

SERFF Tracking Number: MDIC-125606274 State: Arkansas
Filing Company: Medico Insurance Company State Tracking Number: 38694
Company Tracking Number: CR-AR A18 DVH POLICY
TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
Product Name: AR A18 DVH Policy
Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Filing at a Glance

Company: Medico Insurance Company

Product Name: AR A18 DVH Policy

TOI: H10I Individual Health - Dental

Sub-TOI: H10I.000 Health - Dental

Filing Type: Form/Rate

SERFF Tr Num: MDIC-125606274 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 38694

Co Tr Num: CR-AR A18 DVH
POLICY

State Status: Approved-Closed

Co Status:

Author: Cathy Richter

Reviewer(s): Rosalind Minor

Date Submitted: 04/11/2008

Disposition Date: 04/21/2008

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: CR-AR A18 DVH Policy

Project Number: CR-AR A18 DVH Policy

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: We have filed in
Nebraska, our state of domicile, and are
awaiting their approval.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 04/21/2008

State Status Changed: 04/21/2008

Corresponding Filing Tracking Number:

Filing Description:

Market Type: Individual

Group Market Size:

Group Market Type:

Deemer Date:

Filing of new Dental, Vision and Hearing Policy A18, with associated forms.

Company and Contact

SERFF Tracking Number: MDIC-125606274 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 38694
 Company Tracking Number: CR-AR A18 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18 DVH Policy
 Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Filing Contact Information

Cathy Richter, Assistant Compliance Analyst cathyrichter@gomedico.com
 1515 S. 75th Street (800) 695-5976 [Phone]
 Omaha, NE 68124 (402) 391-4858[FAX]

Filing Company Information

Medico Insurance Company	CoCode: 31119	State of Domicile: Nebraska
1515 S. 75th Street	Group Code: 364	Company Type: Life and Health
Omaha, NE 68124	Group Name: Medico	State ID Number:
(800) 695-5976 ext. [Phone]	FEIN Number: 47-0122200	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Policy flg - \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$50.00	04/11/2008	19484300

SERFF Tracking Number: MDIC-125606274 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 38694
 Company Tracking Number: CR-AR A18 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18 DVH Policy
 Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2008	04/21/2008

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Toll-Free Notice	Form	Cathy Richter	04/14/2008	04/14/2008

SERFF Tracking Number: MDIC-125606274 *State:* Arkansas
Filing Company: Medico Insurance Company *State Tracking Number:* 38694
Company Tracking Number: CR-AR A18 DVH POLICY
TOI: H101 Individual Health - Dental *Sub-TOI:* H101.000 Health - Dental
Product Name: AR A18 DVH Policy
Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Disposition

Disposition Date: 04/21/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MDIC-125606274 State: Arkansas
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Form	Dental, Vision Hearing Policy	Approved-Closed	Yes
Form	Replacement Notice	Approved-Closed	Yes
Form	Guaranty Association Notice	Approved-Closed	Yes
Form (revised)	Toll-Free Notice	Approved-Closed	Yes
Form	Toll-Free Notice	Withdrawn	No
Rate	A18 rates	Approved-Closed	Yes

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 Company Tracking Number: CR-AR A18 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18 DVH Policy
 Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Amendment Letter

Amendment Date:
 Submitted Date: 04/14/2008

Comments:

We amended this filing to include a .pdf version of UR-AR-763 instead of the .doc file.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
UR-AR-763	Other	Toll-Free Notice	Initial					UR-AR-763-mic.pdf

SERFF Tracking Number: MDIC-125606274 State: Arkansas
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 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18 DVH Policy
 Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Form Schedule

Lead Form Number: MI-DVA18

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MI-DVA18	Policy/Cont	Dental, Vision ract/Fratern Hearing Policy al Certificate	Initial			MI-DVA18-04032008.pdf A18 Schedule.pdf
Approved-Closed	MI9F-1060	Other	Replacement Notice	Initial			MI9F-1060-11032006.pdf
Approved-Closed	MI9F-2701(AR)	Other	Guaranty Association Notice	Initial			MI9F-2701(AR)-07012007.pdf
Approved-Closed	UR-AR-763	Other	Toll-Free Notice	Initial			UR-AR-763-mic.pdf



MEDICO™
INSURANCE COMPANY

A STOCK INSURANCE COMPANY

1515 South 75th Street • Omaha, Nebraska 68124 • 1-800-228-6080

DENTAL, VISION AND HEARING EXPENSE POLICY

CAUTION: The issuance of this policy is based upon your responses to the questions on your application. A copy of your application is attached to the policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from us.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your attached application), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

Insuring Clause: We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

Please read your policy. If you are not satisfied, send it back to us, or to the Producer who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force.

PART B GUARANTEED RENEWABLE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS

We guarantee to renew your policy for life as long as the premium is paid within the allowable time. We do have the right to change your premium as stated below.

Premium Change: We can change your premium only if we do the same to all policies of this form issued to persons of your class. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

NOTICE TO BUYER: This policy may not cover all of the costs incurred by you during the period of coverage. You are advised to carefully review all policy limitations.

LIMITED BENEFIT INSURANCE POLICY FOR DENTAL, VISION AND HEARING EXPENSES

ALPHABETICAL GUIDE TO YOUR POLICY

	Part		Part
Benefits.....	F	Policy Year Deductible And Maximum Benefit.....	D
Definitions.....	E	Renewal Agreement And Premium Change.....	B
Exceptions And Limitations.....	C	Right To Return.....	A
How To File A Claim.....	H	Schedule.....	Last Page
Other Important Provisions.....	J	Termination.....	G
Payment Of Claims.....	I		

PART C EXCEPTIONS AND LIMITATIONS

We will NOT pay benefits for the following items and/or services during the first six months following the Policy Date:

1. root canals; or
2. existing eyeglasses or contact lenses (including the renewal or changing of prescriptions).

We will NOT pay benefits for the following items and/or services during the first Policy Year:

1. bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions or fluoride treatments; or
2. existing hearing aids.

We will NOT pay benefits for:

1. any loss resulting from war, declared or undeclared;
2. any intentionally self-inflicted Injury;
3. any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation;
4. any expense for which payment is provided under Medicare;
5. any services that are not recommended by a Physician, as defined by this policy;
6. any Experimental or Investigational procedure or treatment;
7. orthodontic treatment;
8. any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state;
9. expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts);
10. charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures;
11. prescription drugs;
12. charges in excess of Reasonable and Customary Charges;
13. treatment or diagnosis received while outside the territorial limits of the United States;
14. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
15. loss that occurs while this policy is not in force.

PART D POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFIT

There is a Policy Year Deductible which is shown in the Schedule. After the Policy Year Deductible has been met, benefits are limited to the Policy Year Maximum Benefit shown in the Schedule.

PART E DEFINITIONS

Audiologist: A person duly licensed and legally entitled to practice audiology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Covered Expenses: Expenses for necessary medical and dental services or supplies prescribed by a Physician. They may not be more than the Reasonable and Customary Charges for such services or supplies. Covered Expenses for services or supplies will be deemed to be incurred on the date or dates such services or supplies are received by you. Covered Expenses must be incurred while this policy is in force.

Dentist: A person duly licensed and legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Experimental or Investigational: The use of a treatment (drugs, devices or procedures) for a specific condition when all of the following are true:

1. the safety and effectiveness of a device is not proven; that is, pre-market approval has not been granted (devices only);
2. benefits to at least one-third of subjects are not documented in controlled clinical trials published in peer-reviewed English language medical journals; and
3. the treatment is not generally accepted medical practice as determined by review of peer-reviewed English language medical literature or authoritative medical journals or publications.

Immediate Family: Your spouse, parent, child, brother or sister, or any person living with you.

Injury: A bodily Injury caused directly by an accident, independent of sickness, disease, bodily infirmity or any other cause, occurring on or after the Policy Date and while coverage is in force. See the Exceptions and Limitations Section for Injuries not covered by this policy.

Medically Necessary: A service or care:

1. required for the treatment or management of a medical symptom or condition;
2. which is the most efficient and economical care or service which can be safely provided in keeping with current medical practices;
3. not administered solely for the convenience of an insured person or any provider; and
4. which is prescribed by a Physician.

Medicare: The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Ophthalmologist: A Physician duly licensed and legally entitled to practice ophthalmology at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Optometrist: A Physician duly licensed and legally entitled to practice optometry at the time and in the state or jurisdiction in which services are performed, other than a member of the insured person's Immediate Family.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license, other than a member of the insured person's Immediate Family. Physician includes a licensed Dentist, Optometrist, Ophthalmologist, or Audiologist.

Policy Date: The date on which this policy first became effective. That date is shown on the Schedule.

Policy Renewal Date: The month and day your policy's premium is due. The frequency of the Policy Renewal Date can vary depending on the premium payment option you selected. This is shown on the Schedule.

Policy Year: The year beginning on the Policy Date and on each following policy anniversary of the Policy Date.

Policy Year Deductible: The dollar amount for which you are responsible during each Policy Year. The amount of the Policy Year Deductible is shown in the Schedule.

Policy Year Maximum Benefit: The maximum benefit we will pay during any Policy Year. This amount is shown in the Schedule.

Producer: A person required to be licensed under the laws of the state to sell, solicit or negotiate insurance.

Reasonable and Customary Charge: The normal and prevailing charge, fee or expense for the service rendered or for the material furnished in the geographic area where rendered or furnished.

Schedule: Is attached to and is a part of this policy.

We, Us or Our: Medico™ Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BENEFITS

After the Policy Year Deductible is satisfied, the policy pays the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit:

1. 60% - First Policy Year;
2. 70% - Second Policy Year; and
3. 80% - Third Policy Year and thereafter.

Covered Expenses, subject to the Exceptions and Limitations, are:

1. Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.
2. Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of \$150 in any one Policy Year.
3. Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

After the policy has been in force three months, the policy will pay 100% of the cost of one dental cleaning up to a maximum benefit of \$50 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

PART G TERMINATION

Your policy will terminate on the earliest of:

1. the Policy Renewal Date following the date we receive your written or verbal request to cancel the policy, unless you request a later termination date (the grace period will not apply);
2. the Policy Renewal Date if sufficient premium has not been paid before the end of the grace period; or
3. the date of your death. In the event of your death, we will promptly return the unearned portion of any premium paid beyond the date of death.

Except in the case of your death, if the termination date occurs within a period for which we have accepted a premium, or if we accept a premium after such date, this policy will continue in effect until the end of the period for which premiums have been accepted. This does not apply where the acceptance of premium was a result of misstatement of age by you. In that case, the Misstatement of Age Provision controls.

PART H

HOW TO FILE A CLAIM

Notice of Claim: You must give us written notice of a claim within 20 days after loss starts or as soon as reasonably possible. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our Producers.

Claim Forms: When we receive your notice of claim, we will send you forms for filing proof of loss. If these forms are not sent to you within 15 days, you will have met the proof of loss rule below if you give us a written statement within 90 days after the loss began.

Proof of Loss: You must give us written proof of your loss within 90 days or as soon as reasonably possible. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

PART I

PAYMENT OF CLAIMS

Time of Payment of Claims: All benefits will be paid immediately upon receipt of due written proof of loss.

Payment of Claims: Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor or to any person not able to give a valid release, we may pay up to \$1,000.00 (\$5,000 in Nebraska) to any relative of yours by blood or connection by marriage, or any beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

Claim Review and Appeal Procedure: In the event of any claim denial with which you do not agree, you have the right to submit a written request to us at our Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

PART J

OTHER IMPORTANT PROVISIONS

Entire Contract; Changes: This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No Producer may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

Time Limit On Certain Defenses: For a policy or certificate that has been in force for less than six months, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that is material to the acceptance of coverage.

For a policy or certificate that has been in force for at least six months, but less than two years, we may rescind the policy or deny an otherwise valid claim upon a showing of misrepresentation that:

1. is material to the acceptance for coverage; and
2. pertains to the condition for which benefits are sought.

After a policy or certificate has been in force for two years, it is not contestable upon grounds of misrepresentation alone. The policy may be contested only upon a showing that you knowingly and intentionally misrepresented relevant facts relating to your health.

Grace Period: Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.

Reinstatement: Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the policy. The premium we accept to reinstate this policy will be used for a period for which premiums had not been paid. We must receive all back premiums for the policy to be reinstated.

Physical Examination: We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

Misstatement Of Age: If your age has been misstated, a premium adjustment will be made so that we receive the premiums that would have been due at the correct age.

Legal Action: You cannot bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You cannot start such an action more than three years after the date written proof of loss is required.

Other Insurance With Us: You may have only one policy like this one with us at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.

Insurance With Other Insurers (Expense-Incurred Benefits): If there is other valid coverage, not with us, providing benefits for the same loss on a provision-of-service basis or on an expense-incurred basis and of which we have not been given written notice prior to the occurrence or commencement of loss, the only liability under any expense-incurred coverage of this policy shall be for the proportion of the loss as the amount which would otherwise have been payable under this policy plus the total of the like amounts under all the other valid coverages for the same loss of which we have notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premiums paid as shall exceed the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision-of-service basis, the "like amount" of the other coverage shall be taken as the amount which the services rendered would have cost in the absence of the coverage.

Insurance With Other Insurers (Other Benefits): If there is other valid coverage, not with us, providing benefits for the same loss on other than an expense-incurred basis and of which we have not been given written notice prior to the occurrence or commencement of loss, the only liability for the benefits under this policy shall be for the proportion of the indemnities otherwise provided under this policy for the loss as the like indemnities of which we have notice, including the indemnities under this policy, bear to the total amount of all like indemnities for the loss, and for the return of the portion of the premiums paid as shall exceed the pro rata portion for the amount thus determined.

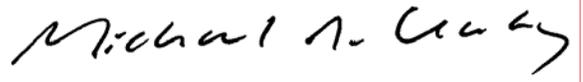
Term Of Coverage: Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first Policy Renewal Date. Each time you renew your policy, the new term begins when the old term ends.

Conformity With State Statutes: The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.

Our President and Secretary sign this policy in our behalf.



President



Secretary

Countersigned By _____
Licensed Resident Producer

MEDICO INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NEBRASKA 68124

SCHEDULE

POLICY NO. - [0000000]

POLICY TYPE – A18

INSURED - [JOHN E. DOE]
[1234 ANY STREET]
[ANYTOWN, USA 00000]

POLICY DATE [11/01/05]
FIRST RENEWAL DATE [11/01/06]
TOTAL FIRST PREMIUM \$ [XXXX.XX]
AGE AT ISSUE [62]

--- POLICY PREMIUMS---
[MODE] \$ [XXX.XX]

---- ANNUAL ----

POLICY YEAR DEDUCTIBLE\$100.00

POLICY YEAR MAXIMUM BENEFIT \$ [1,500.00]

POLICY A18

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by Medico™ Insurance Company. Your new policy provides 30 days after receipt of the policy within which you may decide whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) If, after due consideration, 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/health history. **FAILURE TO INCLUDE ALL MATERIAL MEDICAL INFORMATION ON AN APPLICATION MAY PROVIDE A BASIS FOR THE COMPANY TO DENY ANY FUTURE CLAIMS.** After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

(Date)

(Applicant's Signature)

(Agent's Signature)

**MEDICO™ INSURANCE COMPANY
Omaha, Nebraska**

**LIMITATIONS AND EXCLUSIONS UNDER THE
ARKANSAS LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities, or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
425 W. Capitol Ave.
Suite 3700
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are **NOT** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **NOT** provide coverage for:

- any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends and voting rights and experience rating credits;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution;
- portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

MEDICO™ INSURANCE COMPANY
1515 SOUTH 75TH STREET
OMAHA, NE 68124

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 1

TOLL-FREE CUSTOMER SERVICE

If you have any questions about your policy, you can call this Company's Toll-Free Customer Service Line at 1-800-228-6080 between 7:30 A.M. and 4:45 P.M., Monday through Thursday; and 7:30 A.M. and 11:30 A.M. on Friday, Central Time.

If you prefer to write to us, please direct your letter to the Policyholder Service Department, using the Company's name and address shown above.

Questions can also be directed to your producer. (Producer: Attach your business card below.)

In addition, you may submit written inquiries to:

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904

You may also call:

Arkansas Insurance Department
Consumer Services Division at
(800) 852-5494 or (501) 371-2640

SERFF Tracking Number: MDIC-125606274 *State:* Arkansas
Filing Company: Medico Insurance Company *State Tracking Number:* 38694
Company Tracking Number: CR-AR A18 DVH POLICY
TOI: H101 Individual Health - Dental *Sub-TOI:* H101.000 Health - Dental
Product Name: AR A18 DVH Policy
Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MDIC-125606274 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 38694
 Company Tracking Number: CR-AR A18 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18 DVH Policy
 Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	A18 rates	MI-DVA18	New		AR A18_rates as filed.pdf

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18
Gross Premium Code: A18 - Rate Group: A18
Dental/Vision/Hearing

RATE SCHEDULE - Arkansas
\$1,000 Annual Benefit Maximum

Issue Age	Premium
18 - 39	276.00
40 - 59	312.00
60 - 74	348.00
75 - 79	360.00
80 - 84	384.00

AVAILABLE DISCOUNT:
When two persons from the same household
are issued policies at the same time,
a 10% discount is applied to the premium rates

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 0.27
Bi-Monthly = 2/11
Monthly = 1/11

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 50% anticipated loss ratio.

MIRSA18(AR) 4/08

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18
Gross Premium Code: A18 - Rate Group: A18
Dental/Vision/Hearing

RATE SCHEDULE - Arkansas
\$1,500 Annual Benefit Maximum

Issue Age	Premium
18 - 39	372.60
40 - 59	421.20
60 - 74	469.80
75 - 79	486.00
80 - 84	518.40

AVAILABLE DISCOUNT:
When two persons from the same household
are issued policies at the same time,
a 10% discount is applied to the premium rates

MODAL FACTORS

Direct-Billed
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 0.27
Bi-Monthly = 2/11
Monthly = 1/11

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 3/12
Bi-Monthly = 2/12
Monthly = 1/12

Rates certify to a 50% anticipated loss ratio.

MIRSA18(AR) 4/08

SERFF Tracking Number: MDIC-125606274 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 38694
 Company Tracking Number: CR-AR A18 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18 DVH Policy
 Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 04/21/2008
Comments:
Attachment:
 AR-Certification.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 04/21/2008
Comments:
Attachment:
 MIHAA18(AR)-04072008.pdf

Satisfied -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 04/21/2008
Comments:
Attachment:
 AR DVH_A18_ActlMemo.pdf

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 04/21/2008
Comments:
Attachment:
 MI9F-4331(AR)-04072008.pdf

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 04/21/2008
Comments:
Attachment:
 AR cover letter.pdf

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 04/21/2008

SERFF Tracking Number: MDIC-125606274 *State:* Arkansas
Filing Company: Medico Insurance Company *State Tracking Number:* 38694
Company Tracking Number: CR-AR A18 DVH POLICY
TOI: H101 Individual Health - Dental *Sub-TOI:* H101.000 Health - Dental
Product Name: AR A18 DVH Policy
Project Name/Number: CR-AR A18 DVH Policy/CR-AR A18 DVH Policy

Comments:

Attachment:

AR-Flesch Certificate MIC.pdf

ARKANSAS CERTIFICATION

Medico™ Insurance Company hereby

Insurer

certifies that this filing complies with the requirements of Arkansas Insurance Rule and Regulation 19 as well as all other requirements of the Arkansas Insurance Department.


Signature

Desiree Buckley, VP & Director of Compliance
Officer's name and title

April 11, 2008
Date

Application for Dental, Vision and Hearing Insurance

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

Part A: General Information – Please Print
Applicant Information

Name _____ Date of Birth (Mo./Day/Yr.) _____ Age _____ Sex _____

Address _____
 Street Address _____ City _____ State _____ Zip _____

Social Security # _____

Phone # _____ E-mail Address _____

Co-Applicant Information

Name _____ Date of Birth (Mo./Day/Yr.) _____ Age _____ Sex _____

Social Security # _____ E-mail Address _____

Part B: Medical Information

	Applicant		Co-Applicant	
	Yes	No	Yes	No
1. (a) Do you currently wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you been advised to have any dental work which has not been completed? If "Yes," provide details: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. (a) Do you currently wear eyeglasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you received advice or treatment within the past nine months for correction of a vision problem? If "Yes," provide details: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. (a) Do you currently wear a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you been treated for hearing loss within the past nine months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part C: Applicant Information

1. (a) Do you have any dental, vision or hearing insurance currently in force?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company? If "Yes," provide type of contract or policy number, and name of company: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) If replacement is involved, have you received a replacement form (in states where required by law)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part D: Benefit Option
Applicant: Check the Benefit you prefer:

 Policy Year Maximum: \$1,000 \$1,500

Co-Applicant: Check the Benefit you prefer:

 Policy Year Maximum: \$1,000 \$1,500

Part E: Payment Options

Applicant: Provide the following information:

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

Frequency of Payment:

Monthly*

Bi-Monthly

Quarterly

Semi-Annually

Annually

*Monthly is not a payment option for Direct Bill.

Amount Received

Renewal

with Application \$ _____

Premium \$ _____

Requested Effective Date of Policy (optional) _____

(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Co-Applicant: Provide the following information:

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

Frequency of Payment:

Monthly*

Bi-Monthly

Quarterly

Semi-Annually

Annually

*Monthly is not a payment option for Direct Bill.

Amount Received

Renewal

with Application \$ _____

Premium \$ _____

Requested Effective Date of Policy (optional) _____

(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part F: Application Agreement

I hereby apply to Medico™ Insurance Company for a **Dental, Vision and Hearing 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 authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, or prescription/pharmaceutical database that has any record or knowledge of me or my health, to give to Medico™ Insurance Company any such information. I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for 24 months unless revoked by me in writing to the Home Office of Medico™ Insurance Company.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if you are eligible for Medicare and "A Guide to Health Insurance for People With Medicare" is required in your state:

Applicant Co-Applicant

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products . |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. I have received a hard copy of the Medicare Buyers Guide. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. I am not eligible for Medicare. |

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.

I acknowledge that in states where it is required, the producer met with me on this date, made the necessary inquiries concerning my insurance needs and proposed a program of insurance which is suitable for my needs. I am applying for this Dental, Vision and Hearing insurance.

Applicant's Signature _____ Date _____

Co-Applicant's Signature _____ Dated at _____
City State

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____



LIMITED BENEFIT POLICY
DENTAL, VISION AND HEARING COVERAGE

RETAIN THIS OUTLINE FOR YOUR RECORDS
THE POLICY IS NOT A MEDICARE SUPPLEMENT POLICY

READ YOUR POLICY CAREFULLY: This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract. Only the actual policy provisions will control. The policy sets forth in detail the rights and obligations of both you and your insurance company. It is therefore important that you **READ YOUR POLICY CAREFULLY**.

Limited Benefit Coverage: Policies of this type are designed to provide, to persons insured, limited or supplemental coverage. This policy does not provide any benefits other than the coverage described below.

BENEFITS PROVIDED BY THE POLICY

Policy Year Maximum Benefit: The maximum benefit we will pay during any one Policy Year. You may choose from:

- \$1,000 \$1,500

Policy Year Deductible: You are responsible for the first \$100 of Covered Expenses during each Policy Year.

After satisfaction of the \$100 Policy Year Deductible, the policy will pay the following percentages of actual charges, not to exceed Reasonable and Customary Charges for Covered Expenses up to the Policy Year Maximum Benefit based on the Policy Year:

- 60% – First Policy Year
70% – Second Policy Year
80% – Third Policy Year and thereafter

Covered Expenses, subject to the limitations described in the Exceptions and Limitations Section, are:

- (1) Dental services, performed by a licensed Dentist, including semi-annual examinations and cleanings, x-rays, the cost of fillings, prophylaxis, bridges, crowns, dentures and outpatient dental surgery prescribed as Medically Necessary.
- (2) Visits to a Physician for a basic eye examination or eye refraction, including the cost of eyeglasses or contact lenses prescribed by the Physician, up to a maximum benefit of \$150 in any one Policy Year.
- (3) Hearing examinations performed by a Physician or Audiologist, the purchase of hearing aids prescribed as Medically Necessary by a Physician or Audiologist, including the cost of the hearing aid and any necessary repairs.

After the policy has been in force three months, the policy will pay 100% of the cost of one dental cleaning up to a maximum benefit of \$50 each Policy Year. This benefit is not subject to the Policy Year Deductible; however, it is included in the Policy Year Maximum Benefit.

Reasonable and Customary Charges are the normal and prevailing charges, fees or expenses for the service rendered or for the material furnished in the geographic area where rendered or furnished.

EXCEPTIONS AND LIMITATIONS

Benefits will not be payable for the following items and/or services **during the first six months following the Policy Date:**

- (1) Root canals; or
- (2) Existing eyeglasses or contact lenses (including the renewal or changing of prescriptions).

Benefits will not be payable for the following items and/or services **during the first Policy Year:**

- (1) Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, “full mouth” extractions or fluoride treatments; or
- (2) Existing hearing aids.

Benefits will not be paid under this policy for: (1) any loss resulting from war, declared or undeclared; (2) any intentionally self-inflicted Injury; (3) any loss to which a contributing cause was your commission of or attempt to commit a felony or your being engaged in an illegal occupation; (4) any expense for which payment is provided under Medicare; (5) any services that are not recommended by a Physician, as defined by the policy; (6) any Experimental or Investigational procedure or treatment; (7) orthodontic treatment; (8) any expenses incurred for the diagnosis or treatment of temporomandibular joint disorder (TMJ), unless benefits are otherwise required by your state; (9) expenses incurred for surgical procedures (other than outpatient dental surgery) performed on an inpatient or outpatient basis (including any surgical procedure performed in the treatment of cataracts); (10) charges for radial keratotomy (RK), automated lamellar keratoplasty (ALK), conductive keratoplasty (CK) or other cosmetic procedures; (11) prescription drugs; (12) charges in excess of Reasonable and Customary Charges; (13) treatment or diagnosis received while outside the territorial limits of the United States; (14) services for which you are not liable or for which no charge normally is made in the absence of insurance; and (15) loss that occurs while the policy is not in force.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR DENTAL, VISION AND HEARING NEEDS.

RENEWABILITY AND PREMIUM CHANGES

Renewability – Guaranteed Renewable – This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums before the end of the grace period.

Terms Under Which We May Change Premiums – We can change premiums only if we do the same to all policies of this form issued to persons of your class in your state, and we notify you in advance of the due date. “Class” means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under the policy. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium.

PREMIUMS

MONTHLY BANK DRAFT	QUARTERLY	SEMI-ANNUALLY	ANNUALLY

Premiums are subject to change on a limited basis, as stated above. You have a 31-day grace period in which to pay your premium. Your policy stays in force during your grace period.



MEDICO™ GROUP

Medico™ Insurance Company • Medico™ Life Insurance Company

April 11, 2008

MEDICO INSURANCE COMPANY
NAIC # 31119

Commissioner Julie Benafield Bowman
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Individual Dental, Vision and Hearing Policy

Enclosed Material:

MI-DVA18 – Policy
MI9F-4331(AR) – Outline of Coverage
MIHAA18(AR) - Application
MI9F-1060 – Replacement Notice
MI9F-2701(AR) – Guaranty Association Notice
UR-AR-763 – Toll-Free Customer Service Notice
Actuarial Memorandum and rate sheets
Flesch Certification
Filing Fee - \$50.00

Enclosed, you will find Individual Dental, Vision and Hearing Policy and accompanying forms for your approval. These new forms will not replace any forms currently on file with your Department.

MI-DVA18 is a limited benefit policy. This form is new and will be used to provide benefits for dental, vision and hearing. The applicant may select a policy year maximum amount of \$1,000 or \$1,500.

We intend to offer this new policy through our producers to eligible individuals who are ages 18 through 84. A sample schedule is attached to the policy. Any information contained in the brackets will vary to fit each policyholder. The outline of coverage will be furnished to each applicant as required by state law.

A copy of the application is enclosed for your approval.

MI9F-1060 will be used when required by state law. I would like to request approval of this form so it can be used with any similar products the company may have approved in the future.

We will not attach any elimination waivers or riders to exclude, limit or reduce coverage or benefits for named pre-existing conditions or physical conditions beyond any stated waiting period.

The Guaranty Association Notice will be delivered with the policy. Also the Toll-Free Customer Service Notice will be delivered with the policy, as required by law.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please feel free to contact me.

Sincerely,

Cathy Richter
Compliance Assistant II
1-800-695-5976 Ext. 236
Fax (402) 391-4858
cathyrichter@gomedico.com

Protecting Your Future Today®

FLESCH READABILITY CERTIFICATION

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

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The Flesch Readability Score was computed to be _____.

Form Number _____ has been Flesch tested.
The Flesch Readability Score was computed to be _____.

MEDICO INSURANCE COMPANY



Desiree Buckley
Vice President, Director of Compliance