MEDICO®
INSURANCE COMPANY

1515 South 75th Street
Omaha, Nebraska 68124

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

Application for Medicare Supplement Insurance

Part A: General Information – Please Print

Name _____ Date of Birth Mo./Day/Yr. _____ Age _____ Sex _____

Address _____
Street Address City State Zip

Phone # _____ E-mail Address _____

Social Security # _____ Medicare Claim # _____

Beneficiary (Optional) _____ Relationship _____

Beneficiary's Address _____
Street Address City State Zip

Best time to call for Personal Health Interview _____

Are you eligible for Open Enrollment? ❒ Yes ❒ No If "Yes," we will need documentation, unless you are turning 65.

Part B: Insurance Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

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

1. (a) Did you turn age 65 in the last 6 months? ❒ Yes ❒ No
   (b) Did you enroll in Medicare Part B in the last 6 months? ❒ Yes ❒ No
   (c) If "Yes," what is the effective date? _____
2. Are you insured under Parts A and B of Medicare? (If "No," you are not eligible for coverage) ❒ Yes ❒ No
3. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.) ❒ Yes ❒ No

   If "Yes," (a) Will Medicaid pay your premiums for this Medicare supplement policy? ❒ Yes ❒ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ❒ Yes ❒ No
4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START _____ END _____

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❒ Yes ❒ No
   (c) Was this your first time in this type of Medicare plan? ❒ Yes ❒ No
   (d) Did you drop a Medicare supplement policy to enroll in this Medicare plan? ❒ Yes ❒ No
5. (a) Do you have another Medicare supplement policy in force? ❒ Yes ❒ No
   (b) If "Yes," with which company? _____
   what plan? _____
   (c) If so, do you intend to replace your current Medicare supplement policy with this policy? ❒ Yes ❒ No

Part B: Insurance Information (continued)

PRODUCER: If the answer to this question is yes, please complete and submit NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE.

6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.) ❒ Yes ❒ No
   (a) If "Yes," with which company?_____
   what kind of policy?_____
   (b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)
   START_____ END_____
7. If you have lost or are losing other health insurance coverage, have you provided a copy of the notice from your prior insurer? ❒ Yes ❒ No
   If "No," please provide an explanation._____

Producer shall list any other health insurance policies he/she has sold to the applicant.

1) List policies you sold to the applicant that are still in force (If none, indicate "None"): ❒ None

Name of Insurer	Type	Policy #

2) List policies you sold to the applicant in the past five (5) years that are no longer in force (If none, indicate "None"): ❒ None

Name of Insurer	Type	Policy #

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ❒ Yes ❒ No

Part C: Medical Information

NOTE: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue. If you answer "Yes," to any of questions 1 through 5 you are not eligible for coverage.

Height: _____ Weight: _____

1. Have you ever:
   (a) had any fractures due to osteoporosis or amputation due to disease? ❒ Yes ❒ No
   (b) had kidney disease requiring dialysis; diabetes requiring insulin; Parkinson's disease; liver disease; multiple or lateral sclerosis; or amyotrophic lateral sclerosis (Lou Gehrig's disease)? ❒ Yes ❒ No
   (c) been diagnosed with emphysema; chronic obstructive pulmonary disorder (COPD); or any other chronic pulmonary disorder? ❒ Yes ❒ No
   (d) been diagnosed with or treated for Alzheimer's disease; senile dementia; or organic brain disorder? ❒ Yes ❒ No
   (e) had an organ transplant or been advised by a physician to have an organ transplant? ❒ Yes ❒ No
   (f) had or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? ❒ Yes ❒ No
2. Within the past 5 years have you been treated for or been diagnosed as having internal cancer; leukemia; or malignant melanoma? ❒ Yes ❒ No

Part C: Medical Information (continued)

3. Within the past 24 months have you:
   (a) been hospitalized 3 or more times? ❒ Yes ❒ No
   (b) had a stroke or transient ischemic attack (TIA)? ❒ Yes ❒ No
   (c) had heart trouble or disease that required treatment by a physician other than just prescription medication (not including high blood pressure)? ❒ Yes ❒ No
   (d) been diagnosed with or treated for alcohol or drug abuse; degenerative bone disease; crippling or rheumatoid arthritis; or been advised by a physician to have a joint replacement? ❒ Yes ❒ No
4. Within the past 12 months have you been advised that surgery for cataracts may be required? ❒ Yes ❒ No
5. Currently:
   (a) are you bedridden; confined (or has any doctor recommended that you be confined) to a hospital or nursing facility; or do you need the assistance of a walker or wheelchair? ❒ Yes ❒ No
   (b) do you have diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart or circulatory condition (including high blood pressure)? ❒ Yes ❒ No
   (c) are you receiving physical therapy or using oxygen? ❒ Yes ❒ No
   (d) have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? ❒ Yes ❒ No
   (e) do you have surgery pending? ❒ Yes ❒ No
6. List all medications taken within the past 12 months (if none, indicate none).

   Please provide the following information:

Medication				
Date originally prescribed				
Frequency and dosage				
Diagnosis/condition				

Part D: Preferred Rate Information

NOTE: This question should not be answered if you apply during "Open Enrollment" or if you are eligible for a guaranteed issue.

To qualify for preferred rates you must be able to answer "No" to the following question:

Have you used tobacco in the past 12 months? ❒ Yes ❒ No

Part E: Notices

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.

Part E: Notices (continued)

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Part F: Benefit Options – Check the Plan you prefer:

❒ Policy Form MSA20A – Plan A ❒ Policy Form MSA20C– Plan C ❒ Policy Form MSA20F – Plan F
❒ Policy Form MSA20N – Plan N

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

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

Effective Date of Policy _____
(Day after applicant signs the application or expiration date of current policy)

If you currently have health insurance in force, on what date does it end?_____

Part G: Application Agreement

I hereby apply for insurance to be issued solely and entirely upon the answers and statements in the Parts above that I adopt as my own and represent to be true, full and complete. I understand and agree that no insurance will be in force until coverage has been issued. If I am not applying during "Open Enrollment" or not eligible for a guaranteed issue, I do not have a right to have this policy issued to me if I have answered "Yes" to any of questions 1 through 5 in the Medical Information Part above. I have read, or had read to me, the complete application.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if "A Guide to Health Insurance for People With Medicare" is required in the applicants' state:

❒ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at www.gomedico.com/products.

❒ 2. I have received a hard copy of the Medicare Buyers Guide.

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

I understand that it may be necessary to phone me to verify the answers to the questions in this application.

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

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____