MEDICO®
INSURANCE COMPANY

Medico® Hospital Indemnity Insurance

APPLICATION BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

☐ Application for Hospital Indemnity Insurance Policy

☐ Bank Draft and/or Credit Card Authorization (if applicable)

☐ Additional forms which may be required. See forms marked Complete and Send with Application. All other forms should be left with the applicant.

Submit applications electronically by MyEnroller, Mail or Fax.

MyEnroller
Electronic Application Submission Tool
Website: mic.GoMedico.com

Mail
Medico Insurance Company
PO Box 10386
Des Moines, IA 50306

Fax
1-888-363-3420

If you have any questions, please call 1-800-547-2401-Option 3.

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MEDICO®
INSURANCE COMPANY

PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Application for Hospital Indemnity Insurance Policy

Application for: ❒ New Coverage ❒ Reinstatement ❒ Increase of Benefits

If Reinstatement or Benefit Increase requested, please print Medico policy number affected: _____

Requested Effective Date of New Policy (optional)

_____

Requested Effective Date must be after the Application Date.
If no Effective Date is requested, the Effective Date will be the day the Application is approved by our Underwriting Department.

Policy Delivery Options

Upon approval of this Application, the policy will be mailed to:

❒ Applicant ❒ Producer

Part A: General Information – Please Print

Applicant Information

First Name | M.I. | Last Name | Suffix

Date of Birth (MM/DD/YY) | Age | Gender | Social Security Number

Address

City | State | ZIP Code

Phone Number | Email Address

Beneficiary | Relationship

Address

City | State | ZIP Code

1. Do you have coverage that meets the minimum essential coverage requirement under the Affordable Care Act? ❒ Yes ❒ No
2. Are you replacing any type of coverage? ❒ Yes ❒ No

   If "Yes", please provide the following:

   Company Name | Policy Type

   Is this minimum essential coverage? ❒ Yes ❒ No
3. Have you received a replacement form (in states required by law)? ❒ Yes ❒ No

Part B: Medical Information

QUALIFYING INFORMATION (If any answer to questions 1 through 10 is "YES," you are not eligible for coverage.)

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

1. Are you pregnant or undergoing infertility treatment? ❒ Yes ❒ No
2. In the past 12 months have you received home health care, been bedridden, been confined to a wheelchair, used oxygen, or been confined to a nursing home or a hospital as an inpatient (other than for childbirth)? ❒ Yes ❒ No
3. In the past 12 months have you been treated for or diagnosed with chronic obstructive lung disease, emphysema, Parkinson's disease, neuromuscular disease, multiple sclerosis, dementias, Alzheimer's disease, ulcerative colitis, cirrhosis, hepatitis C or other chronic liver disease? ❒ Yes ❒ No
4. In the past 24 months have you been treated for diabetes:
   a) requiring insulin or injectable medication; ❒ Yes ❒ No
   b) requiring two or more oral medications; ❒ Yes ❒ No
   c) that was diagnosed prior to the age of 40; ❒ Yes ❒ No
   d) that involved any complication, including, but not limited to, peripheral neuropathy, peripheral vascular disease or diabetic retinopathy? ❒ Yes ❒ No
5. In the past 12 months have you been advised to have surgery which will require an inpatient stay but not yet done so? ❒ Yes ❒ No
6. In the past 12 months have you lost more than 10 pounds without trying? ❒ Yes ❒ No
7. In the past 24 months have you had or been treated for or diagnosed with:
   a) a heart attack, stroke, transient ischemic attack (TIA), heart surgery/bypass and/or stent placement, congestive heart failure; ❒ Yes ❒ No
   b) lupus, rheumatoid arthritis, kidney disease, osteoporosis causing fractures; ❒ Yes ❒ No
   c) cancer (other than skin cancer), malignancy, leukemia, melanoma, Hodgkin's disease? ❒ Yes ❒ No
8. In the past 24 months have you received medical advice, treatment or counseling relating to schizophrenia, psychotic disorder, bipolar/manic depression, alcohol or substance abuse? ❒ Yes ❒ No
9. Have you ever been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or Human Immunodeficiency Virus (HIV) Infection? ❒ Yes ❒ No
10. Within the last 24 months:
    a) Have you been advised by a Licensed Health Care Practitioner/Physician to have medical tests or examinations to diagnose a possible condition but have not done so yet? ❒ Yes ❒ No
    b) Have you experienced any of the following, for which medical advice, diagnosis or treatment has not yet been obtained: coughing or vomiting blood; passing blood through either the bowels or urine; breast discharge; fatigue; unexplained weight loss; a lump, growth or tumor in a breast or elsewhere; a change in a mole or a bleeding mole? ❒ Yes ❒ No
    c) Have you had laboratory or diagnostic test results outside of the normal range or been advised by a Licensed Health Care Practitioner/Physician to have medical tests or examinations to diagnose one of the conditions above (refer to Questions 1-9) but have not done so yet? ❒ Yes ❒ No

Part C: Benefit Options

Choose one of your base options:

Option 1

❒ Hospital Indemnity Insurance Policy Form HIA60

Daily Benefit for Hospital Confinement ($250 to $600 in $25 increments): $_____

Maximum Hospital Confinement Period (6, 7, 8, 9 or 10 Days): _____

RA89 Accidental Death And Dismemberment Benefit Rider: $ 1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

OR

Option 2

❒ Lump Sum Hospital Confinement Insurance Policy Form HIA62

Lump Sum Benefit Amount ($1,500, $2,000 or $2,500): $_____

Maximum Lump Sum Hospital Confinement Benefit Days per Calendar Year (3 Days) 3 Days

RA89 Accidental Death And Dismemberment Benefit Rider $ 1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

OR

Option 3

❒ Lump Sum Hospital Confinement Insurance Policy Form HIA62

Lump Sum Benefit Amount $5,000 $ 5,000

Maximum Lump Sum Hospital Confinement Benefit Days per Calendar Year (1 Day) 1 Day

RA89 Accidental Death And Dismemberment Benefit Rider $ 1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

Optional Riders - Choose any optional Rider(s):

❒ RA67 Ambulance Services Indemnity Benefit Rider

Ground - per Day $ 250

Air - per Day $ 250

Combined Maximum Days per Calendar Year 3 Days
(Not available age 81 or over.)

❒ RA87 Lump Sum Cancer Benefit Rider

$1,000, $2,500, $5,000, $7,500 or $10,000 $_____
(One benefit per Lifetime; not available age 80 or over)

❒ RA89 Accidental Death And Dismemberment Benefit Rider

$5,000, $10,000 or $20,000 $_____
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime, not available age 81 or over.)

Part D: Payment Options

Household Discount – When the Applicant lives in the same household with another person over 18 years of age, regardless of whether both sign up for coverage with Medico Insurance Company, a discount is applied to the premium rates.

Do you live in the same household with another person who is over the age of 18? ❒ Yes ❒ No

Name_____
First MI Last

Initial Method of Payment: **Initial Frequency of Payment:**

❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Amount Received with Application $_____ Renewal Premium $_____

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

Part E: Application Agreement

I hereby apply to Medico Insurance Company (the Company) for a **Hospital Indemnity Insurance Policy** with limited benefits to be issued solely and entirely in reliance on my answers to the questions. This Application will become a part of any policy to which this form is attached.

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a policy is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- I must tell the Company if my health changes in a way that could affect my answers to the above health questions between the time I signed the Application and the time the policy becomes effective.
- The policy, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the policy is issued.
- Health conditions present before the Application is signed will be covered only if listed on this Application.
- No portion of the premium will be paid, during the period the policy is in force, by or on behalf of a third party (not to include an immediate family member), either directly, or through wage adjustments or other means of reimbursement.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy (in states where 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.

NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Part E: Application Agreement (continued)

This policy does not meet the definition of minimum essential coverage and will not satisfy the individual responsibility requirements under the Affordable Care Act. I hereby attest that I am purchasing this policy as a supplement to my health coverage, which meets the federal requirement of minimum essential coverage.

I acknowledge that in states where it is required, the Producer made the necessary inquiries concerning my insurance needs and proposed a program of insurance which is suitable for my needs. I am applying for this Hospital Indemnity Insurance Policy with limited benefits.

X _____

Applicant's Signature Date

Producer's Certification: I certify the information in this Application was provided by the Applicant and correctly recorded. I have no information to add that could affect the acceptance or rejection of the risk. Any intention to replace coverage is reflected in the Application. If the Applicant is Medicare eligible, I have provided the Applicant a link to the Medicare Buyer's Guide at GoMedico.com or a hard copy of it.

_____

Producer's Printed Name Producer's Number

X _____

Producer's Signature Date

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MEDICO®
INSURANCE COMPANY

Medico Hospital Indemnity Premium Worksheet

(Please complete and submit this form with the application.)

Applicant's Name _____
First MI Last

Age _____ ❒ Male ❒ Female

Household Discount – When the applicant lives in the same household with another person over 18 years of age, regardless of whether both sign up for coverage with Medico Insurance Company, a discount is applied to the premium rates.

Does the applicant live in the same household with another person who is over the age of 18? ❒ Yes ❒ No

Name_____
First MI Last

Method of Payment:	**Mode - Frequency of Payment:**			
❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Base Options

Option 1

❒ Hospital Indemnity Insurance Policy Form HIA60
Daily Benefit for Hospital Confinement ($250 to $600 in $25 increments).....$_____Daily Benefit

Maximum Hospital Confinement Period (6, 7, 8, 9 or 10 Days) _____Days

$_____ premium per $25 unit X number of units (10 to 24) _____ = $_____
(To calculate the number of units, divide the daily benefit by 25. For example: $475 daily benefit ÷ 25 = 19 units.)

Automatically Included: Accidental Death and Dismemberment Benefit Rider RA89: $1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

Option 2

❒ Lump Sum Hospital Confinement Insurance Policy Form HIA62
Lump Sum Benefit Amount:
($1,500, $2,000 or $2,500)..... $_____ Lump Sum .....$_____

Maximum Lump Sum Hospital Confinement Benefit Days per Calendar Year: 3 days

Automatically Included: Accidental Death and Dismemberment Benefit Rider RA89: $1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

Option 3

❒ Lump Sum Hospital Confinement Insurance Policy Form HIA62
Lump Sum Benefit Amount $5,000:
Maximum Lump Sum Hospital Confinement Benefit Days per Calendar Year: 1 Day .....$_____

Automatically Included: Accidental Death and Dismemberment Benefit Rider RA89: $1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

(Continued)

Premium for chosen riders

Optional Riders (available on either policy form HIA60 or HIA62). Applicants may apply for any combination or all of the following optional riders (subject to issue age limitations):

❒ Ambulance Services Indemnity Benefit Rider RA67; Available through age 80 ..... $_____

❒ Lump Sum Cancer Benefit Rider RA87
$1,000, $2,500, $5,000, $7,500 or $10,000: ..... $_____Benefit
(One Benefit per Lifetime; Available through age 79)

$_____ premium per unit X number of units (2, 5, 10, 15 or 20) _____ = $_____
(To calculate the number of units, divide the benefit by 500. For example: $7,500 ÷ 500 = 15 units.)

❒ Accidental Death and Dismemberment Benefit Rider RA89
$5,000, $10,000 or $20,000: ..... $_____Benefit
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)
(Your policy will be automatically issued with a $1,000 Accidental Death and Dismemberment Benefit Rider RA89 (regardless of age). Applicants ages 40 through 80 may also choose to apply for an additional benefit amount.

$_____ premium per unit X number of units (1, 2 or 4) _____ = $_____
(To calculate the number of units, divide the benefit by 5,000. For example: $10,000 ÷ 5,000 = 2 units.)

Total Premium $_____

If eligible for Household Discount, multiply by 0.93 $_____

Total Premium $_____

Multiply by *Modal Factor, if applicable: _____

Total Premium $_____

*Modal Factors to Apply to Monthly Bank Draft Rates			
Mode	**Bank Draft**	**Direct Bill**	**Credit Card**
Monthly	1.000		1.032
Quarterly	3.000	3.240	3.096
Semi-Annual	6.000	6.240	6.180
Annual	12.000	12.000	12.360

Rate quotes are for illustrative purposes only and are not guaranteed. This quote is not an offer or contract. We reserve the right to adjust the quoted rates based on the information provided by the application, the underwriting process, applicant interviews, or to correct any errors on the quotation.

BANK DRAFT INFORMATION

STOP! Complete this section *only* if you have chosen the monthly automatic payment option.

A. If you requested the "Bank Draft" option, what is to be included?

☐ Only the Coverage Applied for Today ☐ All Coverage (New and Existing)

B. Initial Premium

Authorization to Bank or Other Financial Institution

☐ Checking ☐ Savings

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

C. Ongoing Premium ***(Complete C only if different from Initial Premium information)***

Authorization to Bank or Other Financial Institution

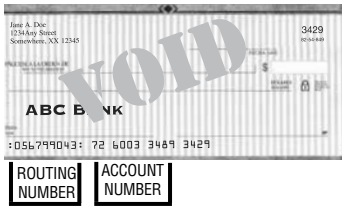
☐ Checking ☐ Savings

First Name (as it appears on account) | M.I. | Last Name (as it appears on account)

Bank or Financial Institution Name (including branch, if any) | Routing Number

Bank or Financial Institution's Address | Account Number

D. Please read: By providing my account information here and signing the application for insurance coverage, I authorize the bank whose name and address I am providing to pay and to charge to my account the amount of any check, instrument, or any other funds made by and payable to Medico Insurance Company and/or Medico Corp Life Insurance Company for insurance premiums. I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to contact my bank or financial institution on my behalf for the sole purpose of obtaining information necessary to administer my preauthorized withdrawals in conjunction with my insurance coverage. This authorization is to remain in effect until revoked by me in writing. Until you receive and have reasonable time to act on such notices, you shall be fully protected in accepting any preauthorized withdrawal against my account.



CREDIT CARD AUTHORIZATION

STOP! Complete this section *only* if you are paying by credit card.

By providing this information and signing the application for insurance coverage, you authorize Medico Insurance Company and/or Medico Corp Life Insurance Company to bill your MasterCard/Visa account for the initial premium.

A. If you requested the "Credit Card" option, what is to be included?

☐ Only the Coverage Applied for Today ☐ All Coverage (New and Existing)

B. Initial Premium

Credit Card Information: ☐ MasterCard ☐ Visa

Credit Card Number | Card Security Code (3 digits) | Expiration Date MM / YYYY

Billing Address:

Billing information must be entered exactly as it appears on the credit card statement. Please check the statement for accuracy to avoid delays in processing.

First Name | M.I. | Last Name

Billing Address | City | State | Zip Code

C. Ongoing Premium ***(Complete C only if different than Initial Premium Information)***

Credit Card Information: ☐ MasterCard ☐ Visa

Credit Card Number | Card Security Code (3 digits) | Expiration Date MM / YYYY

Billing Address:

Billing information must be entered exactly as it appears on the credit card statement. Please check the statement for accuracy to avoid delays in processing.

First Name | M.I. | Last Name

Billing Address | City | State | Zip Code

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HIPAA and MIB Authorization

HIPAA AUTHORIZATION

I authorize any person described below who has health or non-health information about me to disclose such information to Medico Insurance Company and/or Medico Corp Life Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; Pharmacy Benefit Manager (PBM); or the Medical Information Bureau (MIB).

I authorize the Company or it's reinsurers to make a brief report of my personal health information to the MIB.

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P. O. Box 10482, Des Moines, Iowa 50306-0482.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it. (180 days for confidential HIV-related information).
- I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.

I agree that a copy of this Authorization is as valid as the original.

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

AUTHORIZATION TO DISCLOSE INFORMATION (MIB)

I authorize Medico Insurance Company and/or Medico Corp Life Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention.

I understand that I do not have to authorize this disclosure to MIB.

Issuance of coverage will not be conditioned on me signing this authorization. ..... ☐ **Yes** ☐ **No**

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and must send my written request to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386 and/or Medico Corp Life Insurance Company, P. O. Box 10482, Des Moines, Iowa 50306-0482.

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Date

MM / DD / YYYY

Your Name (Please print)

Your Signature

X

Your Spouse's Name (if applying) (Please print)

Your Spouse's Signature (if applying)

X

If you are signing as a personal representative for an individual to be insured, read and sign below

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal Representative (Please print)

Personal Representative Signature

X

Person(s) to be Insured
(Please print)

1.

2.

My relationship to applicant(s)
(Please print)

1.

2.

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MEDICO®
INSURANCE COMPANY

PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

RECEIPT

The Applicant Has Applied For Policy:

- ❒ **Option 1 - HIA60** Hospital Indemnity Insurance Policy
  OR
- ❒ **Option 2 or Option 3 - HIA62** Lump Sum Hospital Confinement Insurance Policy

Optional Riders (Additional Premium Required):

- ❒ **RA67** Ambulance Services Indemnity Benefit Rider
- ❒ **RA87** Lump Sum Cancer Benefit Rider
- ❒ **RA89** Accidental Death And Dismemberment Benefit Rider

Received of _____
(Applicant's Name)

an application for insurance as shown above and $ _____.

This receipt is given and accepted for an application for insurance. This insurance will not be in force until the policy is issued and the first premium is paid in full.

If your application cannot be approved, we will promptly refund your money. ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO **MEDICO INSURANCE COMPANY**. DO NOT MAKE CHECK PAYABLE TO THE PRODUCER OR LEAVE THE PAYEE BLANK.

If you do not receive your policy within 30 days, please contact us by one of the following methods:

Write to: Medico Insurance Company
PO Box 10386 • Des Moines, IA 50306

Call: Customer Service at 1-800-228-6080

E-mail: customerservice@GoMedico.com

_____ _____
Producer's Signature Date

_____
Producer's Name

The Medicare Buyers Guide, "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," can be found on our website at www.GoMedico.com/products.

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MEDICO®
INSURANCE COMPANY

PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Outline of Coverage for Policy HIA60
Hospital Indemnity Benefit Policy

LIMITED BENEFIT POLICY FOR HOSPITAL CONFINEMENT, OBSERVATION UNIT CONFINEMENT, MENTAL HEALTH CONFINEMENT AND EMERGENCY ROOM VISITS

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 and 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.**

Hospital Confinement Indemnity Coverage – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

BENEFITS PROVIDED BY THE POLICY

For any benefit to be payable under the benefits described below, the loss must be incurred while the policy is in force and not excluded from coverage under the Exclusions and Limitations or the Pre-existing Conditions Limitations provision. Benefits under the policy are fixed indemnity benefits. Fixed indemnity benefits are paid in the amount stated on the Policy Schedule without regard to the cost of the services rendered and may be more than or less than the amount(s) charged for any insured loss.

Hospital Confinement Indemnity Benefit: We will pay the Hospital Confinement Indemnity Benefit Amount for each day you are Hospital Confined as a result of a covered loss due to a Sickness or Injury. Benefits are not payable beyond the Maximum Benefit Period for any one Hospital Confinement Period. The Hospital Confinement Indemnity Benefit Amount and Maximum Benefit Period are shown in the Policy Schedule. This benefit is not payable for confinement in a Hospital due to a Mental or Nervous Disorder.

Observation Unit Indemnity Benefit: We will pay the Observation Unit Indemnity Benefit Amount for each day you are in an Observation Unit of a Hospital as a result of a covered loss due to a Sickness or Injury. Benefits are not payable beyond the Calendar-Year Maximum Benefit Days. The Observation Unit Indemnity Benefit Amount and the Calendar-Year Maximum Benefit Days payable are shown in the Policy Schedule.

Mental Health and Substance Abuse Indemnity Benefits: We will pay the Mental Health Benefit Amount for each day you are confined in a Hospital due to a covered Mental or Nervous Disorder. Benefits are not payable beyond the Calendar-Year Maximum Benefit Days. The Mental Health Indemnity Benefit Amount and the Calendar-Year Maximum Benefit Days payable are shown in the Policy Schedule.

We will pay the Substance Abuse Indemnity Benefit Amount for each day you are confined in a Hospital due to a covered Substance Abuse Disorder. Benefits are not payable beyond the Substance Abuse Calendar-Year Maximum Benefit Days. The Substance Abuse Indemnity Benefit Amount and the Substance Abuse Calendar-Year Maximum Benefit Days payable are shown in the Policy Schedule.

We will not pay benefits for the Hospital Confinement Indemnity Benefit, Observation Unit Indemnity Benefit and/or the Mental Health and Substance Abuse Indemnity Benefit for the same date of service. We will pay the greater of these benefits for that date of service.

Emergency Room Indemnity Benefit: We will pay the Emergency Room Indemnity Benefit Amount for each day you receive services in a Hospital emergency room or Hospital affiliated emergency care facility as a result of a covered loss due to an Injury, provided the emergency treatment is followed within 24 hours by a covered Hospital Confinement of at least one 24-hour day. Benefits are not payable beyond the Calendar-Year Maximum. The Emergency Room Indemnity Benefit Amount and the Calendar-Year Maximum Benefit Days payable are shown in the Policy Schedule. The Emergency Room Benefit is payable only once per any one Hospital Confinement Period.

Accidental Death And Dismemberment Benefit Rider (Rider Form RA89) If you become eligible for one of the following benefits, we will pay one of the following benefits. We will not pay a benefit for both the Accidental Death Benefit and the Dismemberment Benefit. We will not pay more than one benefit under this Rider. Your coverage under this Rider automatically terminates upon payment of either the Accidental Death Benefit or the Dismemberment Benefit. If more than one Loss is sustained as a result of one Accident, we will pay only one amount, the largest to which you are entitled.

> **Accidental Death Benefit:** We will pay the Accidental Death Benefit to the beneficiary named in the application (or as later changed) if you die solely as a result of an Accidental bodily Injury. In order for the Accidental Death Benefit to be payable, death must occur within 90 days of the covered Injury and while this Rider and the policy are in force. This Rider will not pay more than one Accidental Death Benefit. The Accidental Death Benefit Amount is shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Accidental Death Benefit.
>
> **Dismemberment Benefit:** We will pay the appropriate Dismemberment Benefit to you if you suffer total and irrecoverable Loss of eyesight or limbs solely as a result of an Injury. In order for the Dismemberment Benefit to be payable, your Loss must occur while this Rider and the policy are in force. This Rider will not pay more than one Dismemberment Benefit. The Dismemberment Benefit Amounts are shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Dismemberment Benefit.

This Rider is automatically issued with your policy in the amount of $1,000.
You may also choose to apply for a higher benefit amount if you are age 80 or under.

OPTIONAL BENEFITS (Available for an Additional Premium)

The following optional Riders are available for additional premium. The Riders are subject to all the provisions of the policy including, but not limited to, policy definitions, conditions, provisions, limitations and exclusions. The benefit amount and period maximums are shown in the Policy Schedule (unless the Rider is issued after the Policy Date). Benefits provided by the Riders are fixed indemnity benefits. The amount we pay will not be determined by the amount of the charges for the services and may be more than or less than the amount(s) charged for any insured loss.

Ambulance Services Indemnity Benefit Rider (Rider Form RA67) We will pay the applicable Ground Ambulance Services Indemnity Benefit Amount or Air Ambulance Services Indemnity Benefit Amount for each day you receive Ambulance transportation services due to a covered Sickness or Injury. Ambulance Services must be provided by a licensed Ambulance service within 96 hours of the Injury or the onset of Sickness. Benefits are not payable beyond the Combined Ambulance Services Calendar-Year Maximum Benefit Days.

Lump Sum Cancer Benefit Rider (Rider Form RA87) We will pay the Lump Sum Cancer Benefit Amount when you are First Diagnosed as having internal Cancer or malignant melanoma, provided you have met the conditions set forth in this Rider. You are limited to one Lump Sum Cancer Benefit payment while this Rider and policy are in force. Your coverage under this Rider automatically terminates upon payment of the Lump Sum Cancer Benefit.

Accidental Death And Dismemberment Benefit Rider (Rider Form RA89) Although this Rider is automatically attached to your policy with a $1,000 benefit amount, you may also choose to apply for a higher benefit amount if you are age 80 or under. If you become eligible for one of the following benefits, we will pay one of the following benefits. We will not pay a benefit for both the Accidental Death Benefit and the Dismemberment Benefit. We will not pay more than one benefit under this Rider. Your coverage under this Rider automatically terminates upon payment of either the Accidental Death Benefit or the Dismemberment Benefit. If more than one Loss is sustained as a result of one Accident, we will pay only one amount, the largest to which you are entitled.

Accidental Death Benefit: We will pay the Accidental Death Benefit to the beneficiary named in the application (or as later changed) if you die solely as a result of an Accidental bodily Injury. In order for the Accidental Death Benefit to be payable, death must occur within 90 days of the covered Injury and while this Rider and the policy are in force. This Rider will not pay more than one Accidental Death Benefit. The Accidental Death Benefit Amount is shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Accidental Death Benefit.

Dismemberment Benefit: We will pay the appropriate Dismemberment Benefit to you if you suffer total and irrecoverable Loss of eyesight or limbs solely as a result of an Injury. In order for the Dismemberment Benefit to be payable, your Loss must occur while this Rider and the policy are in force. This Rider will not pay more than one Dismemberment Benefit. The Dismemberment Benefit Amounts are shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Dismemberment Benefit.

EXCLUSIONS AND LIMITATIONS

We will NOT pay benefits for:

1. Any loss that occurs while this policy is not in force.
2. For services or supplies not covered under this policy.
3. For treatment of complications of a noncovered loss.
4. Treatment, services or supplies which:
    a. Are not Medically Necessary as determined by us;
    b. Are not prescribed by a Physician as necessary to treat a Sickness or Injury;
    c. Are determined to be Experimental or Investigational as determined by us;
    d. Are received without charge or legal obligation to pay;
    e. Would not routinely be paid in the absence of insurance;
    f. Are received from any Family Member.
5. Suicide or any suicide attempt while sane or insane (in Missouri, while sane) or any intentionally self-inflicted Injury.
6. Mental health and substance abuse treatment that is required by a diversion agreement, court order or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.
7. Injuries received or caused directly or indirectly while under the influence of a controlled substance, unless prescribed by a Physician, or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred.
8. Loss to which a contributing cause was your commission of or attempt to commit a felony or being engaged in an illegal occupation.
9. Service for which benefits are available for you under state or federal workers' compensation.
10. Loss that occurs outside the territorial limits of the United States.
11. Any loss resulting from war, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent.
12. Durable medical equipment (D.M.E.).
13. Prosthetics or orthopedic shoes.
14. Drugs and self-administered drugs.
15. Physical therapy, occupational therapy or speech therapy, except as specifically provided elsewhere in this policy.
16. Dental care or treatment (except expenses otherwise covered due to Injury to sound natural teeth); ordinary dental care, dentures and dental implants; cosmetic surgery, except for reconstructive surgery which is incidental to or follows surgery.
17. Vision surgery, including any complications arising therefrom, to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
18. Hearing services.
19. Any loss resulting from any device for aerial navigation, except as a fare-paying passenger.

20. Any loss resulting, either directly or indirectly, from your participation in a high risk activity for pay, profit or other commercial purposes including, but not limited to:
    a. Sporting event;
    b. Skydiving;
    c. Hang gliding;
    d. Parachuting;
    e. Piloting experimental or ultralight aircraft;
    f. Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot;
    g. Riding in a hot air balloon;
    h. Bungee jumping;
    i. Rappelling;
    j. Professional mountain and/or rock climbing;
    k. Rodeo participation; and
    l. Organized contests including, but not limited to, organized contests of speed, go-cart racing, dirt bike racing, demolition derbies, and mountain bike racing. This exclusion also includes the practice, qualification and/or testing for such activities.
21. Abortion, except for Medically Necessary abortions performed to save the mother's life.
22. Sex change, reversal of tubal ligation or reversal of vasectomy.
23. Cosmetic or elective procedures that are not Medically Necessary, including, but not limited to organ donation, elective sterilization and fertility treatments.
24. Hospital Confinement primarily for rest care, convalescent care or for rehabilitation.

Pre-Existing Conditions Limitation: We will NOT pay benefits for any loss for Pre-Existing Conditions during the first six months after the Policy Date. If, after the Policy Date, a Rider is added to this policy, or benefits are increased under the policy or any attached Rider, we will NOT pay the increased benefits for any loss for Pre-Existing Conditions during the first six months after the date the increased benefits become effective.

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

RENEWABILITY AND PREMIUM CHANGES

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

Terms Under Which We May Change Premiums – We can change your premium only if we do the same to all policies of this form, or optional Riders attached to this form, which are issued to persons of your class. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If you have a change in residence, premiums may change to reflect your current geographic area. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy or any Rider, we will send you written notice at least 31 days in advance of the change in premium.

Cancellation by Insured – You may cancel your policy at any time by writing us. Cancellation is effective on the date we receive your notice unless you specify a later date. If you do cancel, we will promptly refund to you the excess of premium paid above the prorated premium for the expired time (this date we received notice from you). Cancellation will not affect an existing claim.

PREMIUMS

Base Policy

❒ Hospital Indemnity Insurance Policy Form HIA60
Daily Benefit for Hospital Confinement ($250 to $600 in $25 increments): $_____
Maximum Hospital Confinement Period (6, 7, 8, 9 or 10 days): _____

RA89 Accidental Death And Dismemberment Benefit Rider: $ 1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.

Optional Riders

❒ RA67 Ambulance Services Indemnity Benefit Rider
Ground: $ 250
Air: $ 250
Combined Maximum of 3 Days per Calendar Year: 3 Days
(Not available age 81 or over.)

❒ RA87 Lump Sum Cancer Benefit Rider
$1,000, $2,500, $5,000, $7,500 or $10,000: $_____
(One benefit per Lifetime; not available age 80 or over)

❒ RA89 Accidental Death And Dismemberment Benefit Rider
$5,000, $10,000 or $20,000: $_____
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifet_ime, not available age 81 or over.)

Automatic Bank Withdrawal:

Monthly

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.

Rate quotes are for illustrative purposes only and are not guaranteed. This quote is not an offer or contract. We reserve the right to adjust quoted rates based on the information provided by the application, the underwriting process, applicant interviews, or to correct any errors on the quotation. Any coverage is effective only after approved by the Company, and only after premium has been received by the Company. All plan provisions apply. If an applicant's age increases after the quote is submitted and coverage is not yet approved by the Company, the premium will be adjusted to reflect the new age in the rates. Please refer to the policy schedule for exact policy information.

_____
Producer's Printed Name

_____ _____
Producer's Signature Date

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MEDICO®
INSURANCE COMPANY

PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Outline of Coverage for Policy HIA62
Lump sum Hospital Confinement Benefit Policy

LUMP SUM HOSPITAL CONFINEMENT LIMITED BENEFIT POLICY

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 and 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.

Hospital Confinement Indemnity Coverage – Policies of this category are designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

BENEFITS PROVIDED BY THE POLICY

For any benefit to be payable under the benefits described below, the loss must be incurred while the policy is in force and not excluded from coverage under the Exclusions and Limitations or the Pre-existing Conditions Limitations provision. Benefits under the policy are fixed indemnity benefits. Fixed indemnity benefits are paid in the amount stated on the Policy Schedule without regard to the cost of the services rendered and may be more than or less than the amount(s) charged for any insured loss.

Lump Sum Hospital Confinement Benefit: We will pay the Lump Sum Hospital Confinement Benefit Amount when you are Hospital Confined as a result of a covered loss due to a Sickness or Injury. Benefits are payable only once during any one Hospital Confinement Period. No benefits are payable beyond the Calendar-Year Maximum Benefit Days. The Lump Sum Hospital Confinement Benefit Amount and Lump Sum Hospital Confinement Calendar-Year Maximum Benefit Days are shown in the Policy Schedule.

We will pay the Mental Health Indemnity Benefit Amount for each day you are confined in a Hospital due to a covered Mental or Nervous Disorder. Benefits are not payable beyond the Mental Health Calendar-Year Maximum Benefit Days. The Mental Health Indemnity Benefit Amount and the Mental Health Calendar-Year Maximum Benefit Days payable are shown in the Policy Schedule.

We will pay the Substance Abuse Indemnity Benefit Amount for each day you are confined in a Hospital due to a covered Substance Abuse Disorder. Benefits are not payable beyond the Substance Abuse Calendar-Year Maximum Benefit Days. The Substance Abuse Indemnity Benefit Amount and the Substance Abuse Calendar-Year Maximum Benefit Days payable are shown in the Policy Schedule.

We will not pay benefits for the Hospital Confinement Indemnity Benefit and/or the Mental Health and Substance Abuse Indemnity Benefit for the same date of service. We will pay the greater of these benefits for that date of service.

Accidental Death And Dismemberment Benefit Rider (Rider Form RA89) If you become eligible for one of the following benefits, we will pay one of the following benefits. We will not pay a benefit for both the Accidental Death Benefit and the Dismemberment Benefit. We will not pay more than one benefit under this Rider. Your coverage under this Rider automatically terminates upon payment of either the Accidental Death Benefit or the Dismemberment Benefit. If more than one Loss is sustained as a result of one Accident, we will pay only one amount, the largest to which you are entitled.

Accidental Death Benefit: We will pay the Accidental Death Benefit to the beneficiary named in the application (or as later changed) if you die solely as a result of an Accidental bodily Injury. In order for the Accidental Death Benefit to be payable, death must occur within 90 days of the covered Injury and while this Rider and the policy are in force. This Rider will not pay more than one Accidental Death Benefit. The Accidental Death Benefit Amount is shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Accidental Death Benefit.

Dismemberment Benefit: We will pay the appropriate Dismemberment Benefit to you if you suffer total and irrecoverable Loss of eyesight or limbs solely as a result of an Injury. In order for the Dismemberment Benefit to be payable, your Loss must occur while this Rider and the policy are in force. This Rider will not pay more than one Dismemberment Benefit. The Dismemberment Benefit Amounts are shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Dismemberment Benefit.

This Rider is automatically issued with your policy in the amount of $1,000.
You may also choose to apply for a higher benefit amount if you are age 80 or under.

OPTIONAL BENEFITS (Available for an Additional Premium)

The following optional Riders are available for additional premium. The Riders are subject to all the provisions of the policy including, but not limited to, policy definitions, conditions, provisions, limitations and exclusions. The benefit amount and period maximums are shown in the Policy Schedule (unless the Rider is issued after the Policy Date). Benefits provided by the Riders are fixed indemnity benefits. The amount we pay will not be determined by the amount of the charges for the services and may be more than or less than the amount(s) charged for any insured loss.

Ambulance Services Indemnity Benefit Rider (Rider Form RA67) We will pay the applicable Ground Ambulance Services Indemnity Benefit Amount or Air Ambulance Services Indemnity Benefit Amount for each day you receive Ambulance transportation services due to a covered Sickness or Injury. Ambulance Services must be provided by a licensed Ambulance service within 96 hours of the Injury or the onset of Sickness. Benefits are not payable beyond the Combined Ambulance Services Calendar-Year Maximum Benefit Days.

Lump Sum Cancer Benefit Rider (Rider Form RA87) We will pay the Lump Sum Cancer Benefit Amount when you are First Diagnosed as having internal Cancer or malignant melanoma, provided you have met the conditions set forth in this Rider. You are limited to one Lump Sum Cancer Benefit payment while this Rider and policy are in force. Your coverage under this Rider automatically terminates upon payment of the Lump Sum Cancer Benefit.

Accidental Death And Dismemberment Benefit Rider (Rider Form RA89) Although this Rider is automatically attached to your policy with a $1,000 benefit amount, you may also choose to apply for a higher benefit amount if you are age 80 or under. If you become eligible for one of the following benefits, we will pay one of the following benefits. We will not pay a benefit for both the Accidental Death Benefit and the Dismemberment Benefit. We will not pay more than one benefit under this Rider. Your coverage under this Rider automatically terminates upon payment of either the Accidental Death Benefit or the Dismemberment Benefit. If more than one Loss is sustained as a result of one Accident, we will pay only one amount, the largest to which you are entitled.

Accidental Death Benefit: We will pay the Accidental Death Benefit to the beneficiary named in the application (or as later changed) if you die solely as a result of an Accidental bodily Injury. In order for the Accidental Death Benefit to be payable, death must occur within 90 days of the covered Injury and while this Rider and the policy are in force. This Rider will not pay more than one Accidental Death Benefit. The Accidental Death Benefit Amount is shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Accidental Death Benefit.

Dismemberment Benefit: We will pay the appropriate Dismemberment Benefit to you if you suffer total and irrecoverable Loss of eyesight or limbs solely as a result of an Injury. In order for the Dismemberment Benefit to be payable, your Loss must occur while this Rider and the policy are in force. This Rider will not pay more than one Dismemberment Benefit. The Dismemberment Benefit Amounts are shown on the Policy Schedule, unless the Rider is issued after the Policy Date. Your coverage under this Rider automatically terminates upon payment of the Dismemberment Benefit.

EXCLUSIONS AND LIMITATIONS

We will NOT pay benefits for:

1. Any loss that occurs while this policy is not in force.
2. For services or supplies not covered under this policy.
3. For treatment of complications of a noncovered loss.
4. Treatment, services or supplies which:
    a. Are not Medically Necessary as determined by us;
    b. Are not prescribed by a Physician as necessary to treat a Sickness or Injury;
    c. Are determined to be Experimental or Investigational as determined by us;
    d. Are received without charge or legal obligation to pay;
    e. Would not routinely be paid in the absence of insurance;
    f. Are received from any Family Member.
5. Suicide or any suicide attempt while sane or insane (in Missouri, while sane) or any intentionally self-inflicted Injury.
6. Mental health and substance abuse treatment that is required by a diversion agreement, court order or requested in connection with criminal actions, divorce, child custody or child visitation proceedings.
7. Injuries received or caused directly or indirectly while under the influence of a controlled substance, unless prescribed by a Physician, or by intoxication as defined by the laws and jurisdiction of the geographical area in which the loss or cause of loss was incurred.
8. Loss to which a contributing cause was your commission of or attempt to commit a felony or being engaged in an illegal occupation.
9. Service for which benefits are available for you under state or federal workers' compensation.
10. Loss that occurs outside the territorial limits of the United States.
11. Any loss resulting from war, declared or undeclared, or actively serving in the armed forces or their auxiliary units, including any country's National Guard or Army Reserve or their equivalent.
12. Durable medical equipment (D.M.E.).
13. Prosthetics or orthopedic shoes.
14. Drugs and self-administered drugs.
15. Physical therapy, occupational therapy or speech therapy, except as specifically provided elsewhere in this policy.
16. Dental care or treatment (except expenses otherwise covered due to Injury to sound natural teeth); ordinary dental care, dentures and dental implants; cosmetic surgery, except for reconstructive surgery which is incidental to or follows surgery.
17. Vision surgery, including any complications arising therefrom, to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
18. Hearing services.
19. Any loss resulting from any device for aerial navigation, except as a fare-paying passenger.
20. Any loss resulting, either directly or indirectly, from your participation in a high risk activity for pay, profit or other commercial purposes including, but not limited to:
    a. Sporting event;
    b. Skydiving;
    c. Hang gliding;
    d. Parachuting;
    e. Piloting experimental or ultralight aircraft;
    f. Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot;
    g. Riding in a hot air balloon;
    h. Bungee jumping;
    i. Rappelling;

j. Professional mountain and/or rock climbing;
k. Rodeo participation; and
l. Organized contests including, but not limited to, organized contests of speed, go-cart racing, dirt bike racing, demolition derbies, and mountain bike racing. This exclusion also includes the practice, qualification and/or testing for such activities.

21. Abortion, except for Medically Necessary abortions performed to save the mother's life.
22. Sex change, reversal of tubal ligation or reversal of vasectomy.
23. Cosmetic or elective procedures that are not Medically Necessary, including, but not limited to organ donation, elective sterilization and fertility treatments.
24. Hospital Confinement primarily for rest care, convalescent care or for rehabilitation.

Pre-Existing Conditions Limitation: We will NOT pay benefits for any loss for Pre-Existing Conditions during the first six months after the Policy Date. If, after the Policy Date, a Rider is added to this policy, or benefits are increased under the policy or any attached Rider, we will NOT pay the increased benefits for any loss for Pre-Existing Conditions during the first six months after the date the increased benefits become effective.

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

RENEWABILITY AND PREMIUM CHANGES

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

Terms Under Which We May Change Premiums – We can change your premium only if we do the same to all policies of this form, or optional Riders attached to this form, which are issued to persons of your class. "Class" means the factors of age, gender, underwriting class and geographic area of your state of residence that determined your premium rate when coverage was issued. If you have a change in residence, premiums may change to reflect your current geographic area. If we make a change, it will not be based on any physical impairment you might have or any claims you have incurred under this policy. If it is necessary to change the premium for your policy or any Rider, we will send you written notice at least 31 days in advance of the change in premium.

Cancellation by Insured – You may cancel your policy at any time by writing us. Cancellation is effective on the date we receive your notice unless you specify a later date. If you do cancel, we will promptly refund to you the excess of premium paid above the prorated premium for the expired time (this date we received notice from you). Cancellation will not affect an existing claim.

PREMIUMS

Base Policy

❒ Lump Sum Hospital Confinement Insurance Policy Form HIA62
Lump Sum Benefit Amount ($1,500, $2,000, or $2,500): $_____
Maximum Lump Sum Hospital Confinement Benefit Days per Calendar Year (3 Days) 3 Days

RA89 Accidental Death And Dismemberment Benefit Rider $ 1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

OR

❒ Lump Sum Hospital Confinement Insurance Policy Form HIA62
Lump Sum Benefit Amount $5,000 $ 5,000
Maximum Lump Sum Hospital Confinement Benefit Days per Calendar Year (1 Day) 1 Day

RA89 Accidental Death And Dismemberment Benefit Rider $ 1,000
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifetime.)

Optional Riders

❒ RA67 Ambulance Services Indemnity Benefit Rider
Ground: $ 250
Air: $ 250
Combined Maximum of 3 Days per Calendar Year: 3 Days
(Not available age 81 or over.)

❒ RA87 Lump Sum Cancer Benefit Rider
$1,000, $2,500, $5,000, $7,500 or $10,000: $_____
(One benefit per Lifetime; not available age 80 or over)

❒ RA89 Accidental Death And Dismemberment Benefit Rider
$5,000, $10,000 or $20,000: $_____
(For loss of life, two limbs or both eyes; 50% for one limb or eye. One benefit per Lifet_ime, not available age 81 or over.)

Automatic Bank Withdrawal:

Monthly

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.

Rate quotes are for illustrative purposes only and are not guaranteed. This quote is not an offer or contract. We reserve the right to adjust quoted rates based on the information provided by the application, the underwriting process, applicant interviews, or to correct any errors on the quotation. Any coverage is effective only after approved by the Company, and only after premium has been received by the Company. All plan provisions apply. If an applicant's age increases after the quote is submitted and coverage is not yet approved by the Company, the premium will be adjusted to reflect the new age in the rates. Please refer to the policy schedule for exact policy information.

_____
Producer's Printed Name

_____ _____
Producer's Signature Date

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Important Notice to Persons on Medicare

This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

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

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Hospice
- Other approved items and services

Before You Buy This Insurance

✓ Check the coverage in **all** health insurance policies you already have.

✓ For more information about Medicare and Medicare Supplement insurance, review the ***Guide to Health Insurance for People with Medicare***, available from the insurance company.

✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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Notes

about the company

Medico Insurance Company began operations in 1930. We offer quality health and life insurance products for Americans nationwide.

Today Medico Insurance Company continues a proud tradition of service to our policyholders.

We are located in the heart of the United States. When you call our number, the people who answer the phone understand your problems and are anxious to help you find solutions.

For more information about Medico Insurance Company visit www.GoMedico.com.

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Medico Insurance Company
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