Medico®
Dental Plus Insurance Series
- Traditional  - Preferred

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

First Name  M.I.  Last Name  Suffix

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

Address

City  State  ZIP Code

Phone Number  Alternate Phone Number  Email Address

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

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:  Frequency of Payment:

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

Amount Received with Application  $  Renewal Premium  $
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 and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

I 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)
OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

(Agent or Insurance Company Representative)

(Address)

Completed this questionnaire on ___________________________

describing ___________________________

(Policy Name, Form Number)

an individual health insurance policy providing coverage for ___________________________

This policy is underwritten by ___________________________

(Insurance Company)

(Address)
This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage.

**Are You Considering Replacing Your Current Coverage?** Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

**Are You Considering Adding to Your Current Coverage?**

**Review Your Coverage.** Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

**Which Coverage Will Pay?** If coverage under the offered policy duplicates coverage under your current policy, the offered policy ______ will ______ will not pay if your current policy also pays. (NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

**Questions?** Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

**Read Your Policy!** If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

**Fill Out Your Application Carefully!** Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, the insurer may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.
# 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
- [x] All Coverage (New and Existing)

B. Initial Premium

**Authorization to Bank or Other Financial Institution**

- [ ] Checking  
- [ ] Savings

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<th>First Name (as it appears on account)</th>
<th>M.I.</th>
<th>Last Name (as it appears on account)</th>
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<th>Bank or Financial Institution Name (including branch, if any)</th>
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<th>Account Number</th>
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C. Ongoing Premium (Complete C only if different from Initial Premium information)

**Authorization to Bank or Other Financial Institution**

- [ ] Checking  
- [ ] Savings

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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.

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# 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

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<tr>
<th>Credit Card Number</th>
<th>Card Security Code (3 digits)</th>
<th>Expiration Date</th>
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**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.

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<th>First Name</th>
<th>M.I.</th>
<th>Last Name</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
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C. Ongoing Premium (Complete C only if different than Initial Premium Information)

**Credit Card Information:**

- [ ] MasterCard  
- [ ] Visa

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COMPLETE AND SEND WITH APPLICATION

24 115 3831 0414 US
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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

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
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OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

(Agent or Insurance Company Representative)

(Address)

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We hope this disclosure statement will help you with your insurance purchase. However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding.
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.