MEDICO®
INSURANCE COMPANY

Medico®
Hospital Indemnity Insurance

SALES KIT BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

- ☐ Application for Hospital Indemnity Insurance Policy
- ☐ Bank Draft Information (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.

34 134 2000 020119 MS

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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 Individual Hospital Indemnity Insurance Policy

Application for: ❐ New Coverage ❐ Reinstatement ❐ Benefit Increase

Medico Policy Number for Reinstatement or Benefit Increase: ___________________

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

Note: Policy will be mailed to Applicant in states where proof of delivery is required.

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

Email Address

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

Replacement Question

Will this policy replace any health insurance currently in force with any company? ❐ Yes ❐ No

If "Yes", please provide the following:

Company Name | Policy Number | Type of Coverage

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Part B: Medical Information

Qualifying Information

If any answer to questions 1 through 9 is "YES," you are not eligible for coverage.

I agree to answer the following questions truthfully and to the best of my knowledge.

1. To the best of your knowledge, 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 had or been treated or diagnosed by a member of the medical profession with:
   a) Chronic obstructive lung disease, COPD, emphysema, or chronic bronchitis? ❒ Yes ❒ No
   b) Chronic liver disease including but not limited to hepatitis C or cirrhosis? ❒ Yes ❒ No
   c) Neuromuscular disorders, including, but not limited to, Parkinson's disease, multiple sclerosis, or myasthenia gravis? ❒ Yes ❒ No
   d) Memory disorders such as Alzheimer's disease or dementia? ❒ Yes ❒ No

4. In the past 12 months have you been advised by a member of the medical profession to have surgery that has not yet been completed? ❒ Yes ❒ No

5. In the past 24 months have you had or been treated or diagnosed by a member of the medical profession with diabetes:
   a) Requiring insulin or injectable medication; ❒ Yes ❒ No
   b) Requiring more than two oral medications; ❒ Yes ❒ No
   c) That involved any complication, including, but not limited to, peripheral neuropathy, peripheral vascular disease, or diabetic retinopathy? ❒ Yes ❒ No

6. In the past 24 months have you had or been treated or diagnosed by a member of the medical profession with:
   a) A heart attack, stroke, transient ischemic attack (TIA), heart surgery/bypass and/or stent placement, or congestive heart failure? ❒ Yes ❒ No
   b) Kidney failure or required dialysis? ❒ Yes ❒ No
   c) Autoimmune disorders, including, but not limited to, ulcerative colitis, lupus, or rheumatoid arthritis? ❒ Yes ❒ No
   d) Cancer (other than skin cancer), malignancy, leukemia, melanoma, or Hodgkin's disease? ❒ Yes ❒ No

7. In the past 24 months have you received advice, treatment or counseling by a member of the medical profession relating to schizophrenia, psychotic disorder, bipolar/manic depression, alcohol or substance abuse? ❒ Yes ❒ No

8. Within the last 24 months:
   a) Have you been advised by a member of the medical profession to have medical tests or examinations to diagnose a possible condition that have not yet been completed? ❒ Yes ❒ No
   b) Have you experienced any of the following, for which medical advice, diagnosis or treatment has not yet been obtained: coughing blood; 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; or 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? ❒ Yes ❒ No
   d) Has a member of the medical profession recommended medical tests or examinations that have not yet been completed? ❒ Yes ❒ No

9. In the past 10 years have you been treated or 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

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Part C: Benefit Options

Base Policy Options

	Benefit
Hospital Indemnity Insurance Policy	
Benefit Options:	
Hospital Confinement Daily Benefit Amount:	
$100 to $600 (in $25 increments)	$__________ per day
Maximum Days per Hospital Confinement Period:	
(6, 7, 8, 9, 10, 21, or 31 days)	__________ days

Optional Riders - Choose any optional Rider(s):

	Benefit
❒ Ambulance Services Indemnity Benefit Rider	
❒ Urgent Care Center Indemnity Benefit Rider	
❒ Lump Sum Cancer Benefit Rider (rider not available age 80 or over) Benefit Options: Lump Sum Cancer Benefit Amount: $1,000, $2,500, $5,000, $7,500, $10,000	$__________
❒ Lump Sum Hospital Confinement Benefit Rider Benefit Options: Lump Sum Benefit Amount: $250, $500, $750 Maximum Lump Sum Payments per Calendar Year: 1, 2, or 3	$__________ __________
❒ Outpatient Therapy and Chiropractic Services Indemnity Benefit Rider Benefit Options: Outpatient Therapy Calendar Year Maximum: 15 or 30 days	__________ days
❒ Skilled Nursing Facility Indemnity Benefit Rider Benefit Options: Skilled Nursing Daily Benefit Amount: $100, $150, $200	$__________ per day
❒ Outpatient Surgery Indemnity Benefit Rider Benefit Options: Outpatient Surgery Benefit Amount: $250, $500, $750, $1,000	$__________ per day

Part D: Payment Options

Household Discount

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

Method and Frequency of Payment

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

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Part D: Payment Options - continued

Premium Amount

Total Modal Premium: $_________________

If paying the initial premium by check, make check payable to: Medico Insurance Company (do not make checks payable to the Producer or leave the payee line blank).

Part E: Application Agreement

Applicant Certification

I hereby apply to Medico Insurance Company (the Company) for a **Hospital Indemnity Insurance Policy** to be issued solely and entirely in reliance on my answers to the questions on this application. 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 issued.**
- I have read or had read to me the completed application and understand all statements and answers and certify they are complete, true and correctly recorded.
- 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 Injuries that occur and Sicknesses, the symptoms of which manifest after the date the policy is issued, subject to the Pre-Existing Condition Limitation within the policy.
- 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.
- No agent or other representative of the Company has required, permitted, or encouraged me to answer any question inaccurately or has waived any conditions of this application.

I have received 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 rescind your policy for fraud or misrepresentation of material fact on your application, subject to the Time Limit on Certain Defenses provision in the policy.

This policy does not cover Pre-Existing Conditions during the first six months starting from the date your policy is effective. After the policy is effective, if 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 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.

The policy provides limited benefits. Review your policy carefully.

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

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Part E: Application Agreement - continued

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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Part F: 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

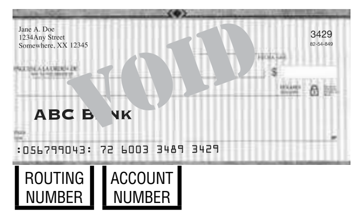
☐ Checking ☐ Savings

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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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, Medico Life and Health 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 and/or Medico Life and Health 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, Medico Life and Health 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 and/or Medico Life and Health 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.

COMPLETE AND SEND WITH APPLICATION

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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

RECEIPT

The Applicant Has Applied For Policy:

Hospital Indemnity Insurance Policy

Optional Riders (Additional Premium Required):

- ❒ Ambulance Services Indemnity Benefit Rider
- ❒ Urgent Care Center Indemnity Benefit Rider
- ❒ Lump Sum Cancer Benefit Rider
- ❒ Lump Sum Hospital Confinement Benefit Rider
- ❒ Outpatient Therapy and Chiropractic Services Indemnity Benefit Rider
- ❒ Skilled Nursing Facility Indemnity Benefit Rider
- ❒ Outpatient Surgery Indemnity 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

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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MEDICO®
INSURANCE COMPANY

Medico Hospital Indemnity Insurance

MONTHLY AUTOMATIC BANK WITHDRAWAL PREMIUMS

BASE FORM - HIA63

Mississippi

Rates Effective: May 1, 2018

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

Base Option - Hospital Confinement Benefit

Monthly - Automatic Bank Withdrawal - Rates Per $25/Day Benefit

AVAILABLE UNITS - 4 to 24 ($100 to $600/Day in $25 Increments)

Issue Age	SINGLE RATES							
	Maximum Hospital Confinement Period							
	6 Days		7 Days		8 Days		9 Days	
	Male	Female	Male	Female	Male	Female	Male	Female
40	$0.91	$0.95	$1.01	$1.06	$1.11	$1.16	$1.20	$1.26
41	$0.94	$0.97	$1.04	$1.08	$1.14	$1.19	$1.24	$1.29
42	$0.97	$0.99	$1.08	$1.11	$1.18	$1.21	$1.28	$1.31
43	$0.99	$1.01	$1.11	$1.13	$1.21	$1.24	$1.31	$1.34
44	$1.02	$1.03	$1.14	$1.15	$1.25	$1.26	$1.35	$1.36
45	$1.05	$1.05	$1.17	$1.17	$1.28	$1.28	$1.39	$1.39
46	$1.10	$1.08	$1.22	$1.21	$1.34	$1.32	$1.45	$1.43
47	$1.15	$1.12	$1.28	$1.24	$1.40	$1.36	$1.52	$1.48
48	$1.20	$1.15	$1.33	$1.28	$1.46	$1.40	$1.58	$1.52
49	$1.24	$1.18	$1.39	$1.32	$1.52	$1.44	$1.64	$1.56
50	$1.29	$1.21	$1.44	$1.35	$1.58	$1.48	$1.71	$1.60
51	$1.34	$1.25	$1.49	$1.39	$1.64	$1.52	$1.77	$1.65
52	$1.39	$1.28	$1.55	$1.43	$1.69	$1.56	$1.83	$1.69
53	$1.44	$1.31	$1.60	$1.46	$1.75	$1.60	$1.90	$1.73
54	$1.48	$1.35	$1.65	$1.50	$1.81	$1.64	$1.96	$1.78
55	$1.53	$1.38	$1.71	$1.54	$1.87	$1.68	$2.02	$1.82
56	$1.58	$1.41	$1.76	$1.58	$1.92	$1.73	$2.08	$1.87
57	$1.62	$1.45	$1.81	$1.62	$1.98	$1.77	$2.14	$1.92
58	$1.66	$1.49	$1.85	$1.66	$2.03	$1.82	$2.20	$1.96
59	$1.71	$1.52	$1.90	$1.70	$2.09	$1.86	$2.26	$2.01
60	$1.75	$1.56	$1.95	$1.74	$2.14	$1.90	$2.32	$2.06
61	$1.80	$1.59	$2.00	$1.78	$2.20	$1.95	$2.37	$2.11
62	$1.84	$1.63	$2.05	$1.82	$2.25	$1.99	$2.43	$2.15
63	$1.89	$1.68	$2.11	$1.87	$2.31	$2.05	$2.50	$2.21
64	$1.94	$1.72	$2.17	$1.92	$2.37	$2.10	$2.57	$2.27
65	$2.00	$1.77	$2.22	$1.97	$2.44	$2.16	$2.64	$2.33
66	$2.05	$1.81	$2.28	$2.02	$2.50	$2.21	$2.70	$2.39
67	$2.10	$1.86	$2.34	$2.07	$2.56	$2.27	$2.77	$2.45
68	$2.17	$1.91	$2.42	$2.13	$2.65	$2.34	$2.86	$2.53
69	$2.24	$1.97	$2.49	$2.20	$2.73	$2.41	$2.96	$2.61
70	$2.31	$2.03	$2.57	$2.26	$2.82	$2.48	$3.05	$2.68
71	$2.38	$2.09	$2.65	$2.33	$2.90	$2.55	$3.14	$2.76
72	$2.45	$2.15	$2.73	$2.39	$2.99	$2.62	$3.23	$2.84
73	$2.54	$2.23	$2.83	$2.48	$3.10	$2.72	$3.36	$2.94
74	$2.64	$2.31	$2.94	$2.57	$3.22	$2.82	$3.48	$3.05
75	$2.73	$2.39	$3.04	$2.66	$3.34	$2.92	$3.61	$3.16
76	$2.83	$2.47	$3.15	$2.75	$3.45	$3.02	$3.73	$3.27
77	$2.92	$2.55	$3.26	$2.85	$3.57	$3.12	$3.86	$3.37
78	$3.03	$2.64	$3.38	$2.94	$3.70	$3.22	$4.00	$3.49
79	$3.14	$2.73	$3.50	$3.04	$3.84	$3.33	$4.15	$3.60
80	$3.25	$2.81	$3.62	$3.14	$3.97	$3.44	$4.29	$3.72
81	$3.36	$2.90	$3.74	$3.23	$4.10	$3.54	$4.44	$3.83
82	$3.47	$2.99	$3.87	$3.33	$4.24	$3.65	$4.58	$3.95
83	$3.58	$3.08	$3.99	$3.43	$4.38	$3.76	$4.73	$4.07
84	$3.70	$3.17	$4.12	$3.53	$4.52	$3.87	$4.89	$4.19
85	$3.82	$3.26	$4.26	$3.64	$4.67	$3.99	$5.05	$4.31

Mississippi

Bank Draft	
Monthly	1
Quarterly	3.000
Semi-Annual	6.000
Annual	12.000

Direct Bill	
Monthly	N/A
Quarterly	3.240
Semi-Annual	6.240
Annual	12.000

Credit Card	
Monthly	1.032
Quarterly	3.096
Semi-Annual	6.180
Annual	12.360

An applicant is eligible for a household discount if he/she lives in the same household with another person over 18 years of age, regardless of whether both apply for coverage.

Household Discount Factor
.93

Base Option - Hospital Confinement Benefit

Monthly - Automatic Bank Withdrawal - Rates Per $25/Day Benefit

AVAILABLE UNITS - 4 to 24 ($100 to $600/Day in $25 Increments)

Issue Age	SINGLE RATES					
	Maximum Hospital Confinement Period					
	10 Days		21 Days		31 Days	
	Male	Female	Male	Female	Male	Female
40	$1.28	$1.35	$1.89	$1.98	$2.13	$2.24
41	$1.32	$1.38	$1.95	$2.02	$2.20	$2.28
42	$1.36	$1.40	$2.01	$2.06	$2.27	$2.33
43	$1.40	$1.43	$2.07	$2.10	$2.33	$2.38
44	$1.45	$1.46	$2.12	$2.14	$2.40	$2.42
45	$1.49	$1.49	$2.18	$2.18	$2.47	$2.47
46	$1.55	$1.53	$2.28	$2.25	$2.58	$2.55
47	$1.62	$1.58	$2.38	$2.32	$2.69	$2.62
48	$1.69	$1.62	$2.48	$2.39	$2.81	$2.70
49	$1.76	$1.67	$2.58	$2.46	$2.92	$2.78
50	$1.83	$1.72	$2.68	$2.52	$3.03	$2.85
51	$1.89	$1.76	$2.78	$2.59	$3.15	$2.93
52	$1.96	$1.81	$2.88	$2.66	$3.26	$3.01
53	$2.03	$1.86	$2.98	$2.73	$3.37	$3.08
54	$2.10	$1.90	$3.08	$2.80	$3.48	$3.16
55	$2.17	$1.95	$3.18	$2.86	$3.60	$3.24
56	$2.23	$2.00	$3.27	$2.94	$3.70	$3.32
57	$2.29	$2.05	$3.37	$3.01	$3.80	$3.40
58	$2.35	$2.10	$3.46	$3.09	$3.91	$3.49
59	$2.42	$2.15	$3.55	$3.16	$4.01	$3.57
60	$2.48	$2.20	$3.64	$3.24	$4.12	$3.66
61	$2.54	$2.25	$3.73	$3.31	$4.22	$3.74
62	$2.60	$2.30	$3.83	$3.39	$4.32	$3.83
63	$2.68	$2.37	$3.93	$3.48	$4.44	$3.93
64	$2.75	$2.43	$4.04	$3.57	$4.56	$4.04
65	$2.82	$2.50	$4.15	$3.67	$4.68	$4.14
66	$2.89	$2.56	$4.25	$3.76	$4.81	$4.25
67	$2.97	$2.62	$4.36	$3.85	$4.93	$4.36
68	$3.06	$2.70	$4.50	$3.98	$5.09	$4.49
69	$3.16	$2.79	$4.65	$4.10	$5.25	$4.63
70	$3.26	$2.87	$4.79	$4.22	$5.42	$4.77
71	$3.36	$2.95	$4.94	$4.34	$5.58	$4.90
72	$3.46	$3.04	$5.08	$4.46	$5.74	$5.04
73	$3.59	$3.15	$5.28	$4.63	$5.97	$5.23
74	$3.73	$3.27	$5.48	$4.80	$6.19	$5.42
75	$3.86	$3.38	$5.68	$4.97	$6.41	$5.61
76	$4.00	$3.49	$5.87	$5.14	$6.64	$5.80
77	$4.13	$3.61	$6.07	$5.31	$6.86	$5.99
78	$4.29	$3.73	$6.30	$5.49	$7.12	$6.20
79	$4.44	$3.86	$6.53	$5.67	$7.37	$6.40
80	$4.60	$3.98	$6.75	$5.85	$7.63	$6.61
81	$4.75	$4.10	$6.98	$6.03	$7.89	$6.81
82	$4.91	$4.22	$7.21	$6.21	$8.15	$7.02
83	$5.07	$4.35	$7.45	$6.39	$8.41	$7.23
84	$5.23	$4.48	$7.69	$6.59	$8.69	$7.44
85	$5.40	$4.62	$7.94	$6.78	$8.97	$7.67

Mississippi

Bank Draft	
Monthly	1
Quarterly	3.000
Semi-Annual	6.000
Annual	12.000

Direct Bill	
Monthly	N/A
Quarterly	3.240
Semi-Annual	6.240
Annual	12.000

Credit Card	
Monthly	1.032
Quarterly	3.096
Semi-Annual	6.180
Annual	12.360

An applicant is eligible for a household discount if he/she lives in the same household with another person over 18 years of age, regardless of whether both apply for coverage.

Household Discount Factor
.93

Optional Riders

Monthly - Automatic Bank Withdrawal Rates

Issue Age	SINGLE RATES					
	Ambulance		Urgent Care		Lump Sum Cancer	
	$250/Day 4 Days Per Year		$50/Day 4 Days Per Year		Per $500 Benefit Available Units: 2, 5, 10, 15 or 20	
	Male	Female	Male	Female	Male	Female
40	$2.02	$2.14	$5.74	$5.74	$0.43	$0.49
41	$2.08	$2.18	$5.68	$5.68	$0.46	$0.51
42	$2.14	$2.21	$5.63	$5.62	$0.48	$0.54
43	$2.20	$2.25	$5.57	$5.56	$0.51	$0.56
44	$2.25	$2.29	$5.51	$5.50	$0.54	$0.58
45	$2.31	$2.33	$5.45	$5.44	$0.57	$0.60
46	$2.41	$2.39	$5.42	$5.41	$0.62	$0.63
47	$2.51	$2.45	$5.39	$5.38	$0.67	$0.66
48	$2.60	$2.52	$5.36	$5.35	$0.72	$0.68
49	$2.70	$2.58	$5.33	$5.32	$0.77	$0.71
50	$2.80	$2.64	$5.30	$5.28	$0.82	$0.74
51	$2.89	$2.70	$5.27	$5.25	$0.87	$0.76
52	$2.99	$2.76	$5.24	$5.22	$0.91	$0.79
53	$3.08	$2.83	$5.21	$5.19	$0.96	$0.82
54	$3.19	$2.89	$5.18	$5.15	$1.01	$0.85
55	$3.28	$2.95	$5.15	$5.12	$1.06	$0.87
56	$3.39	$3.05	$5.12	$5.09	$1.12	$0.90
57	$3.51	$3.14	$5.09	$5.06	$1.18	$0.92
58	$3.62	$3.24	$5.06	$5.03	$1.24	$0.95
59	$3.74	$3.33	$5.03	$5.00	$1.30	$0.97
60	$3.85	$3.43	$5.00	$4.97	$1.36	$1.00
61	$3.96	$3.52	$4.97	$4.94	$1.41	$1.02
62	$4.07	$3.62	$4.95	$4.92	$1.47	$1.05
63	$4.19	$3.71	$4.92	$4.88	$1.53	$1.07
64	$4.31	$3.81	$4.89	$4.85	$1.58	$1.09
65	$4.42	$3.91	$4.86	$4.82	$1.64	$1.11
66	$4.54	$4.01	$4.83	$4.79	$1.69	$1.12
67	$4.66	$4.11	$4.80	$4.76	$1.74	$1.14
68	$4.80	$4.23	$4.79	$4.74	$1.80	$1.16
69	$4.95	$4.36	$4.78	$4.73	$1.85	$1.18
70	$5.10	$4.49	$4.77	$4.72	$1.91	$1.20
71	$5.24	$4.61	$4.76	$4.70	$1.96	$1.22
72	$5.39	$4.74	$4.75	$4.69	$2.02	$1.24
73	$5.60	$4.91	$4.76	$4.70	$2.07	$1.27
74	$5.80	$5.09	$4.78	$4.71	$2.11	$1.29
75	$6.01	$5.27	$4.79	$4.71	$2.16	$1.32
76	$6.22	$5.44	$4.80	$4.72	$2.21	$1.34
77	$6.43	$5.61	$4.82	$4.73	$2.25	$1.37
78	$6.66	$5.80	$4.83	$4.73	$2.29	$1.38
79	$6.90	$5.99	$4.85	$4.74	$2.32	$1.40
80	$7.14	$6.18	$4.86	$4.75		
81	$7.37	$6.37	$4.88	$4.75		
82	$7.61	$6.55	$4.89	$4.76		
83	$7.86	$6.74	$4.91	$4.76		
84	$8.11	$6.94	$4.92	$4.77		
85	$8.37	$7.15	$4.94	$4.78		

Mississippi

Bank Draft	
Monthly	1
Quarterly	3.000
Semi-Annual	6.000
Annual	12.000

Direct Bill	
Monthly	N/A
Quarterly	3.240
Semi-Annual	6.240
Annual	12.000

Credit Card	
Monthly	1.032
Quarterly	3.096
Semi-Annual	6.180
Annual	12.360

An applicant is eligible for a household discount if he/she lives in the same household with another person over 18 years of age, regardless of whether both apply for coverage.

Household Discount Factor
.93

Optional Riders

Monthly - Automatic Bank Withdrawal Rates

SINGLE RATES

Lump Sum Hospital Confinement
Per $50 Benefit - Available Units: 5, 10 or 15

Issue Age	1 Confinement		2 Confinements		3 Confinements	
	Male	Female	Male	Female	Male	Female
40	$0.58	$0.61	$0.67	$0.70	$0.76	$0.80
41	$0.60	$0.63	$0.69	$0.72	$0.78	$0.81
42	$0.62	$0.64	$0.72	$0.74	$0.81	$0.83
43	$0.64	$0.65	$0.74	$0.75	$0.83	$0.85
44	$0.66	$0.67	$0.76	$0.77	$0.86	$0.87
45	$0.68	$0.68	$0.78	$0.78	$0.88	$0.88
46	$0.72	$0.71	$0.82	$0.81	$0.93	$0.92
47	$0.75	$0.73	$0.87	$0.84	$0.98	$0.95
48	$0.79	$0.76	$0.91	$0.87	$1.02	$0.98
49	$0.82	$0.78	$0.95	$0.90	$1.07	$1.01
50	$0.86	$0.81	$0.99	$0.92	$1.12	$1.04
51	$0.90	$0.83	$1.03	$0.95	$1.16	$1.08
52	$0.93	$0.86	$1.07	$0.98	$1.21	$1.11
53	$0.97	$0.88	$1.11	$1.01	$1.25	$1.14
54	$1.00	$0.90	$1.15	$1.04	$1.30	$1.17
55	$1.04	$0.93	$1.19	$1.07	$1.35	$1.21
56	$1.08	$0.96	$1.24	$1.11	$1.40	$1.25
57	$1.12	$1.00	$1.28	$1.15	$1.45	$1.30
58	$1.16	$1.03	$1.33	$1.19	$1.50	$1.34
59	$1.20	$1.07	$1.38	$1.23	$1.56	$1.39
60	$1.24	$1.10	$1.42	$1.27	$1.61	$1.43
61	$1.28	$1.14	$1.47	$1.31	$1.66	$1.48
62	$1.32	$1.17	$1.52	$1.35	$1.71	$1.52
63	$1.37	$1.21	$1.57	$1.40	$1.77	$1.58
64	$1.42	$1.26	$1.63	$1.44	$1.84	$1.63
65	$1.46	$1.30	$1.68	$1.49	$1.90	$1.68
66	$1.51	$1.34	$1.73	$1.54	$1.96	$1.74
67	$1.56	$1.38	$1.79	$1.58	$2.02	$1.79
68	$1.62	$1.43	$1.86	$1.64	$2.10	$1.86
69	$1.68	$1.48	$1.93	$1.71	$2.18	$1.93
70	$1.74	$1.54	$2.00	$1.77	$2.26	$1.99
71	$1.80	$1.59	$2.07	$1.83	$2.34	$2.06
72	$1.86	$1.64	$2.14	$1.89	$2.41	$2.13
73	$1.94	$1.71	$2.23	$1.96	$2.52	$2.22
74	$2.02	$1.78	$2.32	$2.04	$2.62	$2.31
75	$2.10	$1.85	$2.42	$2.12	$2.73	$2.39
76	$2.18	$1.91	$2.51	$2.20	$2.83	$2.48
77	$2.26	$1.98	$2.60	$2.27	$2.94	$2.57
78	$2.36	$2.05	$2.71	$2.36	$3.06	$2.66
79	$2.45	$2.12	$2.81	$2.44	$3.17	$2.76
80	$2.54	$2.20	$2.91	$2.52	$3.29	$2.85
81	$2.63	$2.27	$3.02	$2.60	$3.41	$2.94
82	$2.72	$2.34	$3.12	$2.69	$3.53	$3.03
83	$2.81	$2.41	$3.23	$2.77	$3.65	$3.13
84	$2.91	$2.49	$3.34	$2.86	$3.77	$3.23
85	$3.01	$2.57	$3.46	$2.95	$3.91	$3.33

Bank Draft	
Monthly	1
Quarterly	3.000
Semi-Annual	6.000
Annual	12.000

Direct Bill	
Monthly	N/A
Quarterly	3.240
Semi-Annual	6.240
Annual	12.000

Credit Card	
Monthly	1.032
Quarterly	3.096
Semi-Annual	6.180
Annual	12.360

An applicant is eligible for a household discount if he/she lives in the same household with another person over 18 years of age, regardless of whether both apply for coverage.

Household Discount Factor
.93

Mississippi

Bank Draft	
Monthly	1
Quarterly	3.000
Semi-Annual	6.000
Annual	12.000

Direct Bill	
Monthly	N/A
Quarterly	3.240
Semi-Annual	6.240
Annual	12.000

Credit Card	
Monthly	1.032
Quarterly	3.096
Semi-Annual	6.180
Annual	12.360

An applicant is eligible for a household discount if he/she lives in the same household with another person over 18 years of age, regardless of whether both apply for coverage.

Household Discount Factor
.93

Optional Riders

Monthly - Automatic Bank Withdrawal Rates

Issue Age	SINGLE RATES — Outpatient Therapy and Chiropractic Services, $50 per Day for Outpatient Therapy, $50 per Day for Chiropractic Care: 15 Days for Therapy, 5 Visits for Chiropractic		30 Days for Therapy, 5 Visits for Chiropractic	
	Male	Female	Male	Female
40	$5.28	$5.48	$5.91	$6.16
41	$5.31	$5.48	$5.95	$6.17
42	$5.33	$5.48	$5.99	$6.17
43	$5.36	$5.47	$6.03	$6.18
44	$5.39	$5.47	$6.07	$6.18
45	$5.41	$5.47	$6.11	$6.19
46	$5.47	$5.48	$6.19	$6.21
47	$5.53	$5.50	$6.26	$6.23
48	$5.58	$5.51	$6.33	$6.25
49	$5.64	$5.53	$6.40	$6.27
50	$5.69	$5.54	$6.48	$6.29
51	$5.75	$5.56	$6.55	$6.31
52	$5.81	$5.57	$6.62	$6.33
53	$5.86	$5.58	$6.69	$6.35
54	$5.92	$5.60	$6.77	$6.37
55	$5.97	$5.61	$6.84	$6.39
56	$6.01	$5.63	$6.89	$6.42
57	$6.04	$5.64	$6.93	$6.44
58	$6.07	$5.66	$6.98	$6.46
59	$6.11	$5.68	$7.02	$6.49
60	$6.14	$5.69	$7.07	$6.51
61	$6.18	$5.71	$7.11	$6.53
62	$6.21	$5.72	$7.16	$6.56
63	$6.23	$5.74	$7.19	$6.58
64	$6.26	$5.75	$7.23	$6.60
65	$6.28	$5.77	$7.26	$6.62
66	$6.31	$5.78	$7.29	$6.64
67	$6.33	$5.79	$7.33	$6.66
68	$6.38	$5.83	$7.39	$6.71
69	$6.43	$5.87	$7.45	$6.76
70	$6.48	$5.90	$7.51	$6.80
71	$6.53	$5.94	$7.57	$6.85
72	$6.58	$5.98	$7.63	$6.89
73	$6.66	$6.04	$7.73	$6.97
74	$6.74	$6.10	$7.84	$7.05
75	$6.82	$6.17	$7.94	$7.13
76	$6.91	$6.23	$8.04	$7.21
77	$6.99	$6.30	$8.14	$7.29
78	$7.08	$6.36	$8.25	$7.37
79	$7.17	$6.43	$8.36	$7.46
80	$7.26	$6.50	$8.47	$7.54
81	$7.35	$6.57	$8.59	$7.62
82	$7.44	$6.63	$8.70	$7.70
83	$7.54	$6.70	$8.81	$7.79
84	$7.63	$6.77	$8.93	$7.87
85	$7.73	$6.84	$9.04	$7.96

Optional Riders

Monthly - Automatic Bank Withdrawal Rates

Issue Age	SINGLE RATES			
	Skilled Nursing Facility Per $50 Benefit Confinement Days 1 through 50		Outpatient Surgery Per $50 Benefit 2 Days per Year	
	Available Units: 2, 3 or 4		Available Units: 5, 10, 15 or 20	
	Male	Female	Male	Female
40	$0.64	$0.54	$1.07	$1.13
41	$0.69	$0.59	$1.10	$1.15
42	$0.74	$0.64	$1.13	$1.17
43	$0.79	$0.69	$1.17	$1.20
44	$0.84	$0.74	$1.20	$1.22
45	$0.89	$0.79	$1.24	$1.25
46	$1.00	$0.93	$1.28	$1.27
47	$1.12	$1.06	$1.32	$1.29
48	$1.23	$1.20	$1.36	$1.32
49	$1.34	$1.34	$1.41	$1.34
50	$1.46	$1.48	$1.45	$1.37
51	$1.57	$1.61	$1.49	$1.39
52	$1.68	$1.75	$1.53	$1.42
53	$1.80	$1.89	$1.57	$1.44
54	$1.91	$2.02	$1.62	$1.46
55	$2.02	$2.16	$1.66	$1.49
56	$2.20	$2.43	$1.70	$1.52
57	$2.37	$2.69	$1.74	$1.55
58	$2.54	$2.96	$1.77	$1.58
59	$2.71	$3.22	$1.81	$1.61
60	$2.88	$3.49	$1.85	$1.63
61	$3.05	$3.76	$1.89	$1.66
62	$3.22	$4.02	$1.93	$1.69
63	$3.46	$4.36	$1.95	$1.71
64	$3.70	$4.70	$1.97	$1.72
65	$3.94	$5.04	$1.99	$1.74
66	$4.18	$5.38	$2.01	$1.75
67	$4.42	$5.72	$2.03	$1.76
68	$4.74	$6.20	$2.05	$1.78
69	$5.07	$6.69	$2.06	$1.79
70	$5.40	$7.17	$2.08	$1.80
71	$5.72	$7.65	$2.10	$1.82
72	$6.05	$8.13	$2.12	$1.83
73	$6.54	$8.95	$2.14	$1.84
74	$7.02	$9.77	$2.16	$1.86
75	$7.51	$10.59	$2.18	$1.87
76	$7.99	$11.41	$2.20	$1.89
77	$8.48	$12.23	$2.22	$1.90
78	$9.11	$13.26	$2.23	$1.91
79	$9.73	$14.29	$2.25	$1.92
80	$10.36	$15.31	$2.27	$1.93
81	$10.99	$16.34	$2.28	$1.95
82	$11.61	$17.37	$2.30	$1.96
83	$12.27	$18.47	$2.32	$1.97
84	$12.97	$19.63	$2.33	$1.98
85	$13.71	$20.87	$2.35	$1.99

Mississippi

Bank Draft	
Monthly	1
Quarterly	3.000
Semi-Annual	6.000
Annual	12.000

Direct Bill	
Monthly	N/A
Quarterly	3.240
Semi-Annual	6.240
Annual	12.000

Credit Card	
Monthly	1.032
Quarterly	3.096
Semi-Annual	6.180
Annual	12.360

An applicant is eligible for a household discount if he/she lives in the same household with another person over 18 years of age, regardless of whether both apply for coverage.

Household Discount Factor
.93

UNDERWRITING GUIDELINES

A63 HOSPITAL INDEMNITY PRODUCT

Underwriting Guidelines: The Underwriting Guidelines were developed with an emphasis on predictability. The health questions were structured to be as “black and white” as possible.

- If the applicant answers “Yes” to any question 1-9 in Part B of the application, the applicant will not be eligible for coverage.

A Personal Health Interview (PHI) will not be required at this time.

Attending Physician Statement (APS) will not be required at this time.

Underwriting Hotline: 1-800-626-2068 – We encourage the producer to utilize the Underwriting Hotline. The underwriters taking the calls are able to access our records to see if the applicant currently has or has applied for coverage in the past. They can also answer questions about medications or medical conditions.

Rate Structure: The premium rates shown in the Rate Guide are for single applicants. An applicant qualifies for the Household Discount if he/she 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. To calculate the Household Discount, multiply the single premium rates by 0.93.

Conversion Rules: An Indemnity Benefit Policy cannot be converted from any other policy form.

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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