

SERFF Tracking Number: MDIC-126072438 State: Arkansas
Filing Company: Medico Insurance Company State Tracking Number: 41832
Company Tracking Number: AR A12 INDEMNITY POLICY A17 RIDER
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: AR A12 Indemnity Policy & A17 Rider
Project Name/Number: AR A12 Indemnity Policy & A17 Rider/LM AR A12 Indemnity Policy & A17 Rider

Filing at a Glance

Company: Medico Insurance Company

Product Name: AR A12 Indemnity Policy & A17 SERFF Tr Num: MDIC-126072438 State: ArkansasLH
Rider

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed

State Tr Num: 41832

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: AR A12 INDEMNITY
POLICY A17 RIDER

State Status: Approved-Closed

Filing Type: Form/Rate

Co Status:

Reviewer(s): Rosalind Minor

Author: Luanne Melies

Disposition Date: 03/17/2009

Date Submitted: 03/16/2009

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AR A12 Indemnity Policy & A17 Rider

Status of Filing in Domicile: Pending

Project Number: LM AR A12 Indemnity Policy & A17 Rider

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Nebraska is our
state of domicile and we are awaiting approval.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 03/17/2009

Explanation for Other Group Market Type:

State Status Changed: 03/17/2009

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Enclosed you will find forms relating to our A12 Individual Indemnity Benefit Policy that was previously approved by your Department on January 28, 2009 (SERRF #MDIC-125998949).

The 'Form Schedule' tab previously approved forms that are being reviewed have not been used for sale and we are requesting these new forms being submitted replace the previously approved forms.

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See the Cover Letter attached to 'Supporting Documents' tab.

Company and Contact

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	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$50.00	03/16/2009	26444661

SERFF Tracking Number: MDIC-126072438 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/17/2009	03/17/2009

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Disposition

Disposition Date: 03/17/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MDIC-126072438 State: Arkansas
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Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	AR Cover Letter	Approved-Closed	Yes
Supporting Document	AR Fee Certification	Approved-Closed	Yes
Form	Schedule	Approved-Closed	Yes
Form	Physician and Surgical Indemnity Benefit Rider	Approved-Closed	Yes
Rate	AR 12-1 Rates	Approved-Closed	Yes
Rate	AR A12G-1	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	A12-1 POLICY SCHEDULE E	Schedule	Schedule	Revised	Replaced Form #: A12 POLICY SCHEDULE Previous Filing #: MDIC-125998949		A12-1 Schedule 03042009.pdf
Approved-Closed	MIRA17	Policy/Contractual Certificate: Amendment, Insert Page, Endorsement or Rider	Physician and Surgical Indemnity Benefit Rider	Revised	Replaced Form #: MIRA14 Previous Filing #: MDIC-125998949		MIRA17- 03112009.pdf

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

OPTIONAL RIDERS--[MODE]--

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

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

MIRA17 PHYSICIAN AND SURGICAL INDEMNITY BENEFIT
RIDER PREMIUM..... \$ [XXX.XX]

1. PHYSICIAN INDEMNITY BENEFIT - \$20
2. SURGICAL INDEMNITY BENEFIT - \$300
(DURING ANY ONE CALENDAR YEAR, THE COMBINED BENEFITS UNDER
1 AND 2 SHALL NOT EXCEED \$1,000)

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

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

POLICY NUMBER – [XXXXXXXX]

RIDER PAGE 1 OF 1

PHYSICIAN AND SURGICAL 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]

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

Physician Office Visit: Includes any visit by a Physician in the Physician’s office, clinic, an ambulatory care facility, an emergency room or outpatient unit of a Hospital.

Surgery: Means the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, endoscopic examinations, and any one procedure designated by Current Procedural Terminology codes as surgery, except that venipuncture for the collection of blood for the purpose of performing a test shall not be considered a surgery.

BENEFIT

We will pay up to \$1,000 each calendar year for Medically Necessary charges for Covered Care, as listed below.

1. **Physician Indemnity Benefit:** We will pay the amount shown on the policy Schedule, not to exceed your incurred charge, for each Physician Office Visit.
2. **Surgical Indemnity Benefit:** We will pay the amount shown on the policy Schedule, not to exceed your incurred charge, for all Surgery performed, in or out of the Hospital, in any 24-hour period.

During any one calendar year, the combined benefits under 1 and 2 shall not exceed \$1,000.

In addition to the exclusions shown in the policy, we will not pay benefits for routine physical examinations, immunizations or routine screening procedures.

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

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Rate Information

Rate data does NOT apply to filing.

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Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	AR 12-1 Rates	MI-HIA12(AR)	Revised	Previous State Filing Number:	MDIC- 1259989 AR A12-1 rates - 3-11-09.pdf 49
Approved-Closed	AR A12G-1	MI-HIA12(AR)	Revised	Previous State Filing Number:	MDIC- 1259989 AR A12G-1 rates - 3-11-09.pdf 49

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 or more 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 or more 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 or more 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 or more 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-MIA17
Gross Premium Code: A17 - Rate Group: A12
Physician Services Indemnity Benefit Rider

RATE SCHEDULE - Arkansas

Issue Age	Premium
18 - 49	321.18
50	331.06
51	341.09
52	351.26
53	361.06
54	370.86
55	380.64
56	390.44
57	400.24
58	412.43
59	424.62
60	436.82
61	449.01
62	461.20
63	477.69
64	494.17
65	510.64
66	527.12
67	543.60
68	556.31
69	568.96
70	581.55
71	594.10
72	606.59
73	618.22
74	629.79
75	641.32
76	652.79
77	664.21
78	672.16
79	680.07
80	687.94
81	695.78
82	703.58
83	711.47
84	719.44

AVAILABLE DISCOUNT:

When two or more 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

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Monthly = 1/11

Automatic Bank Withdrawal
Annual = 1.00
Semi-Annual = 0.52
Quarterly = 3/12
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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-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.

Medico™ Insurance Company
 Omaha, Nebraska
 MI-MIA17
 Gross Premium Code: A17G - Rate Group: A12
 Physician Services Indemnity Benefit Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 5%		
Issue Age	Individual Premium	Household Premium
18 - 49	305.12	273.00
50	314.50	281.40
51	324.03	289.92
52	333.69	298.57
53	343.00	306.90
54	352.31	315.23
55	361.61	323.55
56	370.92	331.88
57	380.23	340.21
58	391.81	350.57
59	403.39	360.93
60	414.98	371.30
61	426.56	381.66
62	438.14	392.02
63	453.80	406.03
64	469.46	420.04
65	485.11	434.04
66	500.77	448.05
67	516.42	462.06
68	528.49	472.86
69	540.51	483.62
70	552.48	494.32
71	564.39	504.98
72	576.26	515.60
73	587.30	525.48
74	598.30	535.32
75	609.25	545.12
76	620.15	554.87
77	631.00	564.58
78	638.56	571.34
79	646.07	578.06
80	653.55	584.75
81	660.99	591.41
82	668.40	598.04
83	675.90	604.75
84	683.47	611.52

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-MIA17
 Gross Premium Code: A17G - Rate Group: A12
 Physician Services Indemnity Benefit Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 10%

Issue Age	Individual Premium	Household Premium
18 - 49	289.06	273.00
50	297.95	281.40
51	306.98	289.92
52	316.13	298.57
53	324.95	306.90
54	333.77	315.23
55	342.58	323.55
56	351.40	331.88
57	360.22	340.21
58	371.19	350.57
59	382.16	360.93
60	393.14	371.30
61	404.11	381.66
62	415.08	392.02
63	429.92	406.03
64	444.75	420.04
65	459.58	434.04
66	474.41	448.05
67	489.24	462.06
68	500.68	472.86
69	512.06	483.62
70	523.40	494.32
71	534.69	504.98
72	545.93	515.60
73	556.39	525.48
74	566.81	535.32
75	577.19	545.12
76	587.51	554.87
77	597.79	564.58
78	604.95	571.34
79	612.07	578.06
80	619.15	584.75
81	626.20	591.41
82	633.22	598.04
83	640.32	604.75
84	647.50	611.52

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-MIA17
Gross Premium Code: A17G - Rate Group: A12
Physician Services Indemnity Benefit Rider - Association Group

RATE SCHEDULE - Arkansas

Association Group - 15%	Individual
Issue Age	Premium
18 - 49	273.00
50	281.40
51	289.92
52	298.57
53	306.90
54	315.23
55	323.55
56	331.88
57	340.21
58	350.57
59	360.93
60	371.30
61	381.66
62	392.02
63	406.03
64	420.04
65	434.04
66	448.05
67	462.06
68	472.86
69	483.62
70	494.32
71	504.98
72	515.60
73	525.48
74	535.32
75	545.12
76	554.87
77	564.58
78	571.34
79	578.06
80	584.75
81	591.41
82	598.04
83	604.75
84	611.52

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.

SERFF Tracking Number: MDIC-126072438 State: Arkansas
Filing Company: Medico Insurance Company State Tracking Number: 41832
Company Tracking Number: AR A12 INDEMNITY POLICY A17 RIDER
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: AR A12 Indemnity Policy & A17 Rider
Project Name/Number: AR A12 Indemnity Policy & A17 Rider/LM AR A12 Indemnity Policy & A17 Rider

Supporting Document Schedules

Review Status:
Satisfied -Name: Flesch Certification **Approved-Closed** 03/17/2009
Comments:
Attachment:
AR-Flesch Certificate MIC A17.pdf

Review Status:
Satisfied -Name: Application **Approved-Closed** 03/17/2009
Comments:
On January 28, 2009, Application MIHAA12(AR) was approved by your Department Enclosed are two new applications which, upon approval, will replace previously approved application MIHAA12(AR). Both new applications remove reference to Rider MIRA14 and make reference to Rider MIRA17. The only difference between MIHAA12(AR)-1 and MIHAA12(AR)-1A is that MIHAA12(AR)-1A, Part E, has reference to an association discount and asks for the association name and member number. Otherwise, the two forms are identical.

Attachments:
MIHAA12(AR)-1-03122009.pdf
MIHAA12(AR)-1A-03122009.pdf

Review Status:
Satisfied -Name: Outline of Coverage **Approved-Closed** 03/17/2009
Comments:
On January 28, 2009, Outline of Coverage MI9F-4340 was approved. We are enclosing Outline MI9F-4340-1 which will replace previously approved form MI9F-4340. The new Outline of Coverage removes reference to Rider MIRA14 and makes reference to the MIRA17 rider.
Attachment:
MI9F-4340-1-03052009.pdf

Review Status:
Satisfied -Name: AR Cover Letter **Approved-Closed** 03/17/2009
Comments:
Attachment:
AR Cover Letter-1 3-12-09.pdf

SERFF Tracking Number: MDIC-126072438 State: Arkansas
Filing Company: Medico Insurance Company State Tracking Number: 41832
Company Tracking Number: AR A12 INDEMNITY POLICY A17 RIDER
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: AR A12 Indemnity Policy & A17 Rider
Project Name/Number: AR A12 Indemnity Policy & A17 Rider/LM AR A12 Indemnity Policy & A17 Rider

Review Status:

Satisfied -Name: AR Fee Certification

Approved-Closed

03/17/2009

Comments:

Attachment:

AR Fee Certification A17.pdf

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"/>
Optional Riders		
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
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
MIRA17 – Physician and Surgical Indemnity Benefit Rider	<input type="checkbox"/>	<input type="checkbox"/>

Part E: Payment Options

Household Discount

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) _____ =	\$ _____
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) _____ =	\$ _____
MIRA17 – Physician and Surgical Indemnity Benefit Rider – premium _____ =	\$ _____
Premium Amount With Riders _____	\$ _____
X Mode Factor (on Rate Guide), if applicable _____	_____
Total Premium for Premium Mode Chosen	\$ _____

<u>Indemnity Benefit Policy Premium:</u>	Co-Applicant
	\$ _____
<u>Optional Rider Premium:</u>	
MIRA13 – Daily Hospital Indemnity Benefit Rider	
_____ premium per \$50 unit X number of units (1 to 4) _____ =	\$ _____
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) _____ =	\$ _____
MIRA17 – Physician and Surgical Indemnity Benefit Rider – premium _____ =	\$ _____
Premium Amount With Riders _____	\$ _____
X Mode Factor (on Rate Guide), if applicable _____	_____
Total Premium for Premium Mode Chosen	\$ _____

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 regarding eligibility for Medicare and “A Guide to Health Insurance for People With Medicare”:

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

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 _____



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"/>
Optional Riders		
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
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
MIRA17 – Physician and Surgical Indemnity Benefit Rider	<input type="checkbox"/>	<input type="checkbox"/>

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: **Frequency of Payment:**
 Automatic Bank Withdrawal Monthly Bi-Monthly Quarterly
 Direct Bill 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: **Frequency of Payment:**
 Automatic Bank Withdrawal Monthly Bi-Monthly Quarterly
 Direct Bill 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) _____ =	\$ _____
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) _____ =	\$ _____
MIRA17 – Physician and Surgical Indemnity Benefit Rider – premium _____ =	\$ _____
Premium Amount With Riders _____	\$ _____
X Mode Factor (on Rate Guide), if applicable _____	_____
Total Premium for Premium Mode Chosen	\$ _____
Co-Applicant	
<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) _____ =	\$ _____
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) _____ =	\$ _____
MIRA17 – Physician and Surgical Indemnity Benefit Rider – premium _____ =	\$ _____
Premium Amount With Riders _____	\$ _____
X Mode Factor (on Rate Guide), if applicable _____	_____
Total Premium for Premium Mode Chosen	\$ _____

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 regarding eligibility for Medicare and “A Guide to Health Insurance for People With Medicare”:

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

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

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.

Physician and Surgical Indemnity Benefit Rider (Rider Form MIRA17): We will pay up to \$1,000 each calendar year for Medically Necessary charges for Covered Care, as listed below.

1. Physician Indemnity Benefit: We will pay the amount shown on the policy Schedule, not to exceed your incurred charge, for each Physician Office Visit.
2. Surgical Indemnity Benefit: We will pay the amount shown on the policy Schedule, not to exceed your incurred charge, for all Surgery performed, in or out of the Hospital, in any 24-hour period.

During any one calendar year, the combined benefits under 1 and 2 shall not exceed \$1,000.

In addition to the exclusions shown in the policy, we will not pay benefits for routine physical examinations, immunizations or routine screening procedures.

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™ GROUP

Medico™ Insurance Company • Medico™ Life Insurance Company

March 12, 2009

MEDICO INSURANCE COMPANY
NAIC # 31119

Commissioner Jay Bradford
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

RE: Revised forms for previously approved
Individual Indemnity Benefit Policy MIHIA12(AR)

Enclosed Forms:

A12-1 Policy Schedule
MI9F-4340-1 – Outline of Coverage
MIHIAA12(AR)-1 – Application
MIHIAA12(AR)-1A -Association Application
MIRA17 – Physician and Surgical Indemnity
Benefit Rider
Actuarial Memorandum and rate sheets
Filing Forms

**Previously approved forms associated
with this filing:**

Policy MI-HIA12(AR)
Riders MIRA13, MIRA15, MIRA16
MI9F-4185HI – Medicare Duplication Notice
MI9F-2701(AR) Guaranty Association Notice
UR-AR-763 –Toll-Free Customer Service Notice

Enclosed you will find forms relating to our A12 Individual Indemnity Benefit Policy that was previously approved by your Department on January 28, 2009 (SERRF #MDIC-125998949). We did not revise Policy form MI-HIA12(AR), Riders MIRA13, MIRA15 and MIRA16, MI9F-2701(AR) Guaranty Association Notice, UR-AR-763 Toll-Free Customer Service Notice or the Medicare Duplication Notice MI9F-4185HI. There have been no sales of the indemnity product with the originally filed forms.

We have enclosed a new Schedule page. This Schedule shows reference to the new MIRA17 Rider and removes reference to the MIRA14 Rider. We changed the form number area to show A12-1 instead of A12. Schedule A12-1 will be used in place of Schedule A12.

On January 28, 2009, optional MIRA14 Physician Services Benefit Rider was approved. We wish to withdraw this rider from sale. This rider has not been sold to any individual and there are no riders in force. We wish to replace MIRA14 with optional rider MIRA17 Physician and Surgical Indemnity Benefit Rider. The main difference between these two riders is that MIRA14 was an expense-incurred rider and the MIRA17 Rider is an indemnity rider. Riders MIRA13, MIRA15 and MIRA16 will be issued as previously filed and approved by the Department.

Protecting Your Future Today®



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Page Two

On January 28, 2009, Outline of Coverage MI9F-4340 was approved. We are enclosing Outline MI9F-4340-1 which will replace previously approved form MI9F-4340. The new Outline of Coverage removes reference to Rider MIRA14 and makes reference to the MIRA17 rider.

On January 28, 2009, Application MIHAA12(AR) was approved by your Department Enclosed are two new applications which, upon approval, will replace previously approved application MIHAA12(AR). Both new applications remove reference to Rider MIRA14 and make reference to Rider MIRA17. The only difference between MIHAA12(AR)-1 and MIHAA12(AR)-1A is that MIHAA12(AR)-1A, Part E, has reference to an association discount and asks for the association name and member number. Otherwise, the two forms are identical.

On January 28, 2009 the rates for our MI-HIA12(AR) policy were approved by your Department. The new Actuarial Memorandum and Rate Sheets have the previously approved rates and information for the MI-HIA12(AR) policy, MIRA13, MIRA15 and MIRA16 riders except we removed the MIRA14 rates and information and replaced it with the MIRA17 rates and information.

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

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.