

SERFF Tracking Number: MDIC-126216537 State: Arkansas  
Filing Company: Medico Insurance Company State Tracking Number: 42819  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: AR Reinstatement Applications  
Project Name/Number: AR Reinstatement Applications/LM AR Reinstatement Applications

## Filing at a Glance

Company: Medico Insurance Company

Product Name: AR Reinstatement Applications SERFF Tr Num: MDIC-126216537 State: ArkansasLH  
TOI: H21 Health - Other SERFF Status: Closed State Tr Num: 42819  
Sub-TOI: H21.000 Health - Other Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Luanne Melies Disposition Date: 07/09/2009  
Date Submitted: 07/06/2009 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

## General Information

Project Name: AR Reinstatement Applications Status of Filing in Domicile: Authorized  
Project Number: LM AR Reinstatement Applications Date Approved in Domicile: 06/17/2009  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Individual  
Submission Type: New Submission Group Market Size:  
Overall Rate Impact: Group Market Type:  
Filing Status Changed: 07/09/2009 Explanation for Other Group Market Type:  
State Status Changed: 07/09/2009 Corresponding Filing Tracking Number:  
Deemer Date:  
Filing Description:  
Filing of revised policy reinstatement applications and associated forms.

## Company and Contact

### Filing Contact Information

Luanne Melies, Compliance Analyst Imelies@gomedico.com  
1515 S. 75th Street (800) 695-5976 [Phone]

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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:

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: \$120.00  
Retaliatory? No  
Fee Explanation: 6 forms at \$20.00 each = \$120.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$120.00	07/06/2009	28983838

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/09/2009	07/09/2009

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## **Disposition**

Disposition Date: 07/09/2009

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	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved-Closed	Yes
<b>Supporting Document</b>	AR Cover Letter	Approved-Closed	Yes
<b>Supporting Document</b>	MI9F-4124	Approved-Closed	Yes
<b>Supporting Document</b>	AR Fee Certification	Approved-Closed	Yes
<b>Form</b>	Reinstatement Application for Long Term Care, Home Health Care, Nursing Home and Short Term Care Policies	Approved-Closed	Yes
<b>Form</b>	Reinstatement Application for Cancer Policies	Approved-Closed	Yes
<b>Form</b>	Reinstatement Application for Life Policies	Approved-Closed	Yes
<b>Form</b>	Reinstatement Applications for all other policy types	Approved-Closed	Yes
<b>Form</b>	Accelerated Benefits Disclosure Notice	Approved-Closed	Yes
<b>Form</b>	Accelerated Benefits Disclosure Notice	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	MIA3208	Application/Enrollment Form	Reinstatement Application for Long Term Care, Home Health Care, Nursing Home and Short Term Care Policies	Revised	Replaced Form #: MMA3208 Previous Filing #:		MIA3208-02162009.pdf
Approved-Closed	MI4F-208	Application/Enrollment Form	Reinstatement Application for Cancer Policies	Revised	Replaced Form #: 4F-208 Previous Filing #:		MI4F-208-03192009.pdf
Approved-Closed	MI15F-002F	Application/Enrollment Form	Reinstatement Application for Life Policies	Revised	Replaced Form #: MI15F-002F Previous Filing #:		MI15F-002F-06022009.pdf
Approved-Closed	MIA3085	Application/Enrollment Form	Reinstatement Applications for all other policy types	Revised	Replaced Form #: MMA3085 Previous Filing #:		MIA3085-03192009.pdf
Approved-Closed	MI9F-3337	Other	Accelerated Benefits Disclosure Notice	Revised	Replaced Form #: M9F-3337 Previous Filing #:		MI9F-3337-12062006.pdf
Approved-Closed	MI9F-3337A	Other	Accelerated Benefits Disclosure Notice	Revised	Replaced Form #: M9F-3337A Previous Filing #:		MI9F-3337A-06232009.pdf

**MEDICO® INSURANCE COMPANY**  
**1515 South 75th Street Omaha, Nebraska 68124**

**APPLICATION FOR REINSTATEMENT**

**Policy No.** \_\_\_\_\_

**Phone No.** \_\_\_\_\_

1. Since the date of your original application or in the last five years have you been treated by or consulted with a physician for any of the following conditions?
  - a. Heart disease or any disease of the circulatory system? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - b. Asthma, bronchitis, or any type of lung disease? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - c. Colitis, liver disease, or any disease of the intestinal tract? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - d. Any disease of the kidney, prostate, bladder or urinary tract? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - e. Osteoarthritis, osteoporosis, rheumatoid arthritis or any disease of the bones or joints? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - f. Internal cancer, leukemia, or melanoma? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - g. Memory loss or dementia? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - h. Parkinson's disease or Alzheimer's disease? \_\_\_\_\_ Yes \_\_\_\_\_ No
  - i. Diabetes? \_\_\_\_\_ Yes \_\_\_\_\_ No
2. Do you need any assistance in your daily activities of living (eating, dressing, bathing, etc.)? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Do you use a wheelchair, crutches, cane or walker? \_\_\_\_\_ Yes \_\_\_\_\_ No
4. In the last 12 months have you been hospitalized or confined to a nursing facility? \_\_\_\_\_ Yes \_\_\_\_\_ No

If any of the above questions were answered Yes, please provide us with details:

Question Number	Nature of Condition	Dates Treated From - To	Name/Address of Doctor, Hospital or Nursing Facility

5. Please list your present prescription medications: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

6. Who is your family doctor?

Name \_\_\_\_\_

Address \_\_\_\_\_

7. What issued or pending individual or group accident or sickness insurance do you now have?

Company Name	Amounts, Days Payable, Policy Numbers (If Known), Elimination Periods (If Any)	Type of Policy (Medicare Supplement, Nursing Home, etc.)

I represent that my answers and statements are true and complete to the best of my knowledge and belief, and I agree that: (a) completion of this application and tender of required premium are prerequisites to consideration of reinstatement of the policy; and (b) if the policy is reinstated, reinstatement shall be in accordance with the policy provisions.

The undersigned applicant and producer (if a producer assisted in this application) represent that: the applicant has read, or had read to him/her, the completed application; and that the applicant realizes that any false statement or material misrepresentation in the application may result in loss of coverage under the policy subject to the Time Limit on Certain Defenses Provision.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_  
Month Year

Signature \_\_\_\_\_  
Producer, if applicable

Signature  
 of Applicant X \_\_\_\_\_  
Full Given Name

\_\_\_\_\_  
 Printed Name of Producer, if applicable

\_\_\_\_\_  
 License ID No., where applicable

**Attention Residents of ARKANSAS, LOUISIANA and WEST VIRGINIA:** 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.

**Attention Residents of COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**Attention Residents of DISTRICT OF COLUMBIA:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Attention Residents of FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**Attention Residents of KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Attention Residents of MAINE, TENNESSEE, VIRGINIA and WASHINGTON:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

**Attention Residents of NEW MEXICO:** 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 CIVIL FINES AND CRIMINAL PENALTIES.

**Attention Residents of OHIO:** Any person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code, Section 39999.21.)

**Attention Residents of PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

# APPLICATION FOR REINSTATEMENT

**MEDICO® INSURANCE COMPANY**  
**1515 South 75<sup>th</sup> Street**  
**Omaha, NE 68124**  
**1-800-228-6080**

I hereby apply to Medico™ Insurance Company for reinstatement of my policy.

Policy Number \_\_\_\_\_

1. To the best of your knowledge, have you or any family member included under this policy ever had or been diagnosed as having or been treated by or consulted with a physician for any of the following.
  - (a) Internal or skin cancer, melanoma, leukemia, Hodgkin's disease, premalignant conditions, abnormal Pap smear, abnormal PSA (prostate specific antigen), or abnormal mammogram?  
 YES  NO
  - (b) Acquired immune deficiency syndrome (AIDS), or AIDS-related complex (ARC)?  
 YES  NO
  - (c) Has any Insured been advised within the last 2 years by a physician to undergo examinations or medical tests to diagnose a possible malignancy or evaluate a premalignant condition?  YES  NO

If the answer is "YES" to any of the above questions, list name of each person. Such persons will be excluded from coverage under the policy. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

2. Do you understand and agree that no reinstatement will be effected until this application is approved?  YES  NO

I hereby represent the above statements to be true, full and complete to the best of my knowledge and information.

Signed at \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Applicant

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1515 South 75th Street  
Omaha, Nebraska 68124

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

Life Insurance Reinstatement Application

I hereby apply to Medico Insurance Company of Omaha, Nebraska, for reinstatement of my life insurance policy.

Policy Number \_\_\_\_\_

1. Insured's Name \_\_\_\_\_  
First Middle Initial Last

2. To the best of your knowledge and belief have you had any illness or injury, or consulted with, been prescribed for, or treated by any physician or other medical practitioner within the last five years? Yes  No  If answer is "Yes" give details as follows:

Nature of Disorder	Date	Surgery Yes or No	Name of Physician or Hospital	Address City and State

(If necessary give additional information on reverse side)

3. Do you understand and agree that no reinstatement will be effected until this application is approved? Yes  No

I hereby represent the above statements to be true, full and complete to the best of my knowledge and belief.

I understand that the policy will not be in effect until this application for reinstatement has been received in the Home Office and approved, and until all back premiums including applicable interest have been paid. I further understand that the policy will not be incontestable until it has been in force for two years from the date of reinstatement.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a crime, and upon conviction, may be subject to fines and confinement in prison.

Date \_\_\_\_\_

Signature \_\_\_\_\_

Applicant

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**MEDICO® INSURANCE COMPANY**  
**1515 South 75th Street**  
**Omaha, Nebraska 68124**

**APPLICATION FOR REINSTATEMENT**

I hereby apply for reinstatement of my policy. Policy Number \_\_\_\_\_

1. Present Occupation \_\_\_\_\_ Exact Duties \_\_\_\_\_  
 \_\_\_\_\_

2. To the best of your knowledge and belief, have you or any member of your family included under this policy had any illness or personal injury, or consulted with, been prescribed for, operated on, or treated by any physician or other person since the date of your original application or during the past five years, whichever period of time is shorter?  
 Yes  No If your answer is "Yes," give details as follows:

Person's Name	Nature of Illness or Injury	Date	Name of Attending Physician or Hospital	Address

(If necessary, give additional information on reverse side.)

3. If this policy provides maternity benefits, is any member of your family included under this policy now pregnant?  
 Yes  No If "Yes," give name and relationship of person \_\_\_\_\_  
 \_\_\_\_\_

4. What issued or pending individual or group accident or sickness insurance do you now have?

Company Name	Amounts, Days Payable, Policy Numbers (If Known), Elimination Periods (If Any)	Type of Policy (Medicare Supplement, Nursing Home, etc.)

I represent that my above answers and statements are true and complete to the best of my knowledge and belief and agree that: (a) completion of this application and tender of the required premium are prerequisites to consideration of reinstatement of the policy; and (b) if the policy is reinstated, reinstatement shall be in accordance with the provisions of the policy.

Dated at \_\_\_\_\_, this \_\_\_\_\_ day of \_\_\_\_\_  
Month Year

Producer \_\_\_\_\_ Signature of Applicant X \_\_\_\_\_  
Full Given Name

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## NOTICE REGARDING ACCELERATED BENEFITS

### Situations Which Allow Receipt Of Accelerated Benefits:

1. **Nursing Home Confinement:** You are confined to an Eligible Nursing Home and you give us evidence satisfactory to us that you are expected to stay there until death. Part of that evidence must be a certification by a licensed physician. The benefit this option provides is 80% of the Death Benefit shown in the Schedule, minus any outstanding loan. (The balance of benefits, if any, are not payable if this option is chosen.)
2. **Terminal Illness:** You must give us evidence that satisfies us that your life expectancy is 12 months or less. Part of that evidence must be a certification by a licensed physician. The benefit this option provides is 80% of the Death Benefit shown in the policy Schedule, minus any outstanding loan. (The balance of benefits, if any, are not payable if this option is chosen.)

**Payment of Accelerated Benefit:** This benefit will be paid in one lump sum.

**Premium For Accelerated Benefit:** There is no additional premium required for this benefit.

**Administrative Expense Charge:** The discount of the net proceeds includes administrative expenses.

**Impact on Policy Values:** Cash values, loan values and all benefits of the policy will end upon lump sum payment of the Accelerated Benefit.

### Before Selecting An Accelerated Benefit, Please Note:

1. This accelerated benefit product is NOT a long-term care policy or nursing home insurance policy. The accelerated benefit paid may not be enough to cover your medical, nursing home or other bills. You may use the money you receive from this product for any purpose.
2. Accelerated benefits payable under this product MAY BE TAXABLE. You should consult a personal tax advisor.
3. Receipt of accelerated benefits under this product MAY AFFECT ELIGIBILITY FOR MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME ("SSI") or other government benefits or entitlements. Without exercising your option to accelerate benefits, the mere fact that you own an accelerated benefit product will not in and of itself affect your eligibility for these government programs. However, exercising the option to accelerate benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact your state Department of Public Welfare or the Social Security Administration for more information.

## NOTICE REGARDING ACCELERATED BENEFITS

### Situations Which Allow Receipt Of Accelerated Benefits:

1. **Nursing Home Confinement:** You are confined to an Eligible Nursing Home and you give us evidence satisfactory to us that you are expected to stay there until death. Part of that evidence must be a certification by a licensed physician. The benefit this option provides is explained in your policy.
2. **Terminal Illness:** You must give us evidence that satisfies us that your life expectancy is 12 months or less. Part of that evidence must be a certification by a licensed physician. The benefit this option provides is explained in your policy.

**Payment of Accelerated Benefit:** This benefit will be paid in one lump sum.

**Premium For Accelerated Benefit:** There is no additional premium required for this benefit.

**Administrative Expense Charge:** The discount of the net proceeds includes administrative expenses.

**Impact on Policy Values:** Cash values, loan values and all benefits of the policy will end upon lump sum payment of the Accelerated Benefit.

### Before Selecting An Accelerated Benefit, Please Note:

1. This accelerated benefit product is NOT a long-term care policy or nursing home insurance policy. The accelerated benefit paid may not be enough to cover your medical, nursing home or other bills. You may use the money you receive from this product for any purpose.
2. Accelerated benefits payable under this product MAY BE TAXABLE. You should consult a personal tax advisor.
3. Receipt of accelerated benefits under this product MAY AFFECT ELIGIBILITY FOR MEDICAID, SOCIAL SECURITY, SUPPLEMENTAL SECURITY INCOME ("SSI") or other government benefits or entitlements. Without exercising your option to accelerate benefits, the mere fact that you own an accelerated benefit product will not in and of itself affect your eligibility for these government programs. However, exercising the option to accelerate benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact your state Department of Public Welfare or the Social Security Administration for more information.

*SERFF Tracking Number:* MDIC-126216537      *State:* Arkansas  
*Filing Company:* Medico Insurance Company      *State Tracking Number:* 42819  
*Company Tracking Number:*  
*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* AR Reinstatement Applications  
*Project Name/Number:* AR Reinstatement Applications/LM AR Reinstatement Applications

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: MDIC-126216537 State: Arkansas  
 Filing Company: Medico Insurance Company State Tracking Number: 42819  
 Company Tracking Number:  
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
 Product Name: AR Reinstatement Applications  
 Project Name/Number: AR Reinstatement Applications/LM AR Reinstatement Applications

## Supporting Document Schedules

**Review Status:**  
**Bypassed -Name:** Flesch Certification **Approved-Closed** 07/09/2009  
**Bypass Reason:** N/A, forms in this filing do not require flesch readings.  
**Comments:**

**Review Status:**  
**Bypassed -Name:** Application **Approved-Closed** 07/09/2009  
**Bypass Reason:** Reinstatement Applications have been attached to the Form Schedule Tab.  
**Comments:**

**Review Status:**  
**Bypassed -Name:** Health - Actuarial Justification **Approved-Closed** 07/09/2009  
**Bypass Reason:** N/A, this is a form filing only.  
**Comments:**

**Review Status:**  
**Bypassed -Name:** Outline of Coverage **Approved-Closed** 07/09/2009  
**Bypass Reason:** N/A, this filing is for reinstatement applications and disclosure notices only.  
**Comments:**

**Review Status:**  
**Satisfied -Name:** AR Cover Letter **Approved-Closed** 07/09/2009  
**Comments:**  
**Attachment:**  
 AR Cover Letter.pdf

**Review Status:**  
**Satisfied -Name:** MI9F-4124 **Approved-Closed** 07/09/2009  
**Comments:**  
 MI9F-4124 version 12012008 HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.  
**Attachment:**  
 MI9F-4124-12012008.pdf

SERFF Tracking Number: MDIC-126216537 State: Arkansas  
Filing Company: Medico Insurance Company State Tracking Number: 42819  
Company Tracking Number:  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: AR Reinstatement Applications  
Project Name/Number: AR Reinstatement Applications/LM AR Reinstatement Applications

**Satisfied -Name:** AR Fee Certification **Review Status:** Approved-Closed 07/09/2009  
**Comments:**  
**Attachment:**  
AR Filing Fee Certification.pdf



July 6, 2009

MEDICO® INSURANCE COMPANY  
NAIC #31119

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

Re: Revised Reinstatement Applications and Forms  
**MIA3208** – Reinstatement Application for  
Long Term Care, Home Health Care, Nursing  
Home, and Short Term Care Policies  
**MI4F-208** – Reinstatement Application for  
Cancer Policies  
**MI15F-002F** – Reinstatement Application for  
Life Policies  
**MI9F-3337 & MI9F-3337A** - Accelerated  
Benefits Disclosure Notices  
**MIA3085** – Reinstatement Application for  
All Other Policies  
Informational Form:  
**MI9F-4124** – Authorization HIPAA  
Compliant

Enclosed you will find a variety of reinstatement applications modified to include questions more suitable to underwriting and the reinstatement of lapsed policies for your review and approval. These forms will be used for our Medico® Insurance Company policyholders only.

Once approved, these forms may be used by either home office personnel or our field force to facilitate reinstatement of lapsed policies

MIA3208 reinstatement application will be used for Long Term Care, Home Health Care, Nursing Home and Short Term Care Policies. This form will replace MMA3208 version 01012006. This new form differs from the replaced form with addition of a question regarding Parkinson's Disease and Alzheimer's Disease. Fraud Statements were also added to the end of this form. The medical authorization paragraph was removed from the application. Form MI9F-4124 version 12012008 will be sent with the application to obtain medical authorization from the applicant.

MI4F-208 reinstatement application will be used for Cancer Policies. This form will replace 4F-208 version 01012006. The questions on this form have been modified. Fraud Statements were also added to the end of this form. The medical authorization MI9F-4124 version 12012008 will be sent with the application to obtain medical authorization from the applicant.

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Page 2

MI15F-002F reinstatement application will be used for our Life Policies. This form will replace form MI15F-002F version 12062006. The new form's medical authorization paragraph was removed and fraud statements were added to the end of the form. The medical authorization MI9F-4124 version 12012008 will be sent with the application to obtain medical authorization from the applicant.

Also enclosed for our Life Products is a copy of form MI9F-3337 version 12062006 and MI9F-3337A version 06232009. These forms provide necessary disclosure information to a policyholder, who has one of our life policies that offers the accelerated benefits option. It will only be sent out at the time of the policyholder's application for acceleration of life insurance benefits.

MIA3085 reinstatement application will be used with all of our other policies not specifically mentioned above. This form is identical to replacing form MMA3085 version 01012006 except we removed the medical authorization paragraph and added fraud statements to the end of this form. The medical authorization MI9F-4124 version 12012008 will be sent with the application to obtain medical authorization from the applicant.

MI9F-4124 version 12012008 HIPAA Compliant Medical Authorization form is enclosed for informational purposes only.

I thank you in advance for your prompt review and approval of this submission. If you have any questions, please let me know.

Sincerely,

Luanne Melies  
Compliance Analyst  
1-800-695-5976 Ext. 249  
Fax (402) 391-4858  
[lmelies@gomedico.com](mailto:lmelies@gomedico.com)

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Policy Numbers: _____
_____
_____

**AUTHORIZATION TO USE AND DISCLOSE PERSONAL INFORMATION**

**MEANING OF TERMS**

**Health Care Provider** means: all physicians; medical or dental practitioners; hospitals; other health care facilities (including nursing facilities and assisted living facilities); pharmacies; pharmacy benefit managers; the Medical Information Bureau; and any other person or organization that furnishes, bills or is paid for care, services or supplies related to the health of an individual.

**Personal Information** means: all information about the health of an individual, including medical records in their entirety, information about physical condition and mental condition (excluding psychotherapy notes), prescription drug records and information about drug and alcohol use. Personal Information also includes information about personal finances, occupation, general reputation and insurance claims.

**AUTHORIZATION TO DISCLOSE**

I authorize any Health Care Provider, government agency, insurance company, insurance agent, employer or consumer reporting agency to disclose Personal Information about me, or my dependent named below, to Medico™ Insurance Company and to any persons acting on the Company's behalf for the purposes described below.

**AUTHORIZATION TO USE**

I authorize Medico™ Insurance Company, or any person or entity employed by the Company, to use the Personal Information covered by this authorization for the purposes described below.

**PURPOSES OF DISCLOSURE**

Personal Information will be used to determine my and, if applicable, my dependents' eligibility for insurance and to resolve any issues regarding incomplete or incorrect information on my application for insurance that may arise during the processing of the application or in connection with a claim for insurance benefits.

**POTENTIAL FOR REDISCLOSURE**

The Personal Information used or disclosed based on this authorization may be subject to further disclosure without the protections of federal privacy regulations.

**REFUSAL TO SIGN**

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, Medico™ Insurance Company will not accept my application for insurance, and insurance benefits will not be payable.

**EXPIRATION AND REVOCATION**

This authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time by written notice to: Medico™ Insurance Company, 1515 South 75<sup>th</sup> St., Omaha NE 68124-1655.

I understand that my right to revoke this authorization is limited to the extent that the Company has taken action in reliance on the authorization or the law provides the Company with the right to contest a claim under my insurance policy.

**COPY OF THIS AUTHORIZATION**

I understand that I will receive a copy of this authorization. A copy of this authorization is as valid as the original.

**NAMES AND SIGNATURES**

\_\_\_\_\_  
Printed Name of Applicant/Insured

\_\_\_\_\_  
Signature of Applicant/Insured

\_\_\_\_\_  
Date

**If applicable:** I am the personal representative of the insured named above whose Personal Information is to be disclosed, and I am authorized to grant permission for disclosure.

\_\_\_\_\_  
Printed Name of Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

\_\_\_\_\_  
Signature of Personal Representative

\_\_\_\_\_  
Date

**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.