

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 Plus - \$2,500 Policy Year Maximum Benefit Amount

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:

- Automatic Bank Withdrawal
 Direct Bill
 Credit/Debit Card

Frequency of Payment:

- | | | | |
|----------------------------------|------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> Annually |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semi-Annually | <input type="checkbox"/> 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. Within sixty days of receipt of your application in our home office, Medico Insurance Company will notify you as to whether or not your application has been approved or provide you with a reason for a delay in the acceptance or rejection of your application. 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)

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.
