

SERFF Tracking Number: MDIC-126618366 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 45691
 Company Tracking Number: AR A18-3 DVH POLICY
 TOI: H10I Individual Health - Dental Sub-TOI: H10I.000 Health - Dental
 Product Name: AR A18-3 DVH Policy
 Project Name/Number: AR A18-3 DVH Policy/LM AR A18-3 DVH Policy

Filing at a Glance

Company: Medico Insurance Company

Product Name: AR A18-3 DVH Policy

TOI: H10I Individual Health - Dental

Sub-TOI: H10I.000 Health - Dental

Filing Type: Form

SERFF Tr Num: MDIC-126618366 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 45691

Co Tr Num: AR A18-3 DVH
POLICY

State Status: Approved-Closed

Author: Luanne Melies

Date Submitted: 05/17/2010

Reviewer(s): Rosalind Minor

Disposition Date: 05/21/2010

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: AR A18-3 DVH Policy

Project Number: LM AR A18-3 DVH Policy

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

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

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/21/2010

Market Type: Individual

Group Market Size:

Group Market Type:

Explanation for Other Group Market Type:

State Status Changed: 05/21/2010

Created By: Luanne Melies

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Luanne Melies

Filing Description:

Filing of new Dental, Vision and Hearing Policy A18-3, with associated forms.

Company and Contact

Filing Contact Information

Luanne Melies, Compliance Analyst

lmelies@gomedico.com

SERFF Tracking Number: MDIC-126618366 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 45691
 Company Tracking Number: AR A18-3 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18-3 DVH Policy
 Project Name/Number: AR A18-3 DVH Policy/LM AR A18-3 DVH Policy

1515 S. 75th Street 800-695-5976 [Phone] 249 [Ext]
 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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: Normal fees are \$50.00 for each policy including all forms associated with the policy and filed with the policy.
 Per Company: No

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|--------------------------|---------|----------------|---------------|
| Medico Insurance Company | \$50.00 | 05/17/2010 | 36596852 |
| Medico Insurance Company | \$50.00 | 05/21/2010 | 36723036 |

SERFF Tracking Number: MDIC-126618366 State: Arkansas
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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 05/21/2010 | 05/21/2010 |

Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---------------------------|----------------|------------|----------------|------------------|------------|----------------|
| Status | Created By | Created On | Date Submitted | Responded By | Created On | Date Submitted |
| Pending Industry Response | Rosalind Minor | 05/20/2010 | 05/20/2010 | Luanne Melies | 05/21/2010 | 05/21/2010 |

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Disposition

Disposition Date: 05/21/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Schedule | Schedule Item | Schedule 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 -3 Cover Letter | Approved-Closed | Yes |
| Supporting Document | AR Filing Fee Certification | Approved-Closed | Yes |
| Supporting Document | Previously Filed Forms | Approved-Closed | Yes |
| Form | A18-3 Dental, Vision and Hearing Policy | Approved-Closed | Yes |
| Form | A18-3 Policy Schedule Page | Approved-Closed | Yes |
| Rate | A18-3 Individual Rates | Approved-Closed | Yes |
| Rate | A18-3 Association Rates | Approved-Closed | Yes |

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/20/2010

Submitted Date 05/20/2010

Respond By Date

Dear Luanne Melies,

This will acknowledge receipt of the captioned filing.

Objection 1

- A18-3 Dental, Vision and Hearing Policy, MI-DVA18-3 (Form)

- A18-3 Policy Schedule Page , POLICY A18-3 (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured. Refer to ACA 23-85-134.

Also, our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee and response to our Objection.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
Response Letter Date 05/21/2010
Submitted Date 05/21/2010

Dear Rosalind Minor,

Comments:

On Policy MI-DVA18-3, Page 4, Part G, TERMINATION, we do state that in the event of death we will refund the unearned premium paid beyond the date of death. Please see comments below for the exact provision copied from the policy.

Response 1

Comments:

PART G TERMINATION

Your policy will terminate on the earliest of:

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

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

Related Objection 1

Applies To:

- A18-3 Dental, Vision and Hearing Policy, MI-DVA18-3 (Form)
- A18-3 Policy Schedule Page , POLICY A18-3 (Form)

Comment:

SERFF Tracking Number: MDIC-126618366 *State:* Arkansas
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Also, our filing fees under Rule and Regulation 57 has been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$100.00. Please submit an additional \$50.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee and response to our Objection.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

I have added an additional \$50.00 to this filing. Sorry for the oversight.

Please let me know if you have further questions or problems with the review and possible approval of this filing.

Thank you for your time and help with this filing.

Sincerely,
Luanne Melies

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Form Schedule

Lead Form Number: MI-DVA18(AR)-3

| Schedule Item | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-------------------------------|--------------|-----------------|---|---------|--|-------------|-------------------------|
| Approved-Closed 05/21/2010 | MI-DVA18-3 | Policy/Contract | A18-3 Dental, Vision and Hearing Policy | Revised | Replaced Form #: MI-DVA18 Previous Filing #: MDIC-125606274 | | MI-DVA18-3-04292010.pdf |
| Approved-Closed 05/21/2010 | POLICY A18-3 | Schedule Pages | A18-3 Policy Schedule Page | Revised | Replaced Form #: POLICY A18 Previous Filing #: MDIC-125606274 | | A18-3 Schedule.pdf |



MEDICO®
INSURANCE COMPANY

A STOCK INSURANCE COMPANY

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

DENTAL, VISION AND HEARING EXPENSE POLICY

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

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

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

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

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

PART A PLEASE READ — 30-DAY RIGHT TO RETURN

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

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

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

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

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

LIMITED BENEFIT INSURANCE POLICY FOR DENTAL, VISION AND HEARING EXPENSES

ALPHABETICAL GUIDE TO YOUR POLICY

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

PART C EXCEPTIONS AND LIMITATIONS

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

- 1. dental cleanings.

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

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

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

- 1. bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions or fluoride treatments;
- 2. hearing aids; or
- 3. outpatient dental surgery prescribed as Medically Necessary.

We will NOT pay benefits for:

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

PART D POLICY YEAR DEDUCTIBLE AND MAXIMUM BENEFIT

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

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

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

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

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

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

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

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

Medically Necessary: A service or care:

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

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

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

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

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

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

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

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

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

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

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

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

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

We, Us or Our: Medico Insurance Company.

You or Your: The Insured named in the Schedule.

PART F BENEFITS

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

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

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

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

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

PART G TERMINATION

Your policy will terminate on the earliest of:

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

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

PART H HOW TO FILE A CLAIM

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

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

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

PART I PAYMENT OF CLAIMS

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

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

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

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

PART J OTHER IMPORTANT PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

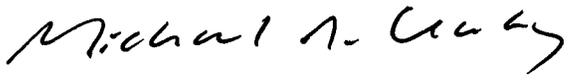
Insurance With Other Insurers (Other Benefits): If there is other valid coverage, not with us, providing benefits for the same loss on other than an expense-incurred basis and of which we have not been given written notice prior to the occurrence or commencement of loss, the only liability for the benefits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

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

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

Our [President] and [Secretary] sign this policy in our behalf.

[]
[President]

[]
[Secretary]

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

SCHEDULE

POLICY NO. - [0000000]

POLICY TYPE – A18

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

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

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

---- ANNUAL ----

POLICY YEAR DEDUCTIBLE\$100.00

POLICY YEAR MAXIMUM BENEFIT \$ [1,500.00]

POLICY A18-3

SERFF Tracking Number: MDIC-126618366 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 45691
 Company Tracking Number: AR A18-3 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18-3 DVH Policy
 Project Name/Number: AR A18-3 DVH Policy/LM AR A18-3 DVH Policy

Rate/Rule Schedule

| Schedule Item Status: | Document Name: | Affected Form Numbers: (Separated with commas) | Rate Action: | Rate Action Information: | Attachments |
|-------------------------------|-------------------------|---|--------------|---|---|
| Approved-Closed 05/21/2010 | A18-3 Individual Rates | MI-DVA18-3 | Other | Previous State Filing Number: Rate Action Other Explanation: | MDIC- AR_A18-125606274 3_I_RateSchd_20100517.pdf Same Rates - Submitting revised policy form. |
| Approved-Closed 05/21/2010 | A18-3 Association Rates | MI-DVA18-3 | Other | Previous State Filing Number: Rate Action Other Explanation: | MDIC- AR_A18-125868707 3_AG_RateSchd_20100517.pdf Same Rates - Submitting revised policy form. |

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18 - Rate Group: A18
Dental/Vision/Hearing

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

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

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

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18 - Rate Group: A18
Dental/Vision/Hearing

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

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

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

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18AG - Rate Group: A18G
Dental/Vision/Hearing - Association Group - Per Person Rate

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

Association Group - A

| Issue Age | Individual | Household |
|-----------|------------|-----------|
| | Premium | Premium |
| 18 - 39 | 262.20 | 234.60 |
| 40 - 59 | 296.40 | 265.20 |
| 60 - 74 | 330.60 | 295.80 |
| 75 - 79 | 342.00 | 306.00 |
| 80 - 84 | 364.80 | 326.40 |

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18AG - Rate Group: A18G
Dental/Vision/Hearing - Association Group - Per Person Rate

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

| Issue Age | Association Group - B | |
|-----------|-----------------------|----------------------|
| | Individual Premium | Household Premium |
| 18 - 39 | 248.40 | 234.60 |
| 40 - 59 | 280.80 | 265.20 |
| 60 - 74 | 313.20 | 295.80 |
| 75 - 79 | 324.00 | 306.00 |
| 80 - 84 | 345.60 | 326.40 |

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18AG - Rate Group: A18G
Dental/Vision/Hearing - Association Group - Per Person Rate

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

| Association Group - C | |
|-----------------------|--------------------|
| Issue Age | Individual Premium |
| 18 - 39 | 234.60 |
| 40 - 59 | 265.20 |
| 60 - 74 | 295.80 |
| 75 - 79 | 306.00 |
| 80 - 84 | 326.40 |

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18AG - Rate Group: A18G
Dental/Vision/Hearing - Association Group - Per Person Rate

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

Association Group - A

| Issue Age | Individual | Household |
|-----------|------------|-----------|
| | Premium | Premium |
| 18 - 39 | 353.97 | 316.71 |
| 40 - 59 | 400.14 | 358.02 |
| 60 - 74 | 446.31 | 399.33 |
| 75 - 79 | 461.70 | 413.10 |
| 80 - 84 | 492.48 | 440.64 |

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18AG - Rate Group: A18G
Dental/Vision/Hearing - Association Group - Per Person Rate

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

| Issue Age | Association Group - B | |
|-----------|-----------------------|----------------------|
| | Individual Premium | Household Premium |
| 18 - 39 | 335.34 | 316.71 |
| 40 - 59 | 379.08 | 358.02 |
| 60 - 74 | 422.82 | 399.33 |
| 75 - 79 | 437.40 | 413.10 |
| 80 - 84 | 466.56 | 440.64 |

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

Medico™ Insurance Company
Omaha, Nebraska
MI-DVA18-3
Gross Premium Code: A18AG - Rate Group: A18G
Dental/Vision/Hearing - Association Group - Per Person Rate

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

| Association Group - C | |
|-----------------------|--------------------|
| Issue Age | Individual Premium |
| 18 - 39 | 316.71 |
| 40 - 59 | 358.02 |
| 60 - 74 | 399.33 |
| 75 - 79 | 413.10 |
| 80 - 84 | 440.64 |

MODAL FACTORS

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

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

Rates certify to a 50% anticipated loss ratio.

MIRSA18-3(AR) 5/10

SERFF Tracking Number: MDIC-126618366 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 45691
 Company Tracking Number: AR A18-3 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18-3 DVH Policy
 Project Name/Number: AR A18-3 DVH Policy/LM AR A18-3 DVH Policy

Supporting Document Schedules

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Satisfied - Item: Flesch Certification | Approved-Closed | 05/21/2010 |
| Comments: | | |
| Attachment: AR-Flesch Certificate -3.pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Application | Approved-Closed | 05/21/2010 |
| Comments: | | |
| Attachments: MIHAA18(AR)-3-04302010.pdf MIHAA18-A-3-04282010.pdf MIHAA18(AR)-3-E-04302010.pdf MIHAA18-A-3-E-04282010.pdf | | |

| | Item Status: | Status Date: |
|---|---------------------|-------------------------|
| Satisfied - Item: Outline of Coverage | Approved-Closed | 05/21/2010 |
| Comments: | | |
| Attachments: MI9F-4331-3-04302010.pdf MI9F-4331-3-E-04302010.pdf | | |

| | Item Status: | Status Date: |
|--|---------------------|-------------------------|
| Satisfied - Item: AR -3 Cover Letter | Approved-Closed | 05/21/2010 |
| Comments: | | |
| Attachment: AR -3 cover letter.pdf | | |

SERFF Tracking Number: MDIC-126618366 State: Arkansas
 Filing Company: Medico Insurance Company State Tracking Number: 45691
 Company Tracking Number: AR A18-3 DVH POLICY
 TOI: H101 Individual Health - Dental Sub-TOI: H101.000 Health - Dental
 Product Name: AR A18-3 DVH Policy
 Project Name/Number: AR A18-3 DVH Policy/LM AR A18-3 DVH Policy

| | | Item Status: | Status Date: |
|---------------------------------|-----------------------------|---------------------|-------------------------|
| Satisfied - Item: | AR Filing Fee Certification | Approved-Closed | 05/21/2010 |
| Comments: | | | |
| Attachment: | | | |
| AR Filing Fee Certification.pdf | | | |

| | | Item Status: | Status Date: |
|--------------------------|------------------------|---------------------|-------------------------|
| Satisfied - Item: | Previously Filed Forms | Approved-Closed | 05/21/2010 |

Comments:
 The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274. The only change from the previous version of this form is that we have bracketed our address. This form is enclosed here for informational purposes, only

The Toll-Free Customer Service Notice, MIR-AR-763 will be delivered with the policy, as required by law. Form MIR-AR-763 was previously approved by your Department on October 27, 2009 under Serff Filing MDIC-126340784. The only change from the previous version of this form is that we have bracketed our address and phone number. This form is enclosed here for informational purposes only.

MI9F-1060 and MI9F-1060-E, the electronic counterpart, will be used when required by state law. The only change from the previous version of these forms, (Serff filings, MDIC-125606274 and MDIC-126077344 respectively) is that we have bracketed our address. These forms are enclosed for informational purposes only.

Attachments:
 MI9F-2701(AR)-03122010.pdf
 MIR-AR-763-03122010.pdf
 MI9F-1060-03102010.pdf
 MI9F-1060-E-03102010.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]
[www.gomedico.com]
[Toll-Free 1-800-228-6080]

Application for Dental, Vision and Hearing Insurance

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

Part A: General Information – Please Print

Name (First, MI, Last, Date of Birth, Age, Sex), Address (Street Address, City, State, Zip), Social Security #, Phone #, E-mail Address, Beneficiary, Relationship, Address

Part B: Applicant Information

- 1. (a) Do you have any dental, vision or hearing insurance currently in force?
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company?
(c) If replacement is involved, have you received a replacement form (in states where required by law)?

Part C: Benefit Option – Check the Desired Benefit: Policy Year Maximum: \$1,000 \$1,500

Part D: Payment Options

Household Discount – If eligible, list name(s) of the other person or persons in your household who is/are also applying for this policy:

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, Credit/Debit Card; Frequency of Payment: Monthly, Quarterly, Semi-Annually, Annually

Note: If you select the Automatic Bank Withdrawal [or Credit/Debit Card] method of payment and we receive no money with your application, your first premium will be withdrawn from your account on the day we issue your policy.

Amount Received with Application \$ Renewal Premium \$

Requested Effective Date of Policy (optional)
(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part E: Application Agreement

I hereby apply to Medico Insurance Company for a Dental, Vision and Hearing Insurance Policy to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded.

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

- 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at [gomedico.com/products].
2. I have received a hard copy of the Medicare Buyers Guide.
3. I am not eligible for Medicare.

Policy Delivery Options: Upon approval of this application, the policy will be mailed to: Applicant Producer
Note: Policy will be mailed to Producer in states where a policy delivery receipt is required by law.

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

I am applying for this Dental, Vision and Hearing insurance.

Applicant's Signature Date
Dated at City State

Producer's Name (Please print) Producer's License Number

Producer's Signature Date



[1515 South 75th Street]
[Omaha, Nebraska 68124]
[www.gomedico.com]
[Toll-Free 1-800-228-6080]

Application for Dental, Vision and Hearing Insurance

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

Part A: General Information – Please Print

Name _____
Address _____
Social Security # _____
Phone # _____ E-mail Address _____
Beneficiary _____ Relationship _____ Address _____

Part B: Applicant Information

- 1. (a) Do you have any dental, vision or hearing insurance currently in force?
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company?
(c) If replacement is involved, have you received a replacement form (in states where required by law)?

Part C: Benefit Option – Check the Desired Benefit: Policy Year Maximum: \$1,000 \$1,500

Part D: Payment Options

Household Discount – If eligible, list name(s) of the other person or persons in your household who is/are also applying for this policy:

Make all checks payable to: Medico Insurance Company (do not make checks payable to the producer or leave payee line blank).

Method of Payment: Frequency of Payment:
[] Automatic Bank Withdrawal [] Monthly [] Quarterly
[] Direct Bill [] Quarterly [] Semi-Annually [] Annually
[] Credit/Debit Card [] Monthly [] Quarterly [] Semi-Annually [] Annually

Note: If you select the Automatic Bank Withdrawal [or Credit/Debit Card] method of payment and we receive no money with your application, your first premium will be withdrawn from your account on the day we issue your policy.

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

Requested Effective Date of Policy (optional) _____
(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part E: Application Agreement

I hereby apply to Medico Insurance Company for a Dental, Vision and Hearing Insurance Policy to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me. I have received the Outline of Coverage for the policy (in states where required by law).

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

- 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at [gomedico.com/products].
2. I have received a hard copy of the Medicare Buyers Guide.
3. I am not eligible for Medicare.

Policy Delivery Options: Upon approval of this application, the policy will be mailed to: [] Applicant [] Producer
Note: Policy will be mailed to Producer in states where a policy delivery receipt is required by law.

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

I am applying for this Dental, Vision and Hearing insurance.

Typing your name and selecting "Continue" shall constitute an electronic signature, which has the same force and effect as a signature affixed by hand.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Signature _____ Date _____



[1515 South 75th Street]
[Omaha, Nebraska 68124]

Outline of Coverage for MI-DVA18
Dental, Vision and Hearing Policy

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

LIMITED BENEFIT POLICY
DENTAL, VISION AND HEARING COVERAGE

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

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

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

BENEFITS PROVIDED BY THE POLICY

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

- \$1,000 \$1,500

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

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

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

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

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

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

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

EXCEPTIONS AND LIMITATIONS

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

- (1) Dental cleanings.

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

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

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

- (1) Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, "full mouth" extractions or fluoride treatments;
- (2) Hearing aids; or
- (3) Outpatient dental surgery prescribed as Medically Necessary.

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

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

RENEWABILITY AND PREMIUM CHANGES

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

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

PREMIUMS

| [PAYMENT METHOD] | [MONTHLY] | [QUARTERLY] | [SEMI-ANNUALLY] | [ANNUAL] |
|---------------------|-----------|-------------|-----------------|----------|
| [BANK DRAFT] | | | [N/A] | [N/A] |
| [DIRECT BILL] | [N/A] | | | |
| [CREDIT/DEBIT CARD] | | | | |

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.



[1515 South 75th Street]
[Omaha, Nebraska 68124]

Outline of Coverage for MI-DVA18
Dental, Vision and Hearing Policy

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

LIMITED BENEFIT POLICY
DENTAL, VISION AND HEARING COVERAGE

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

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

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

BENEFITS PROVIDED BY THE POLICY

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

- \$1,000 \$1,500

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

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

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

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

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

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

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

EXCEPTIONS AND LIMITATIONS

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

- (1) Dental cleanings.

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

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

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

- (1) Bridges, crowns, full dentures or partials, any work relating to replacement of natural teeth which were missing at the time coverage becomes effective, “full mouth” extractions or fluoride treatments;
- (2) Hearing aids; or
- (3) Outpatient dental surgery prescribed as Medically Necessary.

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

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

RENEWABILITY AND PREMIUM CHANGES

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

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

PREMIUMS

| [PAYMENT METHOD] | [MONTHLY] | [QUARTERLY] | [SEMI-ANNUALLY] | [ANNUAL] |
|---------------------|-----------|-------------|-----------------|----------|
| [BANK DRAFT] | | | [N/A] | [N/A] |
| [DIRECT BILL] | [N/A] | | | |
| [CREDIT/DEBIT CARD] | | | | |

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.



May 17, 2010

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

MEDICO INSURANCE COMPANY
NAIC # 31119

RE: Individual Dental, Vision and Hearing Policy

Enclosed Material:

MI-DVA18-3 – Policy
POLICY A18-3 – Policy Schedule Page
MIHAA18(AR)-3 - Application
MIHAA18-A-3 - Application Supplement
MI9F-4331-3 – Outline of Coverage
MIHAA18(AR)-3 E- - Electronic Application
MIHAA18-A-3-E – Electronic Application Supplement
MI9F-4331-3-E – Electronic Outline of Coverage
Actuarial Memorandum
Filing Fee - \$50.00

Informational

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

Enclosed, you will find an Individual Dental, Vision and Hearing Policy and accompanying forms for your review and approval. This filing is intended to replace forms that were previously approved by your department under Serff Filing MDIC-125606274, MDIC-125892039, MDIC-125868707, MDIC-125644426, MDIC-125606274 MDIC-126340784, and MDIC-126077344---- and concurrently introduce two new forms for use with the Dental, Vision and Hearing product.

MI-DVA18-3 is a limited benefit policy form and it replaces the previously approved form MI-DVA18. This form will be used to provide benefits for dental, vision and hearing. The applicant may select a policy year maximum amount of \$1,000 or \$1,500. This form has been revised to clarify the Exceptions and Limitations provision of the policy form. The provision now clearly identifies items and services that are not covered under the policy. The revision and clarification eliminates the need for the rider, form RE487DV, filed under Serff Filing MDIC-125892039, to accompany the policy as required by the previously approved MI-DVA18. Variability is requested for bracketed text concerning our contact information that is subject to change (i.e., Home Office physical address, website address and telephone number) as well as company officer name and designation.

MI9F-4331-3 Outline of Cover is replacing the previously approved form MI9F-4331 under Serff Filing MDIC-125644426. The changes in the outline mimic the changes in the policy. Variability is requested for bracketed text concerning our contact information that is subject to change (i.e., Home Office physical address, website address and telephone number) as well as potential changes in payment methods, payment modes.

MIHAA18(AR)-3 is an application form and replaces the previously approved form MIHAA18(AR). This revised application has been simplified to one page. Variability is requested for bracketed text shown on the application for potential changes in payment methods, payment modes and contact information as referenced above.

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Page 2

MIHAA18-A-3 is an application supplement form. This form is a new form submitted for your review and approval. It will be used in addition to MIHAA18(AR)-3 for applicants that qualify for the Association Group Discount.

The Guaranty Association Notice MI9F-2701(AR) will be delivered with the policy. This form received approval by your division on April 21, 2008 under Serff Filing MDIC-125606274. The only change from the previous version of this form is that we have bracketed our address. This form is enclosed here for informational purposes, only

The Toll-Free Customer Service Notice, MIR-AR-763 will be delivered with the policy, as required by law. Form MIR-AR-763 was previously approved by your Department on October 27, 2009 under Serff Filing MDIC-126340784. The only change from the previous version of this form is that we have bracketed our address and phone number. This form is enclosed here for informational purposes only.

MI9F-1060 and MI9F-1060-E, the electronic counterpart, will be used when required by state law. The only change from the previous version of these forms, (Serff filings, MDIC-125606274 and MDIC-126077344 respectively) is that we have bracketed our address. These forms are enclosed for informational purposes only.

Rates and an Actuarial Memorandum have been submitted as part of this revised form filing. The rates will remain the same, including the association rates filed under Serff Filing MDIC-125868707.

All appropriate forms that were previously approved by your department for the Dental, Vision and Hearing product will accompany these new forms for use.

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

We are also submitting three forms in electronic format for our Dental, Vision and Hearing Product. Forms MIHAA18(AR)-3-E and MIHAA18-A-3-E mirror revised form MIHAA18(AR)-3 and new form MIHAA18-A-3 respectively, in that the only difference between the forms is in the signature area. Form MIHAA18(AR)-3-E will replace previously approved form MIHAA18(AR)-E, approved under SERFF #MDIC-126077344. MIHAA18-A-3-E is a new form submitted for your review and approval. This form will be used in addition to MIHAA18(AR)-3-E for applicants that likewise qualify for the Association Group Discount. It eliminates the need for application MIHAA18(AR)-EA previously approved under Serff Filing MDIC-126077344. All the other previously approved forms, will continue to be used for the on-line application process.

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

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**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.

MEDICO INSURANCE COMPANY
[Omaha, Nebraska]

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

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

DISCLAIMER

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

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

LIMITS ON AMOUNT OF COVERAGE

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

MEDICO® INSURANCE COMPANY

[1515 SOUTH 75TH STREET]

[OMAHA, NE 68124]

POLICY NUMBER – XXXXXXXX

RIDER PAGE 1 OF 1

TOLL-FREE CLIENT SERVICES

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

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

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

In addition, you may submit written inquiries to:

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

You may also call:

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

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

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

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

(Date)

(Applicant's Signature)

(Agent's Signature)

NOTICE TO APPLICANT

REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

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

(Date)

Typing your name and selecting "Continue" shall constitute an electronic signature, which has the same force and effect as a signature affixed by hand.

(Applicant's Signature)