

SERFF Tracking Number: MDIC-125998949 State: Arkansas  
Filing Company: Medico Insurance Company State Tracking Number: 41900  
Company Tracking Number: AR A12 INDEMNITY POLICY  
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: AR A12 Indemnity Policy  
Project Name/Number: LM AR A12 Indemnity Policy/LM AR A12 Indemnity Policy

## Filing at a Glance

Company: Medico Insurance Company  
Product Name: AR A12 Indemnity Policy SERFF Tr Num: MDIC-125998949 State: ArkansasLH  
TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 41900  
Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: AR A12 INDEMNITY POLICY State Status: Approved-Closed  
Filing Type: Form/Rate Co Status: Reviewer(s): Rosalind Minor  
Author: Luanne Melies Disposition Date: 01/28/2009  
Date Submitted: 01/21/2009 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: LM AR A12 Indemnity Policy Status of Filing in Domicile: Pending  
Project Number: LM AR A12 Indemnity Policy Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments: We have filed in  
Nebraska, our state of domicile, and are  
awaiting their approval.  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 01/28/2009 Deemer Date:  
State Status Changed: 01/28/2009  
Corresponding Filing Tracking Number:  
Filing Description:  
Filing of our new Indemnity Benefit A12 policy with associated forms.

## Company and Contact

SERFF Tracking Number: MDIC-125998949 State: Arkansas  
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**Filing Contact Information**

Luanne Melies, Compliance Analyst Imelies@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	

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: One New Policy Filing @ \$50.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$50.00	01/21/2009	25169429

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/28/2009	01/28/2009

*SERFF Tracking Number:* MDIC-125998949      *State:* Arkansas  
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## **Disposition**

Disposition Date: 01/28/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved-Closed	No
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	Previously Approved Forms	Approved-Closed	Yes
<b>Supporting Document</b>	Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	AR Fee Certificatin	Approved-Closed	Yes
<b>Form</b>	Policy	Approved-Closed	Yes
<b>Form</b>	Schedule	Approved-Closed	Yes
<b>Form</b>	Medicare Duplication Form	Approved-Closed	Yes
<b>Form</b>	Daily Hospital Indemnity Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Physician Services Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Registered Nurse At Home Indemnity Benefit Rider	Approved-Closed	Yes
<b>Form</b>	Daily Skilled Nursing Facility Indemnity Benefit Rider	Approved-Closed	Yes
<b>Rate</b>	AR A12 rates	Approved-Closed	Yes
<b>Rate</b>	AR A12G rates	Approved-Closed	Yes

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## Form Schedule

**Lead Form Number:** MI-HIA12(AR)

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MI-HIA12(AR)	Policy/Cont	Policy ract/Fratern al Certificate	Initial			MI-HIA12(AR)-01212009.pdf
Approved-Closed	A12 SCHEDULE E	Schedule	Schedule Pages	Initial			A12 Schedule.pdf
Approved-Closed	MI9F-4185HI	Other	Medicare Duplication Form	Initial			MI9F-4185HI-01152009.pdf
Approved-Closed	MIRA13	Policy/Cont	Daily Hospital ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			MIRA13-12152008.pdf
Approved-Closed	MIRA14	Policy/Cont	Physician Services ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			MIRA14-01082009.pdf
Approved-Closed	MIRA15	Policy/Cont	Registered Nurse At ract/Fratern al Certificate: Amendmen	Initial			MIRA15-12152008.pdf

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MIRA16-  
12222008.pdf





**MEDICO™**  
**INSURANCE COMPANY**

**A STOCK INSURANCE COMPANY**

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

## INDEMNITY BENEFIT 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 policy Schedule. The policy 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, or optional riders attached to this form, which are 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 or any rider, we will send you written notice at least 30 days (31 days in SC; 45 days in MT; 60 days in MS, NM and NV) before your premium is due.

**NOTICE TO BUYER: This policy may not cover all of the costs incurred by the buyer during the period of coverage. The buyer is advised to carefully review all policy limitations.**

## LIMITED BENEFIT INSURANCE POLICY FOR HOSPITAL CONFINEMENT AND AMBULANCE BENEFITS

## ALPHABETICAL GUIDE TO YOUR POLICY

	<b>Part</b>		<b>Part</b>
Benefits .....	E	Renewal Agreement And Premium Change .....	B
Definitions .....	D	Right To Return .....	A
Exceptions And Limitations .....	C	Other Important Provisions .....	H
How To File A Claim .....	F	Schedule .....	Last Page
Payment Of Claims .....	G		

### PART C

### EXCEPTIONS AND LIMITATIONS

We will NOT pay benefits for:

1. any loss that occurs while this policy is not in force;
2. suicide or any suicide attempt while sane or insane (in Missouri, while sane) or any intentionally self-inflicted injury;
3. Mental or Nervous Disorders without demonstrable organic disease (**subject to the other policy provisions, we will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the policy**);
4. alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician;
5. injuries received or caused directly or indirectly while under the influence of a controlled substance, unless prescribed by a Physician, or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred;
6. loss to which a contributing cause was your commission of or attempt to commit a felony or being engaged in an illegal occupation;
7. service rendered by any agency of the federal or state government unless the Insured is legally obligated to pay for such service (Medicare and Medicaid are not excluded);
8. service for which benefits are available for you under state or federal workers' compensation;
9. loss that occurs outside the territorial limits of the United States;
10. any loss resulting from war, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent;
11. durable medical equipment (D.M.E.), prosthetics or orthopedic shoes;
12. drugs and self-administered drugs;
13. physical therapy, occupational therapy or speech therapy;
14. dental operations or dental treatment (except expenses otherwise covered due to Injury to sound natural teeth); ordinary dental care, dentures and dental implants; eyeglasses and hearing aids (and examinations for them); and cosmetic surgery, except for reconstructive surgery which is incidental to or follows surgery;
15. any loss resulting from aviation as other than a fare-paying passenger;
16. pregnancy, unless due to Complications of Pregnancy;
17. elective procedures that are not Medically Necessary, including, but not limited to organ donation, elective sterilization and fertility treatments; or
18. Hospital Confinement primarily for rest care, convalescent care or for rehabilitation.

Pre-Existing Conditions Limitation: We will NOT pay benefits for any loss for Pre-Existing Conditions during the first three months after the Policy Date.

### PART D

### DEFINITIONS

**Certain words have been capitalized throughout this policy to indicate that they have the specific meanings set out below:**

When we use the following words in this policy or in any optional rider, this is what we mean:

Ambulance: A vehicle which is licensed solely as an Ambulance or rescue service by the local regulatory body to provide transportation to a Hospital; transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means; or if the Hospital cannot provide the needed care.

Complications of Pregnancy: A condition (when the pregnancy is not terminated), the diagnosis of which is distinct from pregnancy, but which is adversely affected by pregnancy or caused by pregnancy, and includes, but is not limited to:

1. acute nephritis;
2. nephrosis;
3. cardiac decompensation;
4. missed abortion and similar medical and surgical conditions of comparable severity;
5. an ectopic pregnancy which is surgically terminated or spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible;
6. nonelective Cesarean section; or
7. pernicious vomiting (hyperemesis gravidarum), preeclampsia and toxemia with convulsions (eclampsia of pregnancy).

Complications of Pregnancy cease upon termination of the pregnancy.

Complications of Pregnancy do not include:

1. false labor;
2. preterm contractions of labor;
3. advanced maternal age;
4. occasional spotting;
5. nonemergency Caesarean section;
6. Physician-prescribed rest during the period of pregnancy;
7. morning sickness; or
8. similar conditions which, although associated with the management of a difficult pregnancy and back pain, are not medically classified as distinct Complications of Pregnancy.

Confined or Confinement: Medically Necessary and continuous Confinement within a Hospital as an inpatient, under the care of a Physician, due to Injury or Sickness.

Covered Care: Medically Necessary care or services due to Injury or Sickness for which benefits are payable under this policy.

Hospital: Except as excluded in the following paragraph, a Hospital is an institution licensed or certified as a Hospital by the state in which it is located that:

1. charges for its services;
2. is devoted primarily to the diagnosis, care and treatment of Injury or Sickness requiring resident inpatient stays of 24 hours or more;
3. has licensed professional Nurses on duty 24 hours a day who are under the direction of a Physician; and
4. provides medical, radiological, dietary, surgical and pharmaceutical services to two or more unrelated individuals suffering from Injury or Sickness.

“Hospital” does not include an institution, or part of an institution (regardless of name or location), that is functioning primarily as:

1. a clinic, rest home, convalescent home, home for the aged or assisted living facility or unit;
2. a nursing home facility or unit;
3. a swing bed unit;
4. a rehabilitation unit or facility;
5. a skilled nursing, intermediate care, extended care or custodial care facility or unit;
6. a domiciliary, housing or residential facility or unit;
7. a hospice unit;
8. a psychiatric unit; or
9. an alcohol, drug, or substance abuse treatment facility or unit.

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

Injury: Accidental bodily Injury that results in loss, independent of Sickness or other causes.

Medically Necessary: That service or care which is:

- (a) prescribed by a Physician;
- (b) considered to be necessary and appropriate for the diagnosis and treatment of the condition; or
- (c) commonly accepted as the most efficient and economical care or service which can be safely provided in keeping with current medical practices.

Medically Necessary care does not include care:

- (a) provided only as a convenience to you or the provider; or
- (b) which is in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment. The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

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

Mental or Nervous Disorder: Any disorder listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, excluding Alzheimer's disease, dementia and organic brain damage caused by an accident or head trauma.

Nurse: A person duly licensed and legally entitled to practice as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) in the state or jurisdiction in which services are performed, other than a member of your Immediate Family.

Period of Care: Begins with the first day of Confinement as an inpatient in a Hospital and ends when you have been out of the Hospital 60 continuous days.

Physician: A licensed practitioner of the healing arts acting within the scope of his/her license and legally entitled to practice in the state or jurisdiction in which services are performed, other than a member of your Immediate Family. Practitioners of homeopathic, naturopathic and related medicines are not Physicians.

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

Pre-Existing Condition: Any condition for which you received treatment or medical advice within the 12 months prior to the Policy Date will not be covered during the first 3 months after the Policy Date.

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

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

Sickness: An illness or disease that you have or acquire.

Usual 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.

We, Us or Our: Medico™ Insurance Company.

You or Your: The Insured named in the policy Schedule.

## PART E

## BENEFITS

We will pay the following benefits for expenses due to Medically Necessary Covered Care:

**Hospital Confinement Indemnity Benefit:** We will pay a \$1,000 benefit once per each Period of Care when you are Confined in a Hospital as an inpatient and receive Covered Care.

**Ambulance Benefit:** We will pay \$100 per calendar year if a licensed Ambulance or rescue service transports you to or from a Hospital where you are confined as an inpatient for Covered Care.

**Waiver of Premium Benefit:** After four continuous weeks of your Confinement for Covered Care, we will waive the monthly premiums that come due thereafter during the continued Confinement.

## PART F

## HOW TO FILE A CLAIM

**Notice of Claim:** You must give us written notice of a claim within 20 days (60 days in KY and WY; six months in MT) 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, 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 (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable).

**Proof of Loss:** You must give us written proof of your loss within 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. Proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

## PART G

## PAYMENT OF CLAIMS

**Time of Payment of Claims:** Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid as soon as we receive your proof of loss. Benefits unpaid when our liability ends are paid when we receive your proof of loss.

**Payment of Claims:** Benefits will be paid directly to you unless you assign your benefits. 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 KY and NE) 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.

**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:** After two years from the Policy Date, no misstatements, except fraudulent misstatements in the application for the policy, can be used to void the policy or to deny a claim for loss incurred or disability commencing after the expiration of such two-year period.

**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.

**Refund of Premium Upon Your Death:** Upon your death, we will return the premium for your coverage that was paid in advance beyond the end of the month in which your death occurred.

**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 any such conditions to reinstatement, 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.

**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.

**Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.

**Misstatement of Age:** If your age has been misstated, an adjustment in premiums, coverage or both will be made, based on your true age. No misstatement of age will continue insurance otherwise validly terminated, or terminate insurance otherwise validly in force.

**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.

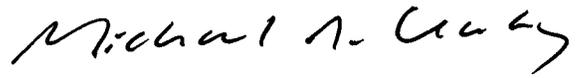
**Term of Coverage:** Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.

**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.

A handwritten signature in black ink, appearing to read "Justin Gray". The signature is fluid and cursive, with the first name "Justin" written in a larger, more prominent script than the last name "Gray".

President

A handwritten signature in black ink, appearing to read "Michael A. Casey". The signature is written in a cursive style, with the first name "Michael" and the last name "Casey" being the most legible parts.

Secretary

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

SCHEDULE

POLICY NO. - [0000000]

POLICY TYPE – A12

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

POLICY DATE ..... [01/01/09]  
FIRST RENEWAL DATE ..... [01/01/10]  
TOTAL FIRST PREMIUM ..... \$ [XXXX.XX]  
AGE AT ISSUE ..... [62]

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

A12 POLICY  
HOSPITAL CONFINEMENT INDEMNITY BENEFIT - \$1,000.00

OPTIONAL RIDERS .....--[MODE]--

MIRA13 DAILY HOSPITAL INDEMNITY BENEFIT RIDER PREMIUM..... \$ [XXX.XX]  
DAILY HOSPITAL BENEFIT – [\$50, \$100, \$150, \$200]

MIRA14 PHYSICIAN SERVICES BENEFIT  
RIDER PREMIUM..... \$ [XXX.XX]

MIRA15 REGISTERED NURSE AT-HOME INDEMNITY BENEFIT  
RIDER PREMIUM..... \$ [XXX.XX]  
REGISTERED NURSE SHIFT AMOUNT – [\$50, \$100]

MIRA16 DAILY SKILLED NURSING FACILITY INDEMNITY BENEFIT  
RIDER PREMIUM..... \$ [XXX.XX]  
DAILY SKILLED NURSING INDEMNITY BENEFIT – [\$50, \$100, \$150, \$200]  
ELIMINATION PERIOD – 20 DAYS

TOTAL POLICY AND RIDER PREMIUM.....\$ [XXXX.XX]

**IMPORTANT NOTICE TO PERSONS ON MEDICARE  
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services 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:**

- any of the services covered by the policy are also covered by Medicare

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

- hospitalization
- physician services
- 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.

**MEDICO™ INSURANCE COMPANY**  
1515 SOUTH 75<sup>TH</sup> STREET  
OMAHA, NE 68124

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 1

**DAILY HOSPITAL INDEMNITY BENEFIT RIDER**

**RIDER SCHEDULE**

**INSURED: COMPUTER SAMPLE**

**RIDER DATE (SAME AS POLICY DATE, IF NO DATE SHOWN): MM/DD/YYYY**

**RIDER PREMIUM (SEE POLICY SCHEDULE, IF NO AMOUNT SHOWN): \$999,999.99**

**DAILY HOSPITAL BENEFIT: \$999.99**

The additional premium you paid and your application put this rider in force. This rider is part of the policy to which it is attached. All the policy provisions that are not inconsistent with the rider provisions apply to this rider. When applying them, the word “policy” is changed to the word “rider.”

**BENEFIT**

We will pay the Daily Hospital Benefit for each day you are Confined to a Hospital for Medically Necessary Covered Care, up to 14 days per Period of Care, beginning with the first day of Confinement. Benefits are payable only when the Hospital Confinement is covered under the policy to which this rider is attached.

**TERM OF COVERAGE**

This coverage starts on the Rider Date at 12:01 a.m. standard time, where you live. It terminates at 12:01 a.m. standard time, on the first renewal date. Each time you renew your rider, the new term begins when the old term ends.

**ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.**



President

**MEDICO™ INSURANCE COMPANY**  
1515 SOUTH 75<sup>TH</sup> STREET  
OMAHA, NE 68124

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 1

**PHYSICIAN SERVICES BENEFIT RIDER**

**RIDER SCHEDULE**

**INSURED: COMPUTER SAMPLE**

**RIDER DATE (SAME AS POLICY DATE, IF NO DATE SHOWN): MM/DD/YYYY**

**RIDER PREMIUM (SEE POLICY SCHEDULE, IF NO AMOUNT SHOWN): \$999,999.99**

The additional premium you paid and your application put this rider in force. This rider is part of the policy to which it is attached. All the policy provisions that are not inconsistent with the rider provisions apply to this rider. When applying them, the word “policy” is changed to the word “rider.”

**BENEFIT**

When you require the services of a Physician for Covered Care, in or out of the Hospital, and incur a charge, we will pay up to \$1,000 each calendar year for Medically Necessary charges as listed below.

1. Physician Services Benefit: We will pay 20% of the Usual and Customary Charge, not to exceed your incurred charge, for services by a Physician, including services provided by a surgeon, anesthesiologist or a certified registered nurse anesthetist (C.R.N.A.).
2. Lab and X-Ray Benefit: We will pay 20% of the Usual and Customary Charge, not to exceed your incurred charge, for laboratory charges or services of a radiologist.

During any one calendar year, the combined benefits under 1 and 2 shall not exceed \$1,000.00.

Routine physical examinations and immunizations are not covered.

**TERM OF COVERAGE**

This coverage starts on the Rider Date at 12:01 a.m. standard time, where you live. It terminates at 12:01 a.m. standard time, on the first renewal date. Each time you renew your rider, the new term begins when the old term ends.

**ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.**



President

**MEDICO™ INSURANCE COMPANY**  
1515 SOUTH 75<sup>TH</sup> STREET  
OMAHA, NE 68124

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 1

**REGISTERED NURSE AT-HOME INDEMNITY BENEFIT RIDER**

**RIDER SCHEDULE**

**INSURED: COMPUTER SAMPLE**

**RIDER DATE (SAME AS POLICY DATE, IF NO DATE SHOWN): MM/DD/YYYY**

**RIDER PREMIUM (SEE POLICY SCHEDULE, IF NO AMOUNT SHOWN): \$999,999.99**

**REGISTERED NURSE SHIFT AMOUNT: \$999.99**

The additional premium you paid and your application put this rider in force. This rider is part of the policy to which it is attached. All the policy provisions that are not inconsistent with the rider provisions apply to this rider. When applying them, the word “policy” is changed to the word “rider.”

**DEFINITION**

**Home:** Any place where you reside other than an institutional setting. Home does not include a nursing facility, assisted living facility, Hospital or any residential care facility.

**BENEFIT**

We will pay the Registered Nurse Shift Amount per shift, up to 2 shifts per day, for up to 30 days following a Hospital Confinement for each Period of Care when a Physician certifies that services of a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) are Medically Necessary for the treatment of Covered Care in your Home. Continuous periods of service within the same day which total eight hours or less will be considered as one shift. These services must begin within one week following discharge from the Hospital.

**TERM OF COVERAGE**

This coverage starts on the Rider Date at 12:01 a.m. standard time, where you live. It terminates at 12:01 a.m. standard time, on the first renewal date. Each time you renew your rider, the new term begins when the old term ends.

**ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.**



President

**MEDICO™ INSURANCE COMPANY**  
1515 SOUTH 75<sup>TH</sup> STREET  
OMAHA, NE 68124

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 2

**DAILY SKILLED NURSING FACILITY INDEMNITY BENEFIT RIDER**

**RIDER SCHEDULE**

**INSURED: COMPUTER SAMPLE**

**RIDER DATE (SAME AS POLICY DATE, IF NO DATE SHOWN): MM/DD/YYYY**

**RIDER PREMIUM (SEE POLICY SCHEDULE, IF NO AMOUNT SHOWN): \$999,999.99**

**DAILY SKILLED NURSING FACILITY INDEMNITY BENEFIT: \$999.99**

The additional premium you paid and your application put this rider in force. This rider is part of the policy to which it is attached. All the policy provisions that are not inconsistent with the rider provisions apply to this rider. When applying them, the word “policy” is changed to the word “rider.”

**DEFINITIONS**

**Elimination Period:** The number of days for which no benefits are payable. The Elimination Period starts on the date that benefits would otherwise begin and is in effect for 20 days. Only days in which services are actually rendered will satisfy your Elimination Period. Only one Elimination Period will be applied to any one Skilled Nursing Facility Period of Care.

**Skilled Nursing Facility:** A facility, or that part of a facility, which includes all of the following:

1. is licensed by the state as a Skilled Nursing Facility;
2. provides skilled care, rehabilitation, or related services and associated treatment prescribed by and under the supervision of a Physician;
3. provides 24-hour-a-day nursing services delivered by a team of licensed professional Nurses and certified nursing assistants, under the supervision of a Registered Nurse (R.N.) to persons who have a Sickness or Injury;
4. keeps a daily medical record of each patient; and
5. provides full-time bed care for resident patients.

A Skilled Nursing Facility does not include an intermediate nursing facility, a custodial care facility, an assisted living facility, or a place that is used primarily for: persons suffering from a Mental or Nervous Disorder (other than those due to organic disease), educational care, the treatment of alcohol or drug problems, hospice care, or a home for rest or for the aged.

**Skilled Nursing Care:** Is (a) active nursing services needed to treat an unstable condition, including, but not limited to the monitoring of vital signs, the administration of drugs, biologicals, injectables and intravenous procedures; and/or (b) active rehabilitation services needed to regain a lost function. These services must be Medically Necessary and must require the skills of licensed or certified technical or professional personnel. In each case, there must be a plan of care for the patient’s recovery. This care must be given on a daily basis. A Physician must certify that you need such care. The director or administrator of the Skilled Nursing Facility must certify that you actually receive this level of care.

Skilled Nursing Care is not: intermediate nursing care; custodial care; care that can be learned and given by unlicensed or uncertified medical personnel; routine health care services; general maintenance; routine administration of oral or nonprescription drugs; or general supervision of routine daily activities.

**Skilled Nursing Facility Period of Care:** Begins with the first day you are confined to a Skilled Nursing Facility. It ends when you have been out of any Skilled Nursing Facility for 180 continuous days.

**BENEFIT**

When you are confined to a Skilled Nursing Facility and receive Skilled Nursing Care that is Medically Necessary, we will pay the Daily Skilled Nursing Indemnity Benefit for each day of confinement up to 90 days for each Skilled Nursing Facility Period of Care, subject to the Elimination Period shown in the policy Schedule. Only one Elimination Period will be applied to any one Skilled Nursing Facility Period of Care.

**TERM OF COVERAGE**

This coverage starts on the Rider Date at 12:01 a.m. standard time, where you live. It terminates at 12:01 a.m. standard time, on the first renewal date. Each time you renew your rider, the new term begins when the old term ends.

**ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.**



President

*SERFF Tracking Number:* MDIC-125998949      *State:* Arkansas  
*Filing Company:* Medico Insurance Company      *State Tracking Number:* 41900  
*Company Tracking Number:* AR A12 INDEMNITY POLICY  
*TOI:* H14I Individual Health - Hospital Indemnity      *Sub-TOI:* H14I.000 Health - Hospital Indemnity  
*Product Name:* AR A12 Indemnity Policy  
*Project Name/Number:* LM AR A12 Indemnity Policy/LM AR A12 Indemnity Policy

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: MDIC-125998949 State: Arkansas  
 Filing Company: Medico Insurance Company State Tracking Number: 41900  
 Company Tracking Number: AR A12 INDEMNITY POLICY  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: AR A12 Indemnity Policy  
 Project Name/Number: LM AR A12 Indemnity Policy/LM AR A12 Indemnity Policy

## Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	AR A12 rates	Individual Rates	New		AR A12 rates as filed.pdf
Approved-Closed	AR A12G rates	Association Rates	New		AR A12G rates as filed.pdf

Medico™ Insurance Company  
Omaha, Nebraska  
MI-HIA12  
Gross Premium Code: A12 - Rate Group: A12  
Indemnity Benefit Policy

RATE SCHEDULE - Arkansas

Issue Age	Premium
18 - 49	257.06
50	274.78
51	293.33
52	312.05
53	325.90
54	339.39
55	352.53
56	365.35
57	377.86
58	391.47
59	404.91
60	418.20
61	431.35
62	444.36
63	457.24
64	469.98
65	482.58
66	493.19
67	504.58
68	527.23
69	551.50
70	576.76
71	602.98
72	630.19
73	651.37
74	673.10
75	695.22
76	717.78
77	740.68
78	753.25
79	764.85
80	775.76
81	786.05
82	795.63
83	833.14
84	872.53

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA13  
Gross Premium Code: A13 - Rate Group: A12  
Daily Hospital Indemnity Benefit Rider

RATE SCHEDULE - Arkansas

Issue Age	Per \$50 Daily Benefit Premium
18 - 49	78.27
50	82.51
51	86.98
52	91.69
53	96.31
54	101.16
55	106.25
56	111.60
57	117.21
58	123.12
59	129.32
60	135.82
61	142.66
62	149.85
63	157.40
64	165.32
65	173.64
66	182.38
67	191.56
68	201.03
69	210.96
70	221.39
71	232.34
72	243.81
73	255.87
74	268.50
75	281.78
76	295.70
77	310.31
78	325.65
79	341.74
80	358.63
81	376.35
82	394.95
83	414.46
84	434.94

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA14  
Gross Premium Code: A14 - Rate Group: A12  
Physician Services Benefit Rider

RATE SCHEDULE - Arkansas

Issue Age	Premium
18 - 49	219.40
50	227.18
51	235.16
52	243.33
53	251.69
54	260.25
55	269.03
56	278.02
57	287.23
58	296.67
59	306.32
60	316.22
61	326.35
62	336.73
63	347.35
64	358.23
65	369.37
66	380.77
67	392.44
68	396.61
69	400.81
70	405.05
71	409.32
72	413.62
73	417.95
74	422.32
75	426.72
76	431.16
77	435.62
78	440.11
79	444.64
80	449.20
81	453.80
82	458.42
83	463.09
84	467.82

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA15  
Gross Premium Code: A15 - Rate Group: A12  
Registered Nurse At-Home Indemnity Rider

RATE SCHEDULE - Arkansas

\$50 Per Visit Benefit  
Issue Age      Premium

18 - 49	58.67
50	61.46
51	64.29
52	67.14
53	72.30
54	77.84
55	83.80
56	90.21
57	97.07
58	104.46
59	112.37
60	120.88
61	130.00
62	139.79
63	150.27
64	161.53
65	173.58
66	186.50
67	200.34
68	215.41
69	231.57
70	248.88
71	267.45
72	287.34
73	308.64
74	331.46
75	355.87
76	382.00
77	409.94
78	439.82
79	471.77
80	505.89
81	542.35
82	581.26
83	622.96
84	667.67

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA16  
Gross Premium Code: A16 - Rate Group: A12  
Daily Skilled Nursing Indemnity Benefit Rider

RATE SCHEDULE - Arkansas

Issue Age	Per \$50 Daily Benefit Premium
18 - 49	15.36
50	16.90
51	18.57
52	20.42
53	22.24
54	24.20
55	26.35
56	28.69
57	31.23
58	33.99
59	37.00
60	40.27
61	43.83
62	47.69
63	51.89
64	56.47
65	61.44
66	66.85
67	72.72
68	77.89
69	83.41
70	89.32
71	95.64
72	102.40
73	109.63
74	117.37
75	125.63
76	134.47
77	143.91
78	154.02
79	164.81
80	176.34
81	188.68
82	201.85
83	215.94
84	231.01

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-HIA12  
 Gross Premium Code: A12G - Rate Group: A12  
 Indemnity Benefit Policy - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 5%		
Issue Age	Individual Premium	Household Premium
18 - 49	244.21	218.50
50	261.04	233.56
51	278.66	249.33
52	296.45	265.24
53	309.61	277.02
54	322.42	288.48
55	334.90	299.65
56	347.08	310.55
57	358.97	321.18
58	371.90	332.75
59	384.66	344.17
60	397.29	355.47
61	409.78	366.65
62	422.14	377.71
63	434.38	388.65
64	446.48	399.48
65	458.45	410.19
66	468.53	419.21
67	479.35	428.89
68	500.87	448.15
69	523.93	468.78
70	547.92	490.25
71	572.83	512.53
72	598.68	535.66
73	618.80	553.66
74	639.45	572.14
75	660.46	590.94
76	681.89	610.11
77	703.65	629.58
78	715.59	640.26
79	726.61	650.12
80	736.97	659.40
81	746.75	668.14
82	755.85	676.29
83	791.48	708.17
84	828.90	741.65

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-HIA12  
 Gross Premium Code: A12G - Rate Group: A12  
 Indemnity Benefit Policy - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 10%

Issue Age	Individual Premium	Household Premium
18 - 49	231.35	218.50
50	247.30	233.56
51	264.00	249.33
52	280.85	265.24
53	293.31	277.02
54	305.45	288.48
55	317.28	299.65
56	328.82	310.55
57	340.07	321.18
58	352.32	332.75
59	364.42	344.17
60	376.38	355.47
61	388.22	366.65
62	399.92	377.71
63	411.52	388.65
64	422.98	399.48
65	434.32	410.19
66	443.87	419.21
67	454.12	428.89
68	474.51	448.15
69	496.35	468.78
70	519.08	490.25
71	542.68	512.53
72	567.17	535.66
73	586.23	553.66
74	605.79	572.14
75	625.70	590.94
76	646.00	610.11
77	666.61	629.58
78	677.93	640.26
79	688.37	650.12
80	698.18	659.40
81	707.45	668.14
82	716.07	676.29
83	749.83	708.17
84	785.28	741.65

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-HIA12  
Gross Premium Code: A12G - Rate Group: A12  
Indemnity Benefit Policy - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 15%	
Individual	
Issue Age	Premium
18 - 49	218.50
50	233.56
51	249.33
52	265.24
53	277.02
54	288.48
55	299.65
56	310.55
57	321.18
58	332.75
59	344.17
60	355.47
61	366.65
62	377.71
63	388.65
64	399.48
65	410.19
66	419.21
67	428.89
68	448.15
69	468.78
70	490.25
71	512.53
72	535.66
73	553.66
74	572.14
75	590.94
76	610.11
77	629.58
78	640.26
79	650.12
80	659.40
81	668.14
82	676.29
83	708.17
84	741.65

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA13  
 Gross Premium Code: A13G - Rate Group: A12  
 Daily Hospital Indemnity Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 5%  
 Per \$50 Daily Benefit

Issue Age	Individual Premium	Household Premium
18 - 49	74.35	66.53
50	78.38	70.13
51	82.63	73.93
52	87.11	77.94
53	91.50	81.86
54	96.10	85.98
55	100.93	90.31
56	106.02	94.86
57	111.35	99.63
58	116.96	104.65
59	122.85	109.92
60	129.03	115.45
61	135.53	121.26
62	142.35	127.37
63	149.53	133.79
64	157.05	140.52
65	164.95	147.59
66	173.26	155.02
67	181.98	162.83
68	190.98	170.88
69	200.42	179.32
70	210.32	188.18
71	220.72	197.49
72	231.62	207.24
73	243.07	217.49
74	255.08	228.23
75	267.69	239.51
76	280.91	251.34
77	294.80	263.77
78	309.37	276.80
79	324.66	290.48
80	340.69	304.83
81	357.53	319.90
82	375.20	335.70
83	393.74	352.29
84	413.20	369.70

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA13  
 Gross Premium Code: A13G - Rate Group: A12  
 Daily Hospital Indemnity Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 10%  
 Per \$50 Daily Benefit

Issue Age	Individual Premium	Household Premium
18 - 49	70.44	66.53
50	74.26	70.13
51	78.28	73.93
52	82.52	77.94
53	86.68	81.86
54	91.04	85.98
55	95.62	90.31
56	100.44	94.86
57	105.49	99.63
58	110.81	104.65
59	116.39	109.92
60	122.24	115.45
61	128.40	121.26
62	134.86	127.37
63	141.66	133.79
64	148.79	140.52
65	156.27	147.59
66	164.14	155.02
67	172.41	162.83
68	180.93	170.88
69	189.87	179.32
70	199.25	188.18
71	209.10	197.49
72	219.43	207.24
73	230.28	217.49
74	241.65	228.23
75	253.60	239.51
76	266.13	251.34
77	279.28	263.77
78	293.09	276.80
79	307.57	290.48
80	322.76	304.83
81	338.72	319.90
82	355.45	335.70
83	373.02	352.29
84	391.45	369.70

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA13  
Gross Premium Code: A13G - Rate Group: A12  
Daily Hospital Indemnity Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 15%  
Per \$50 Daily Benefit

Issue Age	Individual Premium
18 - 49	66.53
50	70.13
51	73.93
52	77.94
53	81.86
54	85.98
55	90.31
56	94.86
57	99.63
58	104.65
59	109.92
60	115.45
61	121.26
62	127.37
63	133.79
64	140.52
65	147.59
66	155.02
67	162.83
68	170.88
69	179.32
70	188.18
71	197.49
72	207.24
73	217.49
74	228.23
75	239.51
76	251.34
77	263.77
78	276.80
79	290.48
80	304.83
81	319.90
82	335.70
83	352.29
84	369.70

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA14  
 Gross Premium Code: A14G - Rate Group: A12  
 Physician Services Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 5%		
Issue Age	Individual Premium	Household Premium
18 - 49	208.43	186.49
50	215.82	193.10
51	223.40	199.89
52	231.16	206.83
53	239.11	213.94
54	247.24	221.22
55	255.58	228.67
56	264.12	236.32
57	272.87	244.14
58	281.83	252.17
59	291.01	260.38
60	300.41	268.79
61	310.04	277.40
62	319.89	286.22
63	329.98	295.25
64	340.32	304.50
65	350.90	313.96
66	361.74	323.66
67	372.82	333.58
68	376.78	337.12
69	380.77	340.69
70	384.79	344.29
71	388.85	347.92
72	392.94	351.58
73	397.05	355.26
74	401.21	358.97
75	405.39	362.71
76	409.60	366.48
77	413.84	370.27
78	418.10	374.09
79	422.41	377.95
80	426.74	381.82
81	431.11	385.73
82	435.50	389.66
83	439.94	393.63
84	444.43	397.64

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA14  
 Gross Premium Code: A14G - Rate Group: A12  
 Physician Services Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 10%

Issue Age	Individual Premium	Household Premium
18 - 49	197.46	186.49
50	204.46	193.10
51	211.64	199.89
52	219.00	206.83
53	226.52	213.94
54	234.23	221.22
55	242.13	228.67
56	250.22	236.32
57	258.51	244.14
58	267.00	252.17
59	275.69	260.38
60	284.60	268.79
61	293.72	277.40
62	303.05	286.22
63	312.61	295.25
64	322.41	304.50
65	332.43	313.96
66	342.70	323.66
67	353.20	333.58
68	356.95	337.12
69	360.73	340.69
70	364.54	344.29
71	368.38	347.92
72	372.26	351.58
73	376.15	355.26
74	380.09	358.97
75	384.05	362.71
76	388.04	366.48
77	392.06	370.27
78	396.10	374.09
79	400.18	377.95
80	404.28	381.82
81	408.42	385.73
82	412.58	389.66
83	416.78	393.63
84	421.04	397.64

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA14  
Gross Premium Code: A14G - Rate Group: A12  
Physician Services Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 15%	Individual
Issue Age	Premium
18 - 49	186.49
50	193.10
51	199.89
52	206.83
53	213.94
54	221.22
55	228.67
56	236.32
57	244.14
58	252.17
59	260.38
60	268.79
61	277.40
62	286.22
63	295.25
64	304.50
65	313.96
66	323.66
67	333.58
68	337.12
69	340.69
70	344.29
71	347.92
72	351.58
73	355.26
74	358.97
75	362.71
76	366.48
77	370.27
78	374.09
79	377.95
80	381.82
81	385.73
82	389.66
83	393.63
84	397.64

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA15  
 Gross Premium Code: A15G - Rate Group: A12  
 Registered Nurse At-Home Indemnity Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 5%  
 \$50 Per Visit Benefit

Issue Age	Individual Premium	Household Premium
18 - 49	55.73	49.87
50	58.39	52.24
51	61.08	54.65
52	63.78	57.07
53	68.69	61.46
54	73.95	66.16
55	79.61	71.23
56	85.70	76.68
57	92.22	82.51
58	99.23	88.79
59	106.75	95.52
60	114.84	102.75
61	123.50	110.50
62	132.80	118.82
63	142.76	127.73
64	153.45	137.30
65	164.90	147.54
66	177.18	158.53
67	190.32	170.29
68	204.64	183.10
69	219.99	196.83
70	236.44	211.55
71	254.08	227.33
72	272.98	244.24
73	293.21	262.35
74	314.88	281.74
75	338.07	302.49
76	362.90	324.70
77	389.45	348.45
78	417.83	373.85
79	448.18	401.00
80	480.60	430.01
81	515.23	461.00
82	552.20	494.07
83	591.81	529.52
84	634.28	567.52

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA15  
 Gross Premium Code: A15G - Rate Group: A12  
 Registered Nurse At-Home Indemnity Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 10%  
 \$50 Per Visit Benefit

Issue Age	Individual Premium	Household Premium
18 - 49	52.80	49.87
50	55.32	52.24
51	57.86	54.65
52	60.42	57.07
53	65.07	61.46
54	70.06	66.16
55	75.42	71.23
56	81.19	76.68
57	87.36	82.51
58	94.01	88.79
59	101.14	95.52
60	108.79	102.75
61	117.00	110.50
62	125.81	118.82
63	135.24	127.73
64	145.37	137.30
65	156.22	147.54
66	167.85	158.53
67	180.30	170.29
68	193.87	183.10
69	208.41	196.83
70	223.99	211.55
71	240.71	227.33
72	258.61	244.24
73	277.78	262.35
74	298.31	281.74
75	320.28	302.49
76	343.80	324.70
77	368.95	348.45
78	395.84	373.85
79	424.59	401.00
80	455.31	430.01
81	488.11	461.00
82	523.14	494.07
83	560.66	529.52
84	600.90	567.52

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA15  
Gross Premium Code: A15G - Rate Group: A12  
Registered Nurse At-Home Indemnity Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 15%  
\$50 Per Visit Benefit

Issue Age	Individual Premium
18 - 49	49.87
50	52.24
51	54.65
52	57.07
53	61.46
54	66.16
55	71.23
56	76.68
57	82.51
58	88.79
59	95.52
60	102.75
61	110.50
62	118.82
63	127.73
64	137.30
65	147.54
66	158.53
67	170.29
68	183.10
69	196.83
70	211.55
71	227.33
72	244.24
73	262.35
74	281.74
75	302.49
76	324.70
77	348.45
78	373.85
79	401.00
80	430.01
81	461.00
82	494.07
83	529.52
84	567.52

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA16  
 Gross Premium Code: A16G - Rate Group: A12  
 Daily Skilled Nursing Indemnity Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 5%  
 Per \$50 Daily Benefit

Issue Age	Individual Premium	Household Premium
18 - 49	14.59	13.06
50	16.05	14.36
51	17.64	15.79
52	19.40	17.36
53	21.12	18.90
54	22.99	20.57
55	25.03	22.40
56	27.25	24.38
57	29.67	26.54
58	32.29	28.89
59	35.15	31.45
60	38.25	34.23
61	41.63	37.25
62	45.30	40.53
63	49.30	44.11
64	53.65	48.00
65	58.37	52.22
66	63.51	56.82
67	69.08	61.81
68	73.99	66.20
69	79.24	70.90
70	84.85	75.92
71	90.86	81.29
72	97.28	87.04
73	104.15	93.19
74	111.50	99.76
75	119.35	106.79
76	127.75	114.30
77	136.72	122.33
78	146.31	130.91
79	156.57	140.09
80	167.53	149.89
81	179.24	160.37
82	191.76	171.57
83	205.14	183.55
84	219.46	196.36

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 55% anticipated loss ratio.

Medico™ Insurance Company  
 Omaha, Nebraska  
 MI-MIA16  
 Gross Premium Code: A16G - Rate Group: A12  
 Daily Skilled Nursing Indemnity Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 10%  
 Per \$50 Daily Benefit

Issue Age	Individual Premium	Household Premium
18 - 49	13.82	13.06
50	15.21	14.36
51	16.72	15.79
52	18.38	17.36
53	20.01	18.90
54	21.78	20.57
55	23.72	22.40
56	25.82	24.38
57	28.11	26.54
58	30.59	28.89
59	33.30	31.45
60	36.24	34.23
61	39.44	37.25
62	42.92	40.53
63	46.70	44.11
64	50.82	48.00
65	55.30	52.22
66	60.16	56.82
67	65.45	61.81
68	70.10	66.20
69	75.07	70.90
70	80.38	75.92
71	86.07	81.29
72	92.16	87.04
73	98.67	93.19
74	105.63	99.76
75	113.07	106.79
76	121.02	114.30
77	129.52	122.33
78	138.61	130.91
79	148.33	140.09
80	158.71	149.89
81	169.81	160.37
82	181.67	171.57
83	194.35	183.55
84	207.91	196.36

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 55% anticipated loss ratio.

Medico™ Insurance Company  
Omaha, Nebraska  
MI-MIA16  
Gross Premium Code: A16G - Rate Group: A12  
Daily Skilled Nursing Indemnity Benefit Rider - Association Group - Per Person Rate

RATE SCHEDULE - Arkansas

Association Group - 15%  
Per \$50 Daily Benefit

Issue Age	Individual Premium
18 - 49	13.06
50	14.36
51	15.79
52	17.36
53	18.90
54	20.57
55	22.40
56	24.38
57	26.54
58	28.89
59	31.45
60	34.23
61	37.25
62	40.53
63	44.11
64	48.00
65	52.22
66	56.82
67	61.81
68	66.20
69	70.90
70	75.92
71	81.29
72	87.04
73	93.19
74	99.76
75	106.79
76	114.30
77	122.33
78	130.91
79	140.09
80	149.89
81	160.37
82	171.57
83	183.55
84	196.36

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 55% anticipated loss ratio.

SERFF Tracking Number: MDIC-125998949 State: Arkansas  
 Filing Company: Medico Insurance Company State Tracking Number: 41900  
 Company Tracking Number: AR A12 INDEMNITY POLICY  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: AR A12 Indemnity Policy  
 Project Name/Number: LM AR A12 Indemnity Policy/LM AR A12 Indemnity Policy

## Supporting Document Schedules

**Satisfied -Name:** Flesch Certification **Review Status:** Approved-Closed 01/28/2009  
**Comments:**  
**Attachments:**  
 AR-Certification.pdf  
 AR-Flesch Certificate MIC.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 01/28/2009  
**Comments:**  
**Attachment:**  
 MIHAA12(AR)-01212009.pdf

**Satisfied -Name:** Outline of Coverage **Review Status:** Approved-Closed 01/28/2009  
**Comments:**  
**Attachment:**  
 MI9F-4340-01122009.pdf

**Satisfied -Name:** Previously Approved Forms **Review Status:** Approved-Closed 01/28/2009  
**Comments:**  
 Enclosed are the previously approved forms on 04-21-2008, submitted with out A18 Dental, Vision and Hearing Policy.

These forms are submitted for informational purposes only.

Replacement Notice MI9F-1060 will be used when required by state law.

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy.

Also the Toll-Free Customer Service Notice UR-AR-763 will be delivered with the policy, as required by law.

*SERFF Tracking Number:* MDIC-125998949      *State:* Arkansas  
*Filing Company:* Medico Insurance Company      *State Tracking Number:* 41900  
*Company Tracking Number:* AR A12 INDEMNITY POLICY  
*TOI:* H14I Individual Health - Hospital Indemnity      *Sub-TOI:* H14I.000 Health - Hospital Indemnity  
*Product Name:* AR A12 Indemnity Policy  
*Project Name/Number:* LM AR A12 Indemnity Policy/LM AR A12 Indemnity Policy

**Attachments:**

MI9F-2701(AR)-07012007.pdf  
UR-AR-763-mic.pdf  
MI9F-1060-11032006.pdf

SERFF Tracking Number: MDIC-125998949 State: Arkansas  
Filing Company: Medico Insurance Company State Tracking Number: 41900  
Company Tracking Number: AR A12 INDEMNITY POLICY  
TOI: H141 Individual Health - Hospital Indemnity Sub-TOI: H141.000 Health - Hospital Indemnity  
Product Name: AR A12 Indemnity Policy  
Project Name/Number: LM AR A12 Indemnity Policy/LM AR A12 Indemnity Policy

**Satisfied -Name:** Cover Letter **Review Status:** Approved-Closed 01/28/2009  
**Comments:**  
**Attachment:**  
AR Cover Letter.pdf

**Satisfied -Name:** AR Fee Certificatin **Review Status:** Approved-Closed 01/28/2009  
**Comments:**  
**Attachment:**  
AR-Fee Certification.pdf

**ARKANSAS CERTIFICATION**

Medico<sup>®</sup> 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,  
Vice-President & Director of Compliance  
Officer's name and title

January 21, 2009  
Date

**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 \_\_\_\_\_.

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 \_\_\_\_\_.

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 \_\_\_\_\_.

**MEDICO INSURANCE COMPANY**

  
\_\_\_\_\_  
*Desiree Buckley*  
*Vice President, Director of Compliance*



1515 South 75th Street  
Omaha, Nebraska 68124

Application for  
Indemnity Benefit Insurance

www.gomedico.com  
Toll-Free 1-800-228-6080

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

**Applicant Information**

Name \_\_\_\_\_  
First MI Last Date of Birth Age Sex Height Weight  
Mo./Day/Yr.

Address \_\_\_\_\_  
Street Address City State Zip

Social Security # \_\_\_\_\_

Phone # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Best time to call for Personal Health Interview \_\_\_\_\_

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_

**Co-Applicant Information**

Name \_\_\_\_\_  
First MI Last Date of Birth Age Sex Height Weight  
Mo./Day/Yr.

Social Security # \_\_\_\_\_ E-mail Address \_\_\_\_\_

Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_ Address \_\_\_\_\_

**Part B: Medical Information**

QUALIFYING INFORMATION (If any answer to questions 1 through 7 is "YES," you are not eligible for coverage.)

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

	Applicant		Co-Applicant	
	Yes	No	Yes	No
1. In the past 24 months have you been confined as an inpatient to a hospital, nursing home or have you received home health care, been bedridden or confined to a wheelchair?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past 24 months have you had a heart attack, stroke, heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. In the past 24 months have you been treated for chronic obstructive lung disease, Parkinson's disease or neuromuscular disease, insulin dependent diabetes, dementias, Alzheimer's disease, congestive heart failure, or chronic liver or kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past 24 months have you been treated for Paget's disease, lupus, rheumatoid arthritis or osteoporosis causing fractures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. In the past 24 months have you had surgery; or are you scheduled to have surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Are you covered under a state Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Part C: Applicant Information**

	Applicant		Co-Applicant	
	Yes	No	Yes	No
1. (a) Do you have any medical or health 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 Options *Complete appropriate section for each plan selected.***

Benefit	Applicant	Co-Applicant
Indemnity Benefit Policy Form MI-HIA12	<input type="checkbox"/>	<input type="checkbox"/>
<b>Optional Riders</b>		
MIRA13 – Daily Hospital Indemnity Benefit Rider	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200
MIRA14 – Physician Services Benefit Rider	<input type="checkbox"/>	<input type="checkbox"/>
MIRA15 – Registered Nurse At-Home Indemnity Benefit Rider	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100
MIRA16 – Daily Skilled Nursing Facility Indemnity Benefit Rider	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200

**Part E: Payment Options**

Household Discount       Association Discount      Association Name \_\_\_\_\_  
Member Identification Number \_\_\_\_\_

**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  
 Bi-Monthly       Quarterly       Semi-Annually       Annually

Amount Received with Application \$ \_\_\_\_\_      Renewal Premium \$ \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

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.

**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  
 Bi-Monthly       Quarterly       Semi-Annually       Annually

Amount Received with Application \$ \_\_\_\_\_      Renewal Premium \$ \_\_\_\_\_

Requested Effective Date: \_\_\_\_\_

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: Payment Options, continued**

<u>Indemnity Benefit Policy Premium:</u>	Applicant
	\$ _____
<u>Optional Rider Premium:</u>	
MIRA13 – Daily Hospital Indemnity Benefit Rider _____ premium per \$50 unit X number of units (1 to 4) _____ =	\$ _____
MIRA14 – Physician Services Benefit Rider – premium _____ =	\$ _____
MIRA15 – Registered Nurse At-Home Indemnity Benefit Rider _____ premium per \$50 unit X number of units (1 to 2) _____ =	\$ _____
MIRA16 – Daily Skilled Nursing Facility Indemnity Benefit Rider _____ premium per \$50 unit X number of units (1 to 4) _____ =	\$ _____
Premium Amount With Riders	\$ _____
X Mode Factor (on Rate Guide), if applicable	_____
<b>Total Premium for Premium Mode Chosen</b>	<b>\$ _____</b>
<b>Co-Applicant</b>	
<u>Indemnity Benefit Policy Premium:</u>	\$ _____
<u>Optional Rider Premium:</u>	
MIRA13 – Daily Hospital Indemnity Benefit Rider _____ premium per \$50 unit X number of units (1 to 4) _____ =	\$ _____
MIRA14 – Physician Services Benefit Rider – premium _____ =	\$ _____
MIRA15 – Registered Nurse At-Home Indemnity Benefit Rider _____ premium per \$50 unit X number of units (1 to 2) _____ =	\$ _____
MIRA16 – Daily Skilled Nursing Facility Indemnity Benefit Rider _____ premium per \$50 unit X number of units (1 to 4) _____ =	\$ _____
Premium Amount With Riders	\$ _____
X Mode Factor (on Rate Guide), if applicable	_____
<b>Total Premium for Premium Mode Chosen</b>	<b>\$ _____</b>

**Part F: Application Agreement**

I hereby apply to Medico™ Insurance Company for an **Indemnity Benefit 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 <a href="http://gomedico.com/products">gomedico.com/products</a> . |
| <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.  |

I understand that it may be necessary to phone me to verify the answers to the questions in this application.

**CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or, if the misrepresentation was material to our acceptance of the risk, rescind your policy.**

**FRAUD WARNING: 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.**

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 Indemnity Benefit Insurance Policy.

Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Co-Applicant’s Signature \_\_\_\_\_ Dated at \_\_\_\_\_  
City State

Producer’s Name \_\_\_\_\_  
 (Please print)

Producer’s Signature \_\_\_\_\_ Date \_\_\_\_\_



LIMITED BENEFIT POLICY  
FOR HOSPITAL CONFINEMENT AND AMBULANCE BENEFITS

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

**Hospital Confinement Indemnity Benefit:** We will pay a \$1,000 benefit once per each Period of Care when you are Confined in a Hospital as an inpatient and receive Covered Care.

**Ambulance Benefit:** We will pay \$100 per calendar year if a licensed Ambulance or rescue service transports you to or from a Hospital where you are Confined as an inpatient for Covered Care.

**Waiver of Premium Benefit:** After four continuous weeks of your Confinement for Covered Care, we will waive the monthly premiums that come due thereafter during the continued Confinement.

Period of Care begins with the first day of Confinement as an inpatient in a Hospital and ends when you have been out of the Hospital 60 continuous days.

OPTIONAL BENEFITS (Available for an Additional Premium)

**Daily Hospital Indemnity Benefit Rider (Rider Form MIRA13):** We will pay the Daily Hospital Benefit for each day you are Confined to a Hospital for Medically Necessary Covered Care, up to 14 days per Period of Care, beginning with the first day of Confinement. Benefits are payable only when the Hospital Confinement is covered under the policy.

Daily Hospital Benefit selected:  \$50     \$100     \$150     \$200

**Physician Services Benefit Rider (Rider Form MIRA14):** When you require the services of a Physician for Covered Care, in or out of the Hospital, and incur a charge, we will pay up to \$1,000 each calendar year for Medically Necessary charges as listed below.

1. **Physician Services Benefit:** We will pay 20% of the Usual and Customary Charge, not to exceed your incurred charge, for services by a Physician, including services provided by a surgeon, anesthesiologist or a certified registered nurse anesthetist (C.R.N.A.).
2. **Lab and X-Ray Benefit:** We will pay 20% of the Usual and Customary Charge, not to exceed your incurred charge, for laboratory charges or services of a radiologist.

During any one calendar year, the combined benefits under 1 and 2 shall not exceed \$1,000.00.

Routine physical examinations and immunizations are not covered.

Usual and Customary Charge is 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.

Registered Nurse At-Home Indemnity Benefit Rider (Rider Form MIRA15): We will pay the Registered Nurse Shift Amount per shift, up to 2 shifts per day, for up to 30 days following a Hospital Confinement for each Period of Care when a Physician certifies that services of a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) are Medically Necessary for the treatment of Covered Care in your home. Continuous periods of service within the same day which total eight hours or less will be considered as one shift. These services must begin within one week following discharge from the Hospital.

Registered Nurse Shift Amount selected:  \$50       \$100

Daily Skilled Nursing Facility Indemnity Benefit Rider (Rider Form MIRA16): When you are confined to a Skilled Nursing Facility and receive Skilled Nursing Care that is Medically Necessary, we will pay the Daily Skilled Nursing Facility Indemnity Benefit for each day of confinement up to 90 days for each Skilled Nursing Facility Period of Care, subject to the Elimination Period shown in the policy Schedule. Only one Elimination Period will be applied to any one Skilled Nursing Facility Period of Care.

Daily Skilled Nursing Facility Indemnity Benefit selected:  \$50       \$100       \$150       \$200

Skilled Nursing Facility Period of Care begins with the first day you are confined to a Skilled Nursing Facility. It ends when you have been out of any Skilled Nursing Facility for 180 continuous days.

### EXCEPTIONS AND LIMITATIONS

We will NOT pay benefits for: (1) any loss that occurs while this policy is not in force; (2) suicide or any suicide attempt while sane or insane (in Missouri, while sane) or any intentionally self-inflicted injury; (3) Mental or Nervous Disorders without demonstrable organic disease (**subject to the other policy provisions, we will cover Mental or Nervous Disorders, such as Alzheimer's and related dementias, that have a demonstrable organic cause first diagnosed after the effective date of the policy**); (4) alcoholism, drug addiction or their complications, unless addiction resulted from narcotics prescribed by a Physician; (5) Injuries received or caused directly or indirectly while under the influence of a controlled substance, unless prescribed by a Physician, or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred; (6) loss to which a contributing cause was your commission of or attempt to commit a felony or being engaged in an illegal occupation; (7) service rendered by any agency of the federal or state government unless the Insured is legally obligated to pay for such service (Medicare and Medicaid are not excluded); (8) service for which benefits are available for you under state or federal workers' compensation; (9) loss that occurs outside the territorial limits of the United States; (10) any loss resulting from war, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent; (11) durable medial equipment (D.M.E.), prosthetics or orthopedic shoes; (12) drugs and self-administered drugs; (13) physical therapy, occupational therapy or speech therapy; (14) dental operations or dental treatment (except expenses otherwise covered due to Injury to sound natural teeth); ordinary dental care, dentures and dental implants; eyeglasses and hearing aids (and examinations for them); and cosmetic surgery, except for reconstructive surgery which is incidental to or follows surgery; (15) any loss resulting from aviation as other than a fare-paying passenger; (16) pregnancy, unless due to Complications of Pregnancy; (17) elective procedures that are not Medically Necessary, including, but not limited to organ donation, elective sterilization and fertility treatments; or (18) Hospital Confinement primarily for rest care, convalescent care or for rehabilitation.

Pre-Existing Conditions Limitation: We will NOT pay benefits for any loss for Pre-Existing Conditions during the first three months after the Policy Date.

**THIS POLICY MAY NOT COVER ALL OF THE COSTS INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE.**

### 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, or optional riders attached to the policy, which are 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 the policy. If it is necessary to change the premium for your policy or any rider, we will notify you in advance of the change in premium.

PREMIUMS

**Automatic Bank Withdrawal:**

Monthly	Bi-Monthly	Quarterly

**Direct Bill:**

Bi-Monthly	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™ 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

**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™ GROUP

Medico™ Insurance Company • Medico™ Life Insurance Company

January 21, 2009

MEDICO INSURANCE COMPANY  
NAIC # 31119

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

RE: Individual Indemnity Benefit Policy

**Enclosed Material:**

MI-HIA12(AR) – Policy  
MI9F-4340 – Outline of Coverage  
MIHAA12(AR) – Application  
MIRA13 – Daily Hospital Indemnity Benefit Rider  
MIRA14 – Physician Services Benefit Rider  
MIRA15 – Registered Nurse At-Home Indemnity  
Benefit Rider  
MIRA16 – Daily Skilled Nursing Facility Indemnity  
Benefit Rider  
MI9F-4185HI – Medicare Duplication Notice  
Actuarial Memorandum and rate sheets  
Filing Forms

**Previously Approved Form:**

MI9F-1060 – Replacement Notice  
MI9F-2701(AR) Guaranty Association Notice  
UR-AR-763 Toll-Free Customer Service Notice

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

MI-HIA12(AR) is a limited benefit policy. This form is new and will be used to provide benefits for hospital confinement, ambulance benefits and a waiver of premium benefit. The applicant will be able to select from four optional riders, adding additional coverage to the base policy. The four optional riders are enclosed your review and approval.

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 MI9F-4340 will be furnished to each applicant as required by state law.

A copy of the application, MIHAA1(AR)2, is enclosed for your approval.

*Protecting Your Future Today®*



## MEDICO™ GROUP

*Medico™ Insurance Company • Medico™ Life Insurance Company*

Medicare Duplication Notice form MI9F-4185HI is being filed for your approval. This form is required for limited policies marketed to the Medicare eligible individuals. A copy will be left with the applicant. 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.

Replacement Notice MI9F-1060 will be used when required by state law. This form was previously approved by your Department on April 21, 2008 and is enclosed for informational purposes only.

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy. This form was previously approved by your Department on April 21, 2008 and is enclosed for informational purposes only.

The Toll-Free Customer Service Notice, UR-AR-763 will be delivered with the policy, as required by law. This form was previously approved by your Department on April 21, 2008 and is enclosed for informational purposes only.

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.

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,



Luanne Melies

Compliance Analyst

1-800-695-5976 Ext. 249

Fax (402) 391-4858

[lmelies@gomedico.com](mailto:lmelies@gomedico.com)

*Protecting Your Future Today®*

**ARKANSAS  
INSURANCE  
DEPARTMENT**

Lee Douglass  
Insurance Commissioner

400 University Tower Bldg.  
1123 South University Avenue  
Little Rock, AR 72204  
(501) 686-2900

**ATTN: LIFE & HEALTH DIVISION, ARKANSAS INSURANCE DEPARTMENT**

**COMPANY NAME** \_\_\_\_\_

**COMPANY NAIC CODE:** \_\_\_\_\_

**COMPANY CONTACT PERSON & NUMER:** \_\_\_\_\_

**INSURANCE DEPARTMENT USE ONLY**

**ANALYST:** \_\_\_\_\_ **AMOUNT:** \_\_\_\_\_ **ROUTE SLIP:** \_\_\_\_\_

**ALL FEES ARE PER EACH INSURER, PER ANNUAL STATEMENT LINE OF BUSINESS,  
UNLESS OTHERWISE INDICATED.**

**FEE SCHEDULE FOR ADMITTED INSURERS**

**RATE/FORM FILINGS**

Life and/or Disability policy form filing and review,  
per each policy, contract, annuity form, per each  
insurer, per each filing. \* \_\_\_\_\_ x \$50 = \_\_\_\_\_  
\*\* Retaliatory \_\_\_\_\_

Life and/or Disability - Filing and review of  
each rate filing or loss ratio guarantee filing,  
per each insurer. \* \_\_\_\_\_ x \$50 = \_\_\_\_\_  
\*\* Retaliatory \_\_\_\_\_

Life and/or Disability Policy, Contract, or Annuity  
Forms: Filing and review of each certificate, rider,  
endorsement or application if each is filed  
separately from the basic form. \* \_\_\_\_\_ x \$20 = \_\_\_\_\_  
\*\* Retaliatory \_\_\_\_\_

Policy and contract forms, all lines, filing  
corrections in previously filed policy and contract  
forms. \* \_\_\_\_\_ x \$20 = \_\_\_\_\_  
\*\* Retaliatory \_\_\_\_\_

Life and/or Disability: Filing and review of Insurer's  
advertisements, per advertisement, per each insurer. \* \_\_\_\_\_ x \$25 = \_\_\_\_\_  
\*\* Retaliatory \_\_\_\_\_

**AMEND CERTIFICATE OF AUTHORITY**

Review and processing of information to amend an  
Insurer's Certificate of Authority. \* \_\_\_\_\_ x \$400 = \_\_\_\_\_

Filing to amend Certificate of Authority. \*\*\* \_\_\_\_\_ x \$100 = \_\_\_\_\_

\*THESE FEES ARE PAYABLE UNDER THE NEW FEE SCHEDULE AS OUTLINED UNDER RULE AND  
REGULATION 57.

\*\* THESE FEES ARE PAYABLE UNDER THE OLD FEE SCHEDULE AS OUTLINED UNDER ARK. CODE  
ANN. 23-63-102, RETALIATORY TAX.

\*\*\* THESE FEES ARE PAYABLE AS REQUIRED IN ARK. ANN §23-61-401.