APPLICATION BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

☐ Application for Dental or Dental, Vision and Hearing Insurance Policy

☐ Bank Draft and/or Credit Card Authorization (if applicable)

☐ Additional forms which may be required. See forms marked Complete and Send with Application.

Submit applications electronically by MyEnroller, Mail or Fax.

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

Mail
Medico Insurance Company
Administrative Services
PO Box 10386
Des Moines, IA 50306

Fax
1-888-363-3420

If you have any questions, please call 1-800-547-2401-Option 3.
### Application for Dental or Dental, Vision and Hearing Insurance Policy

**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

**Applicant Information**

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<tr>
<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>Suffix</th>
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<tr>
<th>Date of Birth (MM/DD/YY)</th>
<th>Age</th>
<th>Gender</th>
<th>Social Security Number</th>
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**Address**

<table>
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<tr>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
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<tr>
<th>Phone Number</th>
<th>Alternate Phone Number</th>
<th>Email Address</th>
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1. Do you have any dental, vision or hearing insurance currently in force? □ Yes □ No
2. Is the insurance applied for intended to replace any existing insurance with this or any other company? □ Yes □ No

If “Yes,” provide type of contract or policy number and name of company:

<table>
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<tr>
<th>Name of Company</th>
<th>Contract or Policy Number</th>
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If replacement is involved, have you received a Replacement Form (in states where required by law)? □ Yes □ No

### Part B: Benefit – Check the Desired Option:

**Plan Selection:**

- □ Traditional - $1,000 Policy Year Maximum Benefit Amount
- □ Preferred - $1,500 Policy Year Maximum Benefit Amount
- □ Preferred Plus - $2,500 Policy Year Maximum Benefit Amount

### Part C: Payment Options

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

**Method of Payment:**

- □ Automatic Bank Withdrawal
- □ Direct Bill
- □ Credit/Debit Card

**Frequency of Payment:**

- □ Monthly
- □ Quarterly
- □ Semi-Annually
- □ Annually

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<thead>
<tr>
<th>Amount Received with Application</th>
<th>Renewal Premium</th>
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Part D: Application Agreement

I hereby apply to Medico Insurance Company (the Company) for a Dental or Dental, Vision and Hearing Insurance Policy to be issued solely and entirely in reliance on my answers. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid and the policy is delivered and accepted by me. I have received the Outline of Coverage for the policy (in states where required by law).

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.

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 presents false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

I am applying for this Dental or Dental, Vision and Hearing Insurance Policy. The policy provides dental or dental, vision and hearing benefits only. Review your policy carefully.

X

Applicant’s Signature

Date (MM/DD/YYYY)

Producer’s Certification: I certify the information in this application was provided by the applicant and correctly recorded. If the applicant is Medicare eligible, I have provided the applicant a link to the Medicare Buyer’s Guide at GoMedico.com or a hard copy of it.

Producer’s Printed Name

Producer’s Number

X

Producer’s Signature

Date (MM/DD/YYYY)
Important Notice About the Insurance for Which You Have Applied

1. The insurance for which you have applied includes a binding arbitration provision. A copy of which is attached hereto.

2. The arbitration provision requires that any disagreement related to this coverage must be resolved by arbitration and not in a court of law.

3. In an arbitration, an arbitrator (not a judge), who is an independent, neutral party, gives a decision after hearing the position of the parties.

4. The results of an arbitration are final and binding on you and the insurance company and cannot be reviewed in court by a judge and jury, except as provided by the Federal Arbitration Act.

5. From the point in time and forward that you tender an application for consideration of insurance coverage, you agree to resolve any disagreement related to the application and/or the coverage by binding arbitration instead of a trial in court, including a trial by jury.

ACKNOWLEDGMENT OF ARBITRATION AND AGREEMENT TO ARBITRATE APPLICATION ISSUES

I have read and understand that I am voluntarily surrendering my right to have any dispute or disagreement between Medico Insurance Company and/or Medico Corp Life Insurance Company and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that in consideration of Medico Insurance Company and/or Medico Corp Life Insurance Company’s agreement to receive and review my application for insurance, I do hereby agree that any dispute or disagreement that arises between me and Medico Insurance Company and/or Medico Corp Life Insurance Company that relates in any way to my application for insurance, the accuracy of information disclosed in my application for insurance, or the description or explanation of coverage afforded by the insurance applied for shall be resolved exclusively through binding arbitration according to the procedures set forth in the arbitration clause attached hereto.

Additionally, I understand that upon receipt of the insurance, I should read the arbitration clause contained in this coverage and that I have the right to reject this coverage within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration. I understand that this same type of insurance may be available through an insurance company that does not require that coverage related disagreements be resolved by binding arbitration.

Applicant/Insured

X

Date MM / DD / YYYY

Time a.m. p.m.

Spouse (if applying for coverage)

X

Date MM / DD / YYYY

Time a.m. p.m.

Agent’s Signature

X

Date MM / DD / YYYY

Time a.m. p.m.

SEE BACK SIDE FOR ARBITRATION CLAUSE
BINDING ARBITRATION

MEDICO INSURANCE COMPANY AND/OR MEDICO CORP LIFE INSURANCE COMPANY IS
COMMMITTED TO ATTEMPTING TO RESOLVE ANY DISPUTE OR DISAGREEMENT YOU MAY HAVE
THROUGH INFORMAL REVIEW OF YOUR CLAIMS AND OUR APPEALS PROCESS. HOWEVER,
ANY DISPUTE OR DISAGREEMENT YOU HAVE WITH MEDICO INSURANCE COMPANY AND/OR
MEDICO CORP LIFE INSURANCE COMPANY OR ANY OF OUR AGENTS OR EMPLOYEES THAT
IS NOT RESOLVED TO YOUR SATISFACTION THROUGH INFORMAL PROCEDURES SHALL BE
RESOLVED EXCLUSIVELY THROUGH BINDING ARBITRATION PURSUANT TO THE FEDERAL
ARBITRATION ACT. THIS INCLUDES ANY DISPUTES OR DISAGREEMENTS YOU HAVE THAT
ARISE OUT OF OR IN ANY WAY RELATE TO THE INSURANCE COVERAGE PROVIDED UNDER THIS
CONTRACT INCLUDING, WITHOUT LIMITATION, CLAIMS FOR BENEFITS UNDER THIS CONTRACT,
CLAIMS RELATING TO YOUR PURCHASE OF THIS INSURANCE CONTRACT, CLAIMS RELATING
TO ANY EXPLANATION OR DESCRIPTION OF COVERAGE AFFORDED UNDER THIS CONTRACT,
AND ANY CLAIM OF MISREPRESENTATION, IMPROPER DENIAL OF AN INSURANCE CLAIM, OR
OTHER DISPUTE OR DISAGREEMENT IN LAW OR EQUITY.

IF THE SUBJECT OF YOUR DISPUTE OR DISAGREEMENT SOLELY CONCERNS AN INCREASE IN
YOUR PREMIUM RATES, YOU MUST FIRST SUBMIT YOUR CLAIM TO NON-BINDING MEDIATION
AS A PREREQUISITE TO ARBITRATION. YOU MAY OBTAIN A COPY OF THESE PROCEDURES BY
WRITING TO US AT 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.

EXCEPT AS SET FORTH BELOW, ARBITRATION OF YOUR DISPUTE SHALL BE CONDUCTED
PURSUANT TO THE FEDERAL ARBITRATION ACT ACCORDING TO THE RULES AND PROCEDURES
IN THE AMERICAN ARBITRATION ASSOCIATION'S DISPUTE RESOLUTION PROCEDURES FOR
ARBITRATION OF INSURANCE CLAIMS. YOU MAY OBTAIN A COPY OF THESE PROCEDURES
FROM THE AMERICAN ARBITRATION ASSOCIATION AT 2200 CENTURY PARKWAY SUITE 300,
ATLANTA GEORGIA 30345-3203 OR BY WRITING TO US AT 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.

TO INITIATE AN ARBITRATION PROCEEDING, YOU MUST FIRST NOTIFY US IN WRITING BY
REGISTERED MAIL. YOUR LETTER MUST CONTAIN THE FOLLOWING INFORMATION: (1) YOUR
REQUEST FOR THE DISPUTE TO BE RESOLVED THROUGH ARBITRATION; (2) YOUR FULL NAME,
MAILING ADDRESS AND TELEPHONE NUMBER; (3) THE NAME AND MAILING ADDRESS OF THE
POLICYHOLDER; (4) THE POLICY/CERTIFICATE NUMBER; (5) A DESCRIPTION OF THE NATURE
OF YOUR DISPUTE OR DISAGREEMENT; (6) THE PARTY OR PARTIES AGAINST WHOM YOUR
DISPUTE OR DISAGREEMENT IS MADE; AND (7) THE RESULT YOU ARE WANTING INCLUDING THE
DOLLAR AMOUNT IN DISPUTE.

ABSENT OUR MUTUAL AGREEMENT OR OTHER GOOD CAUSE SHOWN, THE ARBITRATION
SHALL COMMENCE WITHIN 90 DAYS AFTER THE ARBITRATION IS INITIATED. THE ARBITRATION
PROCEEDINGS SHALL BE CONDUCTED IN YOUR COUNTY OF RESIDENCE UNLESS WE
MUTUALLY AGREE IN WRITING TO ANOTHER LOCATION.

THE COSTS OF ALL ARBITRATION PROCEEDINGS SHALL BE BORNE BY US WITH THE EXCEPTION
OF: (1) THE COST OF YOUR ATTORNEY OR OTHER REPRESENTATION; AND (2) ANY COSTS WHICH
THE ARBITRATOR RULES YOU MUST PAY, SHOULD THE ARBITRATOR FIND THAT THE DISPUTE
IS WITHOUT SUBSTANTIAL JUSTIFICATION.

THE ARBITRATOR SHALL NOT HAVE JURISDICTION TO DETERMINE WHETHER MEDICO INSUR-
ANCE AND/OR MEDICO CORP LIFE INSURANCE COMPANY IS LIABLE FOR THE PROFESSIONAL
NEGLIGENCE OF ANY PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER PROVIDING
SERVICES COVERED UNDER THE INSURANCE CONTRACT. MEDICO INSURANCE COMPANY AND/
OR MEDICO CORP LIFE INSURANCE COMPANY HAS NO RESPONSIBILITY FOR YOUR SELECTION
OF A HEALTH CARE PROVIDER NOR FOR THE QUALITY OF HEALTH CARE RENDERED.

ONCE THE ARBITRATOR’S DECISION IS RENDERED, THE ARBITRATION AWARD MAY BE
ENTERED IN ANY COURT HAVING JURISDICTION THEREOF. THE ARBITRATION AWARD SHALL
NOT BE SUBJECT TO JUDICIAL REVIEW EXCEPT TO THE EXTENT ALLOWED BY THE FEDERAL
ARBITRATION ACT.

THIS ARBITRATION PROVISION IS BINDING ON BOTH YOU AND MEDICO INSURANCE COMPANY
AND/OR MEDICO CORP LIFE INSURANCE COMPANY.
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

COMPLETE AND SEND WITH APPLICATION
Dental, Vision and Hearing Receipt

The applicant has applied for one of the following.

☐ Traditional - $1,000 Policy Year Maximum Benefit Amount

☐ Preferred - $1,500 Policy Year Maximum Benefit Amount

☐ Preferred Plus - $2,500 Policy Year Maximum Benefit Amount

Received of ____________________________________________________________________________________________
First Name MI Last Name Suffix

an application for insurance as shown above and $ 

This insurance will not be in force until the policy is delivered and accepted and the first premium is paid.

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
PO Box 10386 • Des Moines, IA 50306

Call:
Customer Service at 1-800-228-6080

E-mail:
customerservice@GoMedico.com

X
Producer’s Signature

Date (MM/DD/YYYY)

Producer’s Printed Name
Page intentionally left blank.
Important Notice About the Insurance for Which You Have Applied

1. The insurance for which you have applied includes a binding arbitration provision. A copy of which is attached hereto.

2. The arbitration provision requires that any disagreement related to this coverage must be resolved by arbitration and not in a court of law.

3. In an arbitration, an arbitrator (not a judge), who is an independent, neutral party, gives a decision after hearing the position of the parties.

4. The results of an arbitration are final and binding on you and the insurance company and cannot be reviewed in court by a judge and jury, except as provided by the Federal Arbitration Act.

5. From the point in time and forward that you tender an application for consideration of insurance coverage, you agree to resolve any disagreement related to the application and/or the coverage by binding arbitration instead of a trial in court, including a trial by jury.

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I understand that in consideration of Medico Insurance Company and/or Medico Corp Life Insurance Company’s agreement to receive and review my application for insurance, I do hereby agree that any dispute or disagreement that arises between me and Medico Insurance Company and/or Medico Corp Life Insurance Company that relates in any way to my application for insurance, the accuracy of information disclosed in my application for insurance, or the description or explanation of coverage afforded by the insurance applied for shall be resolved exclusively through binding arbitration according to the procedures set forth in the arbitration clause attached hereto.

Additionally, I understand that upon receipt of the insurance, I should read the arbitration clause contained in this coverage and that I have the right to reject this coverage within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration. I understand that this same type of insurance may be available through an insurance company that does not require that coverage related disagreements be resolved by binding arbitration.

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<tr>
<th>Applicant/Insured</th>
<th>Date</th>
<th>Time</th>
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<td>X</td>
<td>MM / DD / YYYY</td>
<td>☐ a.m. ☐ p.m.</td>
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<tr>
<th>Spouse (if applying for coverage)</th>
<th>Date</th>
<th>Time</th>
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<tr>
<td>X</td>
<td>MM / DD / YYYY</td>
<td>☐ a.m. ☐ p.m.</td>
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<tr>
<th>Agent’s Signature</th>
<th>Date</th>
<th>Time</th>
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<tbody>
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SEE BACK SIDE FOR ARBITRATION CLAUSE
BINDING ARBITRATION

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EXCEPT AS SET FORTH BELOW, ARBITRATION OF YOUR DISPUTE SHALL BE CONDUCTED PURSUANT TO THE FEDERAL ARBITRATION ACT ACCORDING TO THE RULES AND PROCEDURES IN THE AMERICAN ARBITRATION ASSOCIATION'S DISPUTE RESOLUTION PROCEDURES FOR ARBITRATION OF INSURANCE CLAIMS. YOU MAY OBTAIN A COPY OF THESE PROCEDURES FROM THE AMERICAN ARBITRATION ASSOCIATION AT 2200 CENTURY PARKWAY SUITE 300, ATLANTA GEORGIA 30345-3203 OR BY WRITING TO US AT 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.

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ABSENT OUR MUTUAL AGREEMENT OR OTHER GOOD CAUSE SHOWN, THE ARBITRATION SHALL COMMENCE WITHIN 90 DAYS AFTER THE ARBITRATION IS INITIATED. THE ARBITRATION PROCEEDINGS SHALL BE CONDUCTED IN YOUR COUNTY OF RESIDENCE UNLESS WE MUTUALLY AGREE IN WRITING TO ANOTHER LOCATION.

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THIS ARBITRATION PROVISION IS BINDING ON BOTH YOU AND MEDICO INSURANCE COMPANY AND/OR MEDICO CORP LIFE INSURANCE COMPANY.
Important Notice to Persons on Medicare
This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

The insurance provides limited benefits if you meet the conditions listed 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 when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

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 your state insurance department or State Health Insurance Assistance Program (SHIP).
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about the company

Medico Insurance Company began operations in 1930. We offer quality health and life insurance products for Americans nationwide.

Today Medico Insurance Company continues a proud 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 are anxious to help you find solutions.