MEDICO®
INSURANCE COMPANY

Medico®
Dental Insurance Portfolio

- **Dental**
- **Dental Plus**
- **D.V.H. $1,000**
- **D.V.H. $1,500**

SALES KIT BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

☐ Application for Dental or Dental, Vision and Hearing Insurance

☐ Bank Draft Information (if applicable)

☐ Additional forms which may be required. See forms marked Complete and Send with Application.

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.

34 133 3000 030118 US

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MEDICO®
INSURANCE COMPANY

601 6th Avenue, Des Moines, IA 50309
PO Box 10386, Des Moines, IA 50306

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

Application for Dental or Dental, Vision and Hearing Insurance

Requested Effective Date of New Policy (optional)

_____
MM/DD/YYYY

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 delivered to:
❒ Applicant ❒ Producer

Part A: General Information – Please Print

Applicant Information

Full Name of Applicant - *First Name, M.I., Last, Suffix*

Address

City State ZIP Code

Phone Number Alternate Phone Number

Email Address

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

1. Do you have any dental, vision or hearing insurance currently in force? ❒ Yes ❒ No
2. Is the insurance applied for intended to replace any existing insurance with this or any other company? ❒ Yes ❒ No

If "Yes", please provide the following:

Company Name Policy Number Type of Coverage

Part B: Benefit

Plan Selection – Check the Desired Option:

❒ Dental - $1,000 Policy Year Maximum Benefit Amount

❒ Dental, Vision and Hearing - $1,000 Policy Year Maximum Benefit Amount

❒ Dental, Vision and Hearing - $1,500 Policy Year Maximum Benefit Amount

❒ Dental Plus - $2,500 Policy Year Maximum Benefit Amount

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Part C: Payment Options

Method and Frequency of Payment

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

Amount Received with Application $_____ Renewal Premium $_____

Part D: Application Agreement

Applicant Certification

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

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.

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 or Dental, Vision and Hearing Insurance policy. The policy provides dental or dental, vision and hearing benefits only. Review your policy carefully.

X _____

Applicant's Signature Date (MM/DD/YYYY)

Producer's Certification

I certify the information in this application was provided by the applicant and correctly recorded. 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 (MM/DD/YYYY)

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Part E: Fraud Warnings

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.

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

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.

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.

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

Kansas: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.

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.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

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.

Ohio: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: 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 may be a violation of federal law.

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

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BANK DRAFT INFORMATION

Complete this section only if you selected the automatic bank withdrawal payment option.

Ongoing Premium

Authorization to Bank or Other Financial Institution

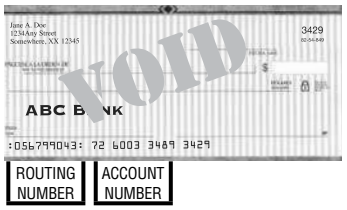
☐ Checking ☐ Savings

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

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, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company (the "Company") for insurance premiums. I authorize the 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.



Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

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MEDICO®
INSURANCE COMPANY

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

Receipt for Initial Premium

Dental, Vision and Hearing Receipt

The applicant has applied for the following (select one):

❒ Dental - $1,000 Plan Year Maximum Benefit Amount

❒ Dental, Vision and Hearing - $1,000 Plan Year Maximum Benefit Amount

❒ Dental, Vision and Hearing - $1,500 Plan Year Maximum Benefit Amount

❒ Dental Plus - $2,500 Plan Year Maximum Benefit Amount

Received of _____
First Name MI Last Name Suffix

an application for insurance as shown above and $ _____.

This insurance will not be in force until the contract is delivered and accepted and the first premium is paid.

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 contract 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

X _____ _____
Producer's Signature Date (MM/DD/YYYY)

_____
Producer's Printed Name

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Important Notice to Persons on Medicare

This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

The insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided 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
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- 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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MEDICO®
INSURANCE COMPANY

Medico®
Dental Insurance Portfolio

- ■ Dental
- ■ Dental Plus
- ■ D.V.H. $1,000
- ■ D.V.H. $1,500

RATE GUIDE

Premium Withdrawal

If the applicant chooses the Automatic Bank Withdrawal or Credit Card method of payment and the application is submitted without any premium, the initial premium will be drafted from the Insured's account on the Policy Date (effective date of coverage).

Note: Unless a future Effective Date is requested, the premium will be drawn as soon as the policy is issued. Please make sure the applicant is aware of this.

Policy Effective Date

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.

Please review the premium differences in the rates shown, as modal factors vary based on payment methods and frequency of payments.

Note: Enrollments using a credit or debit card for premium payments must be submitted electronically. Paper applications cannot contain credit or debit card information.

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

Dental

$1000 Policy Year Maximum Benefit Amount

Monthly Bank Draft	
Issue Age	Premium
18-65	33.86
66-79	35.86
80-89	39.84

Quarterly Bank Draft	
Issue Age	Premium
18-65	102.00
66-79	108.00
80-89	120.00

Semi-Annual Bank Draft	
Issue Age	Premium
18-65	204.00
66-79	216.00
80-89	240.00

Annual Bank Draft	
Issue Age	Premium
18-65	408.00
66-79	432.00
80-89	480.00

Monthly Credit Card	
Issue Age	Premium
18-65	35.09
66-79	37.15
80-89	41.28

Quarterly Credit Card	
Issue Age	Premium
18-65	105.26
66-79	111.46
80-89	123.84

Semi-Annual Credit Card	
Issue Age	Premium
18-65	210.12
66-79	222.48
80-89	247.20

Annual Credit Card	
Issue Age	Premium
18-65	420.24
66-79	444.96
80-89	494.40

Quarterly Direct Bill	
Issue Age	Premium
18-65	110.16
66-79	116.64
80-89	129.60

Semi-Annual Direct Bill	
Issue Age	Premium
18-65	212.16
66-79	224.64
80-89	249.60

Annual Direct Bill	
Issue Age	Premium
18-65	408.00
66-79	432.00
80-89	480.00

For Producer Use Only

D.V.H. $1,000 and D.V.H. $1,500
Form A58

Monthly Bank Draft		
Issue Age	1,000 Max	1,500 Max
18-39	29.00	37.00
40-54	31.00	41.00
55-64	33.00	44.00
65-79	35.00	46.00
80-89	38.00	49.00

Quarterly Bank Draft		
Issue Age	1,000 Max	1,500 Max
18-39	87.00	111.00
40-54	93.00	123.00
55-64	99.00	132.00
65-79	105.00	138.00
80-89	114.00	147.00

Semi-Annual Bank Draft		
Issue Age	1,000 Max	1,500 Max
18-39	174.00	222.00
40-54	186.00	246.00
55-64	198.00	264.00
65-79	210.00	276.00
80-89	228.00	294.00

Annual Bank Draft		
Issue Age	1,000 Max	1,500 Max
18-39	348.00	444.00
40-54	372.00	492.00
55-64	396.00	528.00
65-79	420.00	552.00
80-89	456.00	588.00

Monthly Credit Card		
Issue Age	1,000 Max	1,500 Max
18-39	29.93	38.18
40-54	31.99	42.31
55-64	34.06	45.41
65-79	36.12	47.47
80-89	39.22	50.57

Quarterly Credit Card		
Issue Age	1,000 Max	1,500 Max
18-39	89.78	114.55
40-54	95.98	126.94
55-64	102.17	136.22
65-79	108.36	142.42
80-89	117.65	151.70

Semi-Annual Credit Card		
Issue Age	1,000 Max	1,500 Max
18-39	179.22	228.66
40-54	191.58	253.38
55-64	203.94	271.92
65-79	216.30	284.28
80-89	234.84	302.82

Annual Credit Card		
Issue Age	1,000 Max	1,500 Max
18-39	358.44	457.32
40-54	383.16	506.76
55-64	407.88	543.84
65-79	432.60	568.56
80-89	469.68	605.64

Quarterly Direct Bill		
Issue Age	1,000 Max	1,500 Max
18-39	93.96	119.88
40-54	100.44	132.84
55-64	106.92	142.56
65-79	113.40	149.04
80-89	123.12	158.76

Semi-Annual Direct Bill		
Issue Age	1,000 Max	1,500 Max
18-39	180.96	230.88
40-54	193.44	255.84
55-64	205.92	274.56
65-79	218.40	287.04
80-89	237.12	305.76

Annual Direct Bill		
Issue Age	1,000 Max	1,500 Max
18-39	348.00	444.00
40-54	372.00	492.00
55-64	396.00	528.00
65-79	420.00	552.00
80-89	456.00	588.00

Dental Plus

$2500 Policy Year Maximum Benefit Amount

Monthly Bank Draft	
Issue Age	**Premium**
18-65	59.76
66-79	67.73
80-89	73.70

Quarterly Bank Draft	
Issue Age	**Premium**
18-65	180.00
66-79	204.00
80-89	222.00

Semi-Annual Bank Draft	
Issue Age	**Premium**
18-65	360.00
66-79	408.00
80-89	444.00

Annual Bank Draft	
Issue Age	**Premium**
18-65	720.00
66-79	816.00
80-89	888.00

Monthly Credit Card	
Issue Age	**Premium**
18-65	61.92
66-79	70.18
80-89	76.37

Quarterly Credit Card	
Issue Age	**Premium**
18-65	185.76
66-79	210.53
80-89	229.10

Semi-Annual Credit Card	
Issue Age	**Premium**
18-65	370.80
66-79	420.24
80-89	457.32

Annual Credit Card	
Issue Age	**Premium**
18-65	741.60
66-79	840.48
80-89	914.64

Quarterly Direct Bill	
Issue Age	**Premium**
18-65	194.40
66-79	220.32
80-89	239.76

Semi-Annual Direct Bill	
Issue Age	**Premium**
18-65	374.40
66-79	424.32
80-89	461.76

Annual Direct Bill	
Issue Age	**Premium**
18-65	720.00
66-79	816.00
80-89	888.00

Disclosures

Please leave with your customer.

Notice of Privacy Practices for AmericanEnterprise Group Companies

MEDICAL

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company, ("Company") we respect the confidentiality of your health information and will protect your information in a responsible and professional manner. We are required by law to maintain the privacy of your health information and to send you this notice.

This notice explains how we use information about you and when we can share that information with others. It also informs you of your rights with respect to your health information and how you can exercise those rights.

When we talk about "information" or "health information" in this notice we mean individually identifiable health information, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Individually identifiable health information is health information that:

- Is created or received by the Company's designated health care components;
- Relates to the past, present, or future physical or mental health condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- Identifies the individual, or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

How We Use or Share Information

Subject to state and federal laws, we are permitted to use and/or share your information without your authorization in certain circumstances, such as:

- To use or disclose the information for payment purposes. For example, we may use the information to help pay medical bills that have been submitted to us by doctors and hospitals for payment or to contact your doctor to obtain medical records in order to make claim payment decisions.
- To use or disclose the information to perform health care operations. For example, we may use the information for activities relating to underwriting; customer service; legal services; and auditing functions, including fraud and abuse detection and compliance programs. We will not use or disclose genetic information, including family history, for underwriting purposes.
- To use or disclose your information to provide you with information about health related benefits and services that you may be interested in. We will not share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates without your authorization.
- If you are available and do not object, we may disclose information to a member of your family, a friend, or other person you identify who is involved in your health care or the payment of a claim. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure is in your best interest, we may share limited information with such persons.
- To disclose information to a disaster relief organization in order for the organization to communicate with a family member or other person involved in your care.

There are also state and federal laws that may require or permit us to release your information to others without your authorization.

- To use and disclose information to the extent required to comply with the law.
- To report information to state and federal agencies that regulate us such as the U.S. Department of Health and Human Services and the Iowa Division of Insurance.
- To share information for public health activities. For example, we may report information to government authorities conducting public health investigations.
- To use or disclose information to avert a serious health or safety threat.
- To share information with a health oversight agency for certain oversight activities authorized by law. For example audits, inspections, licensure, and disciplinary actions.
- To disclose information in the course of a judicial or administrative proceeding. For example pursuant to a valid court order or subpoena.
- To report information for law enforcement purposes. For example, we may give information to a law enforcement official for purposes of identifying or locating a suspect, fugitive, material witness or missing person.
- To report information to a government authority regarding child abuse, neglect or domestic violence.
- To share information with a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also share information to a funeral director as necessary to carry out their duties.
- To use or share information for procurement, banking or transplantation of organs, eyes, or tissue.

- To use or disclose information for research purposes, but only as permitted by law.
- To share information for specialized government functions, such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- To report information on job-related injuries because of requirements of your state workers' compensation laws.

In the event that an applicable law prohibits or materially limits one of the uses or disclosures of information described above, we will restrict the use or disclosure in accordance with the more stringent law.

If one of the above reasons for a use or disclosure does not apply, **we must get your written permission, in the form of an authorization, to use or disclose your information**. In any case, we must obtain authorization for the use and disclosure of psychotherapy notes. If you give us written permission and change your mind you may revoke your authorization at any time except to the extent that we have taken action in reliance on the authorization or, if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself.

What Are Your Rights?

The following are your rights with respect to your information. If you would like to exercise the following rights, please contact our Customer Service Center. Contact information for our Customer Service Center is located at the end of this Notice.

- **You have the right to be notified** in the event there is a breach of your health information.
- **You have the right to ask us to restrict** how we use or disclose your information for payment or health care operations. You also have the right to ask us to restrict information that we have been asked to give to family members or to others who are involved in your health care or payment for your health care and uses and disclosures for disaster relief purposes. *Please note that while we will try to accommodate reasonable requests, we are not required to agree to these restrictions*.
- **You have the right to request confidential communications** of information. For example, if you believe that you would be harmed if we send your information to your current mailing address (for example, in situations involving domestic disputes or violence), you can ask us to send the information by alternative means (for example, by fax) or to an alternative address. We will accommodate your reasonable requests as explained above.
- **You have the right to copy and inspect certain components of your information that we maintain**. All requests for access must be made in writing and signed by you or your representative. Access request forms are available from our Customer Service Center at the address below. We may charge you a fee for copying and postage.
- **You have the right to request that certain components of your information be amended to correct an error or omission**. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests must be in writing, signed by you or your representative, and must state the reasons for the requested amendment. Amendment request forms are available from our Customer Service Center at the address below.
- **You have the right to receive an accounting** of certain disclosures of your information. Please note that we are not required to release:
  - Any information collected prior to April 14, 2003.
  - Information disclosed or used for treatment, payment, and/or health care operations purposes.
  - Information disclosed to you or pursuant to your authorization.
  - Information that is incidental to a use or disclosure otherwise permitted.
  - Information disclosed for a facility's directory or to person involved in your care or other notification purposes.
  - Information disclosed for national security or intelligence purposes.
  - Information disclosed to correctional institutions, law enforcement officials or health oversight agencies.
  - Information that was disclosed or used as part of a limited data set for research, public health, or health care operations purposes.

Accounting request forms are available from our Customer Service Center at the address below. The first accounting in any 12-month period is free; however, we may charge you a fee for each subsequent accounting you request in the same 12-month period.

Exercising Your Rights

- **You have a right to receive a copy of this notice upon request at any time**. We are required to abide by the terms of this notice. Should any of our privacy practices change, we reserve the right to change the terms of this notice and to make the new notice effective for all protected health information we maintain. Once revised, we will provide the new notice to you by mail.

If you believe your privacy rights have been violated, you may file a complaint with us by contacting our Customer Service Center. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. **We will not take any action against you for filing a complaint**.

Contact Information

If you have any questions or complaints, please contact us at:

Notice of Privacy Practices
American Enterprise Group Companies, Customer Service Center
P.O. Box 9371, Des Moines, IA 50306-9371

You can call us at: **1-800-247-2190**.

www.americanenterprise.com

Notice of Privacy Practices for AmericanEnterprise Group Companies

FINANCIAL

THIS NOTICE APPLIES TO ALL PROSPECTS, APPLICANTS, CUSTOMERS AND FORMER CUSTOMERS WHO HAVE INQUIRED ABOUT OR PURCHASED INSURANCE PRODUCTS USED PRIMARILY FOR PERSONAL, FAMILY OR HOUSEHOLD PURPOSES.

At AmericanEnterprise Group Companies, including but not limited to American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Life and Health Insurance Company, and Medico Corp Life Insurance Company, ("Company") we keep your personal information confidential and share it only in a responsible manner as necessary to provide and service the products you purchase from us or to offer you additional products.

What Information Do We Collect?

To provide and administer products and services, we must refer to relevant personal information that can be identified to you or your household and that may not be available in public records ("nonpublic personal information"). We collect only the following information required to conduct business:

- Identity information received from your application, such as name, address, social security number, and age.
- Information about your transactions with us, including your identification and policy number(s), the type of products you buy, the premiums you pay, and how you purchased your coverage.
- Information received from a consumer reporting or credit agency or from public records (such as your driving record) as needed by our insurance underwriting practices.
- Information received from a third-party agency, such as consumer purchasing or census data.
- Information received from service providers regarding treatment of health conditions and payment for that treatment.

What Information Do We Share With Others?

To help us provide you with the best possible products and services, we maintain strong relationships with business associates. In the course of conducting business and as permitted or required by law, we may share any of the listed nonpublic personal information with our business associates for the following purposes:

- to process your application and issue your policy.
- to pay your claims.
- to make any policy changes you may request.
- to offer you additional opportunities to improve your financial security.

We may also disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf or with whom we have joint marketing agreements. We will not, however, disclose your health information for marketing purposes.

Other than the disclosures listed above, we do not release your information to nonaffiliated third parties. We will not for any reason share your information with or sell it to telemarketing agencies or other agencies that market products other than those products provided or administered by the Company or its business associates. Our business associates are bound by the same restrictions on the release and use of such information as the Company. Any future alliances with business associates which include personal information sharing will follow the same policy.

Fair Credit Reporting Act

We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law. To the extent that we decide in the future to make any disclosures of your nonpublic personal financial information that are subject to the Act, we will follow the necessary requirements of the Act including providing you with the opportunity to restrict our ability to disclose information.

How Do We Protect Your Information?

We maintain appropriate physical, electronic and procedural safeguards to ensure the confidentiality of your nonpublic personal information. We follow security standards and procedures to help prevent unauthorized access to personal information. Only employees who need the information we collect from or about you to provide products or services to you may access that information. Employees are required to comply with our established policies.

What About Former Customers?

We do not disclose information about former customers unless permitted or required by law.

How Can You Correct Inaccurate Information?

We want to keep our records of your information accurate. If you discover inaccuracies in any communications from us, please call customer service at the number listed on your policy or certificate materials. We will respond promptly when we learn corrections are needed.

Questions?

If you have any questions, please call

our toll-free Customer Service line.

1-800-247-2190

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