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):

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

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

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

ˆ 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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