

SERFF Tracking Number: MDIC-126754866 State: Arkansas
Filing Company: Medico Insurance Company State Tracking Number: 46395
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Universal Application for Reinstatement - AR
Project Name/Number: BG Universal Application for Reinstatement - AR/BG Universal Application for Reinstatement - AR

Filing at a Glance

Company: Medico Insurance Company
Product Name: Universal Application for Reinstatement - AR
TOI: H21 Health - Other

Sub-TOI: H21.000 Health - Other
Filing Type: Form

SERFF Tr Num: MDIC-126754866 State: Arkansas

SERFF Status: Closed-Approved- Closed State Tr Num: 46395

Co Tr Num: State Status: Approved-Closed
Reviewer(s): Rosalind Minor
Author: Gelecki Bryan Disposition Date: 08/10/2010
Date Submitted: 08/04/2010 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name: BG Universal Application for Reinstatement - AR
Project Number: BG Universal Application for Reinstatement - AR
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/10/2010

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 07/15/2010
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/10/2010
Created By: Gelecki Bryan
Corresponding Filing Tracking Number:

Deemer Date:
Submitted By: Gelecki Bryan
PPACA: Not PPACA-Related
Filing Description:
MEDICO® INSURANCE COMPANY
NAIC #31119

Re: Revised Reinstatement Applications and Forms
MIA3023 – Universal Application for Reinstatement

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In an effort to make our reinstatement process more simplistic, Medico® Insurance Company has designed an application to allow all Medico policy types to be reinstated using a single form. Enclosed you will find a universal reinstatement application modified to include questions more suitable to underwriting and the reinstatement of lapsed policies for your review and approval. This form will be used for our Medico Insurance Company policyholders only. Once approved, this form may be used by either home office personnel or our field force to facilitate reinstatement of lapsed policies. This form was approved for use in our domicile state on July 15, 2010.

MIA3023 is designed to replace all of our previous reinstatement applications. MIA3023 combines the common questions asked on each application into one section (Section 1) and allows the policy holder to fill out only the remaining questions for the type of policy he/she is attempting to reinstate (Sections 2-5, respectively). The form was created to make the reinstatement process easier for our policy holders by removing any ambiguity about what forms reinstate what policies.

The form also includes a Personal Information Authorization substantively similar to MI9F-4124. This, again, is designed to reduce the amount of forms required in the reinstatement process. MIA3023 will NOT replace MI9F-4124; it will instead make submission of MI9F-4124 unnecessary for reinstatement. This form will have no effect on any other forms (Accelerated Benefit Disclosure Notices, etc) that would accompany any of our original applications for reinstatement. Those forms will still be sent in the same fashion.

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

Sincerely,

Bryan Gelecki
Medico Insurance Company
1515 South 75th Street
Omaha, NE 68124
402-391-6900 Ext. 238

Company and Contact

Filing Contact Information

Bryan Gelecki, Compliance Research Analyst bgelecki@gomedico.com
1515 S. 75th Street 800-695-5976 [Phone] 238 [Ext]
Omaha, NE 68124 402-391-4858 [FAX]

Filing Company Information

Medico Insurance Company CoCode: 31119 State of Domicile: Nebraska

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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: \$50 fee required for filings of this nature.
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Medico Insurance Company	\$50.00	08/04/2010	38515281

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/10/2010	08/10/2010

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Disposition

Disposition Date: 08/10/2010

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	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Form	Universal Application for Reinstatement	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/10/2010	MIA3023	Application/ Enrollment Form	Universal Application for Reinstatement	Initial			MIA3023-06292010.pdf

Reinstatement Application

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

Policy/Certificate Number: _____

Name: _____
First Middle Last

Phone Number (include area code): _____

Please answer every question in Section 1 of the application AND every question in the applicable section for the type of policy/certificate you are applying to reinstate. Please attach any necessary explanations to this application. If approved, this application and any attached explanations will become part of the policy/certificate.

Note: You may be contacted to provide additional information prior to reinstatement of your policy/certificate.

Section 1 – GENERAL INFORMATION

1. Since the original policy/certificate date or within the last 5 years, whichever is shorter, have you consulted with a physician (excluding routine check-ups) AND been diagnosed with or treated for an injury or illness (excluding acute illnesses like the common cold or flu) or received medical test or examination results that indicate an illness or injury may exist? If yes, please attach an explanation detailing each occurrence..... Yes No
2. Please carefully read and complete the Personal Information Authorization form at the end of this application.
3. Do you understand and agree that no reinstatement will be effected until this application is approved? Yes No

Section 2 – REINSTATEMENT OF SHORT-TERM CARE POLICIES

1. Since the original policy/certificate date, do you have any issued or pending, individual or group accident or sickness policies? If yes, please explain, including issuing company, policy amounts and types. Yes No
2. Do you need assistance in your daily activities of living (eating, dressing, bathing, continence, transferring and toileting)? If yes, please explain..... Yes No
3. Do you use a wheelchair, crutches, cane or walker? If yes, please explain. Yes No
4. In the last 12 months have you been hospitalized or confined to a nursing facility? If yes, please explain. Yes No
5. Are you currently taking any prescription medications? If yes, please explain and include names, dosages, and reason for being prescribed. Yes No
6. Please provide the name and contact information of your current physician.

Section 3 – REINSTATEMENT OF LIFE POLICIES

1. Have you used tobacco or tobacco products within the last 12 months? Yes No

Section 4 – REINSTATEMENT OF CANCER POLICIES

1. Have you ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? Yes No

2. Have you been advised by a physician to undergo examinations or medical tests to diagnose a possible malignancy or evaluate a premalignant condition within the last 10 years? If yes, please explain. Yes No

Section 5 – REINSTATEMENT FOR ALL OTHER POLICIES/CERTIFICATES

1. Since the original policy/certificate date, do you have any issued or pending, individual or group accident or sickness policies? If yes, please explain, including issuing company, policy amounts and types..... Yes No

2. Since the original policy/certificate date, have you changed occupations? If yes, please explain your new occupation including title and exact duties..... Yes No

3. If the policy/certificate to be reinstated provides maternity benefits, is the person to be covered under the reinstated policy pregnant?..... Yes No

SIGNATURE AND NOTICES

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/certificate will not be in effect until this application for reinstatement has been received in the Home Office and approved, and until all back premiums (if required) have been paid. I understand that the policy/certificate will not be incontestable until it has been in force for two years from the date of reinstatement. I also understand that if my policy/certificate is reinstated, this application, and the information it contains, becomes part of the policy/certificate just as if it were an original application and that reinstatement shall be in accordance with the policy/certificate provisions.

This application purports to reinsure one individual only. If original policy provided coverage for more than one individual, separate applications must be submitted for each individual seeking 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.

Signature: _____
Applicant Signature

Producer: _____
(if applicable) Producer Signature

Applicant Printed Name

Producer Printed Name

Date: _____
Month Day Year

Date: _____
Month Day Year

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.)

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 75th 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

Signature: _____
Applicant/Personal Representative Signature

Applicant/Personal Representative Printed Name

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

Date: _____
Month Day Year

Description of Personal Representative's Authority

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Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification	Approved-Closed	08/10/2010
Bypass Reason:	N/A - Form is an application for reinstatement, and contains notice and disclosure information which artificially alters readability certification.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/10/2010
Bypass Reason:	N/A - Policy is a reinstatement Application		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	08/10/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	08/10/2010
Bypass Reason:	N/A		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	08/10/2010
Bypass Reason:	N/A - Not PPACA related		
Comments:			