

# 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

MEDICARE SUPPLEMENT MSA20

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. **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.
4. **Outline of Coverage** – A copy of the outline must be left with the applicant.
5. **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](http://mic.gomedico.com) or call **Agent Services at 1.800.547.2401.***

**For Producer Use Only**

**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** or **Fax: 1.888.363.3420** or **File Upload: mic.gomedico.com**  
**1515 South 75th Street**  
**Omaha, NE 68124**

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.

<b>Total Premium submitted</b>
\$ .

**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**

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 1-5 (Part D) of the application.

If the applicant answers all of the questions 1-5 (Part D) "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. Our goal with the Medicare Supplement product has always been and continues to be to offer competitively priced plans and keep annual rate increases to single digits. If underwritten properly, these goals can be met.

We have recently contracted with a new vendor to conduct the Personal Health Interviews (PHIs). They have developed a more in-depth interview that has been shown to eliminate in many cases the need for additional information from the physician, which in turn shortens the time to issue the policy. This new PHI will also improve the claims experience.

The eligibility requirements have not changed. The interview might take a little longer, but policies will get issued faster and the experience will be better.

You can still call from the applicant's home at the time of application.

Call Toll Free 1-888-801-5144

Monday through Thursday 8:00 am to 9:30 pm (Central Time)

Friday 8:00 am to 5:00 pm (Central Time)

*\*The PHI will be conducted through the 888 number above; however, 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**

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 or statement of claim 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 and subjects such person to criminal and civil penalties.

**Part A: General Information – Please Print**

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Height \_\_\_\_\_\* Weight \_\_\_\_\_\*

Mo./Day/Yr.

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 \_\_\_\_\_

\*You do not need to provide this information if you are eligible for open enrollment and/or 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

**Part B: Insurance Information (continued)**

(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

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. \_\_\_\_\_

**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: Guaranteed Issue Information**

The questions in this Part are designed to assist you in determining if you are eligible for guaranteed issue of a Medicare supplement insurance policy.

1. Within the past 63 days, were you enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and that plan terminates or ceases to provide all supplemental Medicare health benefits? ..... Yes  No

Within the past 63 days, were you enrolled under an employee welfare benefit plan that is primary to Medicare and that plan terminates or ceases to provide health benefits because you left the plan?..... Yes  No

*If you answered "Yes" to either of these questions, you are eligible for a guaranteed issue of Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.*

**Part C: Guaranteed Issue Information (continued)**

2. If you enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the circumstances a-e below apply, or you are enrolled with a PACE Provider under section 1894 of the Social Security Act and are 65 years of age or older, and there are circumstances similar to a-e below that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage plan:
- a. Was the certification of the organization or plan terminated? .....  Yes  No
  - b. Did the organization terminate or otherwise discontinue providing the plan in the area in which you reside? .....  Yes  No
  - c. Are you no longer eligible to elect the plan because of a change in your place of residence or other change in circumstance specified by the HHS Secretary (but not including termination of your enrollment because you have not paid premiums on a timely basis or have engaged in disruptive behavior specified in standards under section 1856 of the Social Security Act) or did the plan terminate for all individuals within your residence area?.....  Yes  No
  - d. Can you demonstrate, in accordance with guidelines established by the HHS Secretary, that:
    - 1. The organization offering the plan substantially violated a material provision of the organization’s contract, such as the failure to provide medically necessary care for which benefits are available under the plan on a timely basis, or the failure to provide such covered care in accordance with applicable quality standards? .....  Yes  No
    - 2. The organization, or producer or other entity acting on the organization’s behalf, materially misrepresented the plan’s provisions in marketing the plan to you? .....  Yes  No
  - e. Do you meet other exceptional conditions the HHS Secretary may provide? .....  Yes  No

*If you answered “Yes” to any of these questions, you are eligible for a guaranteed issue of Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.*

3. Did your enrollment cease under the same circumstances that would permit discontinuance of your election of coverage under Part 2 (above), and you are enrolled with one of the following:
- a. A Medicare Cost plan? .....  Yes  No
  - b. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999? .....  Yes  No
  - c. A health care prepayment plan? .....  Yes  No
  - d. An organization under a Medicare Select policy? .....  Yes  No

*If you answered “Yes” to this question, you are eligible for a guaranteed issue of Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.*

4. Within the past 63 days, did your enrollment in a Medicare supplement policy cease because:
- a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy? .....  Yes  No
  - b. The issuer of the policy substantially violated a material provision of the policy? .....  Yes  No
  - c. The issuer, or a producer or other entity acting on the issuer’s behalf, materially misrepresented the policy’s provisions in marketing the policy to the individual? .....  Yes  No

*If you answered “Yes” to any of these questions, you are eligible for a guaranteed issue of Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.*

**Part C: Guaranteed Issue Information (continued)**

5. Within the past 12 months, were you enrolled under a Medicare supplement policy, and terminated enrollment and subsequently enrolled, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any Medicare Cost plan, any similar organization operating under demonstration project authority, any eligible organization under a contract under section 1876 of the Social Security Act, any PACE Provider under section 1894 of the Social Security Act, or any Medicare Select policy and you terminated this subsequent enrollment within the past 63 days? .....  Yes  No
- If you answered "Yes" to this question, you are eligible from your prior issuer for a guaranteed issue of the same Plan in which you were previously enrolled. If that Plan is not available, you are eligible for a guaranteed issue of Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.*
6. Within the past 12 months, upon first becoming eligible for benefits under Part A and enrolled in Medicare Part B, if eligible, of Medicare, did you enroll in a Medicare Advantage plan under Part C of Medicare or with a PACE Provider under section 1894 of the Social Security Act, and disenroll from the plan within the last 63 days? .....  Yes  No
- If you answered "Yes" to this question, you are eligible for a guaranteed issue of any Medicare supplement policy offered by any issuer.*
7. Within the past 63 days, were you enrolled in a Medicare Part D Plan during the initial enrollment period and, at the time of enrollment in Part D, you were enrolled under a Medicare supplement policy that covered outpatient prescription drugs, and you terminated enrollment in the Medicare supplement policy and submitted evidence of enrollment in Medicare Part D along with your application for a policy? .....  Yes  No
- If you answered "Yes" to this question, you are eligible for a guaranteed issue of Plan A, B, C, F (including F with a high deductible), K or L offered by and available for issuance to new enrollees by the same issuer that issued your Medicare supplement policy with outpatient prescription drug coverage.*

**Part D: 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 5 you are not eligible for coverage.

1. Have you ever:
- (a) had any fractures due to osteoporosis or amputation due to disease? .....  Yes  No
  - (b) had kidney disease requiring dialysis; diabetes requiring insulin; Parkinson's disease; liver disease; multiple or lateral sclerosis; or amyotrophic lateral sclerosis (Lou Gehrig's disease)? .....  Yes  No
  - (c) been diagnosed with emphysema; chronic obstructive pulmonary disorder (COPD); or any other chronic pulmonary disorder? .....  Yes  No
  - (d) been diagnosed with or 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 5 years have you been treated for or been diagnosed as having internal cancer; leukemia; or malignant melanoma? .....  Yes  No
3. 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) had heart trouble or disease that required treatment by a physician other than just prescription medication (not including high blood pressure)? .....  Yes  No
  - (d) been diagnosed with or 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
4. Within the past 12 months have you been advised that surgery for cataracts may be required? .....  Yes  No

**Part D: Medical Information (continued)**

5. 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 diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart or circulatory condition (including high blood pressure)? ....  Yes  No
- (c) are you receiving physical therapy or using oxygen? .....  Yes  No
- (d) have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? .....  Yes  No
- (e) do you have surgery pending? .....  Yes  No

6. 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 E: 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 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 the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

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. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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 G: Benefit Options – Check the Plan you prefer:**

Medicare Supplement Policy – Plan A

Medicare Supplement Policy – Plan B

Medicare Supplement Policy – Plan D

Medicare Supplement Policy – Plan F

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

**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 H: 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. 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 5 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](http://www.gomedico.com/products).

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

**Policy Delivery Options:** Upon approval of this application, the policy will be mailed to:  Applicant  Producer

Note: Policy will be mailed to Producer in states where a policy delivery receipt is required by law

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 \_\_\_\_\_



**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.

Dependent Name (if applicable): \_\_\_\_\_

**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/certificate.

In the case of authorizations signed for the purpose of collecting information in connection with an application for an insurance policy/certificate, a policy/certificate reinstatement, or a request for change in policy/certificate 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/certificate, this authorization may not exceed the term of coverage of my insurance policy/certificate.

**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
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**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
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Signature of Personal Representative	Date
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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)

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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

Bank Withdrawal Authorization

### Bank Withdrawal Authorization

Policy/Certificate Number if Applicable: \_\_\_\_\_

Applicant's Name \_\_\_\_\_  
First Name MI Last Name

Applicant's Address \_\_\_\_\_  
Street Address City State Zip

Payor's Name (As it appears on bank records) \_\_\_\_\_  
First Name MI Last Name

If payor is different than applicant, please provide payor's phone number \_\_\_\_\_

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

Bank Name \_\_\_\_\_

Routing # 

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Account # 

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Optional date for premiums to be withdrawn (select a date from the 1<sup>st</sup> to the 28<sup>th</sup> 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 the insurance policy/certificate is cancelled or my (our) bank account is closed.

Payor's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(As it appears on bank records)

Signature \_\_\_\_\_ Date \_\_\_\_\_  
(If a joint account)



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Receipt

## RECEIPT

The applicant has applied for Medicare Supplement Policy:  A20A  A20B  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](http://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)

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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



## **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, U.S. mail or e-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

## 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](http://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 75<sup>th</sup> St., Omaha NE 68124-1655, telephone: 1-800-228-6080.

## **EFFECTIVE DATE**

This Notice is effective April 14, 2003.

## Notes

# about the company

Medico Insurance Company began operations in 1930. We offer quality health and life insurance products 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](http://www.gomedico.com).



Medico Insurance Company  
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Omaha, NE 68124  
[www.gomedico.com](http://www.gomedico.com)  
1.800.228.6080