Medico® Insurance Company
A Wellabe® Company

First Diagnosis Cancer Insurance

SALES KIT

PRODUCER INSTRUCTIONS

Submit applications electronically using MyEnroller:

MyEnroller
Electronic Application Submission Tool
Website: wellabe.com/signin

If you need assistance, please call 800-547-2401, Option 3.

34 131 1000 062623 MO

Medico® Insurance Company
A Wellabe® Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306
www.wellabe.com
Phone (toll-free): 800-228-6080

Application for
First Diagnosis Cancer Policy Forms MI-CAA28 and MI-CAA29

Part A: General Information – Please Print

Applicant Name _____
First MI Last Date of Birth Mo./Day/Yr. Age Sex

Address _____
Street Address City State ZIP

Social Security #_____ Are you covered by Medicare? ❒ Yes ❒ No

Phone # _____ Email Address _____

Beneficiary_____Relationship_____ Address_____

Do you intend to replace any medical or health insurance coverage with this policy? .....❒ Yes ❒ No

If "Yes," show type of policy being replaced and name of company:_____

_____

Part B: Medical Information

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

1. In the past 10 years have you been diagnosed, hospitalized, treated or been advised by a Licensed Health Care Practitioner/Physician, or had diagnostic procedures or follow-up for:

   a) Cancer, malignancy, leukemia, melanoma, lymphoma, Hodgkin's disease?
   (If answered "Yes," you will not be eligible for coverage.) .....❒ Yes ❒ No

   b) Elevated PSA tests, abnormal Pap smear or mammogram, bleeding moles or blood in the stool?
   (If answered "Yes," please provide dates and details below.).....❒ Yes ❒ No

2. Within the last 2 years:

   a) have you been advised by a Licensed Health Care Practitioner/Physician to have medical tests or examinations to diagnose a possible malignancy but have not done so yet?
   (If answered "Yes," please provide dates and details below.).....❒ Yes ❒ No

   b) have you experienced any medical condition or symptom for any of the conditions listed in number 1 above for which medical advice, diagnosis or treatment has not yet been obtained?
   (If answered "Yes," please provide dates and details below.).....❒ Yes ❒ No

Dates and Details: _____

Physician Name/Address:_____

3. In the past 10 years have you tested positive for the antibody to AIDS in the ELISA-ELISA-Western Blot series?
   Note: Diagnosis must be made by a member of the medical profession. **You do not have to disclose a positive AIDS test result obtained at an anonymous or alternate test site or from a home test.**
   (If answered "Yes," you will not be eligible for coverage.)..... ❒ Yes ❒ No

Part C: Benefit Options

❒ **MI-CAA28 – First Diagnosis Cancer Policy**

❒ **MI-CAA29 – First Diagnosis Cancer Policy With Inflation Protection**

Benefit Amount Upon First Diagnosis of Internal Cancer or Malignant Melanoma:

($10,000, $15,000, $20,000 or $25,000) $_____

Part D: Payment Options

❒ **Household Discount** – If eligible, list full name(s) of the other person or persons in your household who is/are also applying for this policy: _____

Method of Payment:	**Mode - Frequency of Payment:**			
❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly		
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

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

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

Amount Received with Application $_____ Renewal Premium $_____

Requested Effective Date of Policy (optional) _____
(Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the Effective Date will be the day after the applicant signs the application.)

Part E: Application Agreement

I hereby apply to Medico Insurance Company for a **First Diagnosis Cancer Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I have received the Notice of Privacy Practices and where required by state law, the Outline of Coverage for the policy.

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

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

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

❒ 3. I am not eligible for Medicare.

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

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: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Printed Name _____

Producer's Signature _____ Date_____

HIPAA Authorization

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, or any other entity that possesses any diagnosis, treatment, prescription, or other medical information about me to furnish such health information to Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives, for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for two years from this date and may be revoked by sending written notice to the Company.

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

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

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

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company and/or Medico Life and Health 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.
- 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.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

Authorization to Disclose Information (MIB)

I authorize Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health 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 and/or Medico Life and Health 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.

Your name (Please print) Date

X

Your signature

Spouse's name (If applying, please print) Date

X

Your signature

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)

X

Personal representative signature

Person(s) to be insured (Please print):

1.

2.

My relationship to applicant(s) (Please print):

1.

2.

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Cancer Policy Receipt

Received of _____
(Applicant's Full Name)

an application for insurance as shown below and $_____.

❒ First Diagnosis Cancer Policy, Form MI-CAA28

❒ First Diagnosis Cancer Policy with Inflation Protection, Form MI-CAA29

Benefit Amount Upon First Diagnosis of Internal Cancer or Malignant Melanoma:
($10,000, $15,000, $20,000 or $25,000)

$_____

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 the following methods:

Write to:
Wellabe, Inc.
P.O. Box 10386 • Des Moines, Iowa 50306

Call:
Customer Success at 800-228-6080

E-mail:
customerservice@wellabe.com

_____ _____
Producer's Printed Name Date

_____
Producer's Signature

Important Notice to Persons on Medicare

This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the ***Guide to Health Insurance for People with Medicare***, available from the insurance company.

✓ For help in understanding your health insurance, contact the Missouri Department of Insurance, Financial Institutions and Professional Registration (1-800-726-7390) or C.L.A.I.M. (Community Leaders Assisting the Insured of Missouri) at 1-800-390-3330.

CANCER POLICY RATE GUIDE

Monthly Automatic Bank Withdrawal Rates

First Diagnosis Cancer

Individual					Household			
Issue Age	$10,000	$15,000	$20,000	$25,000	$10,000	$15,000	$20,000	$25,000
18 - 39	9.00	13.50	18.00	22.50	8.10	12.15	16.20	20.25
40 - 44	11.00	16.50	22.00	27.50	9.90	14.85	19.80	24.75
45 - 49	13.00	19.50	26.00	32.50	11.70	17.55	23.40	29.25
50 - 54	16.00	24.00	32.00	40.00	14.40	21.60	28.80	36.00
55 - 59	20.00	30.00	40.00	50.00	18.00	27.00	36.00	45.00
60 - 64	24.00	36.00	48.00	60.00	21.60	32.40	43.20	54.00
65 - 69	29.00	43.50	58.00	72.50	26.10	39.15	52.20	65.25
70 - 74	33.00	49.50	66.00	82.50	29.70	44.55	59.40	74.25
75 - 79	36.00	54.00	72.00	90.00	32.40	48.60	64.80	81.00

First Diagnosis Cancer with Inflation Protection

Individual					Household			
Issue Age	$10,000	$15,000	$20,000	$25,000	$10,000	$15,000	$20,000	$25,000
18 - 39	19.00	28.50	38.00	47.50	17.10	25.65	34.20	42.75
40 - 44	21.00	31.50	42.00	52.50	18.90	28.35	37.80	47.25
45 - 49	23.00	34.50	46.00	57.50	20.70	31.05	41.40	51.75
50 - 54	26.00	39.00	52.00	65.00	23.40	35.10	46.80	58.50
55 - 59	30.00	45.00	60.00	75.00	27.00	40.50	54.00	67.50
60 - 64	34.00	51.00	68.00	85.00	30.60	45.90	61.20	76.50
65 - 69	39.00	58.50	78.00	97.50	35.10	52.65	70.20	87.75
70 - 74	43.00	64.50	86.00	107.50	38.70	58.05	77.40	96.75
75 - 79	46.00	69.00	92.00	115.00	41.40	62.10	82.80	103.50

For Quarterly Automatic Bank Withdrawal, multiply the above Monthly Rate by 3.

Annual Direct Bill Rates

First Diagnosis Cancer

Individual					Household			
Issue Age	$10,000	$15,000	$20,000	$25,000	$10,000	$15,000	$20,000	$25,000
18 - 39	108.00	162.00	216.00	270.00	97.20	145.80	194.40	243.00
40 - 44	132.00	198.00	264.00	330.00	118.80	178.20	237.60	297.00
45 - 49	156.00	234.00	312.00	390.00	140.40	210.60	280.80	351.00
50 - 54	192.00	288.00	384.00	480.00	172.80	259.20	345.60	432.00
55 - 59	240.00	360.00	480.00	600.00	216.00	324.00	432.00	540.00
60 - 64	288.00	432.00	576.00	720.00	259.20	388.80	518.40	648.00
65 - 69	348.00	522.00	696.00	870.00	313.20	469.80	626.40	783.00
70 - 74	396.00	594.00	792.00	990.00	356.40	534.60	712.80	891.00
75 - 79	432.00	648.00	864.00	1,080.00	388.80	583.20	777.60	972.00

First Diagnosis Cancer with Inflation Protection

Individual					Household			
Issue Age	$10,000	$15,000	$20,000	$25,000	$10,000	$15,000	$20,000	$25,000
18 - 39	228.00	342.00	456.00	570.00	205.20	307.80	410.40	513.00
40 - 44	252.00	378.00	504.00	630.00	226.80	340.20	453.60	567.00
45 - 49	276.00	414.00	552.00	690.00	248.40	372.60	496.80	621.00
50 - 54	312.00	468.00	624.00	780.00	280.80	421.20	561.60	702.00
55 - 59	360.00	540.00	720.00	900.00	324.00	486.00	648.00	810.00
60 - 64	408.00	612.00	816.00	1,020.00	367.20	550.80	734.40	918.00
65 - 69	468.00	702.00	936.00	1,170.00	421.20	631.80	842.40	1,053.00
70 - 74	516.00	774.00	1,032.00	1,290.00	464.40	696.60	928.80	1,161.00
75 - 79	552.00	828.00	1,104.00	1,380.00	496.80	745.20	993.60	1,242.00

Available Direct Bill Modal Factors (Applied to Annual Direct Bill Rate):
ANNUAL: 1.00 SEMI-ANNUAL: 0.52 QUARTERLY: 0.27

Available Credit/Debit Card Modal Factors (Applied to Annual Direct Bill Rate):
ANNUAL: 1.03 SEMI-ANNUAL: 0.515 QUARTERLY: 0.258 MONTHLY: 0.086

UNDERWRITING GUIDELINES

CAA28/CAA29 First Diagnosis Cancer Policy

Applications for the First Diagnosis Cancer Policy will be underwritten from the information on the application.

Applicants with “Yes” response to questions 1, 2 or 3 in Part B of the application would **not** be eligible for coverage.

Rate Structure
There is one set of premium rates for single applicants and another set of rates for applicants that qualify for a 10% Household Discount. The discount is available when two or more people living in the same household apply for and are issued a First Diagnosis Policy.

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

For Producer Use Only

wellabe®

Medical 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 covers an affiliated covered entity. When the notice refers to "we," "our," or "us," it is referring to the following affiliated entities: American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company. For purposes of complying with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), the combined companies listed are designated as a single covered entity. The single covered entity shall be known as the "Wellabe ACE." This designation may be amended from time to time to add new covered entities that are under common control and ownership with the Wellabe ACE.

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 HIPAA. Individually identifiable health information is health information that:

- Is created or received by the Wellabe ACE'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 Wellabe ACE 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.

State and federal laws may require or permit us to release your information to others without your authorization, such as:

- 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 Insurance Division.
- To share information for public health activities.
- 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 such as audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding, such as pursuant to a subpoena.
- To report information for law enforcement purposes.
- 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
- 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 success team. Contact information for our customer success team 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:**
  (a) how we use or disclose your information for payment or health care operations;
  (b) 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
  (c) 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 success team 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 success team.
- **You have the right to receive an accounting** of certain disclosures of your information. Accounting request forms are available from our customer success team 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. 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.

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 success team. 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
Wellabe
P.O. Box 1
Des Moines, IA 50306-0001

You can call us at **800-247-2190** or visit **www.wellabe.com**.

wellabe®

Financial Notice of Privacy Practices

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 Wellabe, 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. Wellabe includes Wellabe, Inc., and its affiliates including American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, Medico Corp Life Insurance Company, and Great Western Insurance Company.

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 or other forms, such as name, address, social security number, age, and financial information.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and your payment history.
- Information received from a consumer reporting or credit agency or from public records, to assess your creditworthiness, as needed by our insurance underwriting practices.
- Information received from a third-party agency, for example, to verify your identity and to better understand your product and service needs.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

Information by which you cannot be identified, for example, anonymous or aggregated information is not considered personal information and therefore is not subject to this privacy policy.

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.

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 Wellabe or its business associates. Our business associates are bound by the same restrictions on the release and use of such information. Any future alliances with business associates which include personal information sharing will follow the same policy.

There are state and federal laws that may require or permit us to release your information to government agencies, other regulatory bodies and law enforcement officials, or other organizations as permitted or required by law. For example, for tax purposes, fraud prevention, or to respond to a valid court order or subpoena.

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 or our business associates who need the information we collect from or about you to provide products or services to you may access that information. Employees and business associates 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 our customer success team at the number listed on your contract materials. We will respond promptly when we learn corrections are needed.

Contact Information

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

Notice of Privacy Practices
Wellabe
P.O. Box 1
Des Moines, IA 50306-0001

You can call us at **800-247-2190** or visit **www.wellabe.com**.