MEDICO® CORP
LIFE INSURANCE COMPANY

PO Box 10482
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-822-9993
Fax: Toll Free 1-844-850-2550

Application for Medicare Supplement Insurance

Requested Effective Date of New Policy (optional)

_____

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 mailed to:

❒ Applicant ❒ Producer

Part A General Information (Please Print)

First Name | M.I. | Last Name

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

Address

City | State | ZIP Code

Phone Number | Alternate Phone Number | Email Address

Are you eligible for Open Enrollment? ❒ Yes ❒ No

If "Yes", skip Parts C, D and E.

Part B Insurance Information

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

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

1. Please enter your Medicare Claim number .....
2. (a) Did you turn age 65 in the last 6 months? ..... ❒ Yes ❒ No
   (b) Did you enroll in Medicare Part B in the last 6 months? ..... ❒ Yes ❒ No
   (c) What is your Part B effective date? ..... MM/DD/YYYY
3. Are you covered for medical assistance through the state Medicaid program? (If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.) ..... ❒ Yes ❒ No
   If "Yes",
   (a) Will Medicaid pay your premiums for this Medicare supplement policy? ..... ❒ Yes ❒ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ..... ❒ Yes ❒ No
4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. (If you are still covered under the policy, leave **"End"** blank.) .....

Start	End
MM/DD/YYYY	MM/DD/YYYY

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ..... ❒ Yes ❒ No
   (c) Was this your first time in this type of Medicare plan? ..... ❒ Yes ❒ No
   (d) Did you drop a Medicare Supplement policy to enroll in this Medicare plan? ..... ❒ Yes ❒ No