclosures of your information. Please note that we are not required to release:
 - Any information collected prior to April 14, 2003.
 - Information disclosed or used for treatment, payment, and/or health care operations purposes.
 - Information disclosed to you or pursuant to your authorization.
 - Information that is incidental to a use or disclosure otherwise permitted.
 - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
 - Information disclosed for national security or intelligence purposes.
 - Information disclosed to correctional institutions, law enforcement officials or health oversight agencies.
 - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Accounting request forms are available from our Customer Service Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period.

Exercising Your Rights

- **You have a right to receive a copy of this notice upon request at any time.** We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Service Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint.**

Contact Information

If you have any questions or complaints, please contact us at:

Notice of Privacy Practices
American Enterprise Group Companies, Customer Service Center
P.O. Box 9371, Des Moines, IA 50306-9371

You can call us at: **1-800-247-2190.**

www.americanenterprise.com

Notice of Privacy Practices for AmericanEnterprise Group Companies

FINANCIAL

THIS NOTICE APPLIES TO ALL PROSPECTS, APPLICANTS, CUSTOMERS AND FORMER CUSTOMERS WHO HAVE INQUIRED ABOUT OR PURCHASED INSURANCE PRODUCTS USED PRIMARILY FOR PERSONAL, FAMILY OR HOUSEHOLD PURPOSES.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Lincoln Republic Insurance Company, Medico Insurance Company, and Medico Corp Life Insurance Company, (“Company”) we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records (“nonpublic personal information”). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- to process your application and issue your policy.
- to pay your claims.
- to make any policy changes you may request.
- to offer you additional opportunities to improve your financial security.

We may also disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf

or with whom we have joint marketing agreements. We will not, however, disclose your health information for marketing purposes.

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

Questions?

**If you have any questions, please call
our toll-free Customer Service line.**

1-800-247-2190

Important Notice Before You Buy Health Insurance

Dear Consumer:

Insurance is a very important, sometimes confusing and generally expensive consumer purchase. Health insurance is one of the most significant coverages seniors consider buying. Many seniors feel they need extra information before making a decision.

Free Help Is Available

Across Iowa there is a network of trained volunteers who can help you compare and analyze health policies you are considering. These volunteers have been trained by people from the State of Iowa Division of Insurance. This free service is available through the **Senior Health Insurance Information Program (SHIIP)**.

This Is Objective Information

SHIIP volunteers **do not** sell insurance. They work, with the help of the Iowa Insurance Division, to provide objective information about the policies you are considering.

The Decision Is Yours

SHIIP volunteers **will not** recommend companies, policies or agents. They cannot tell you which policy to buy. They can help you understand the “*fine print*” and what the policy does and does not cover.

Where to Call

For the SHIIP volunteer nearest you call **1-800-351-4664**. We hope you will use this valuable service as you consider the purchase of 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.



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