MEDICO® CORP
LIFE INSURANCE COMPANY

Medico® Corp Medicare Supplement Insurance

SALES KIT BOOKLET

PRODUCER INSTRUCTIONS

Please complete the following:

- ☐ Application for Medicare Supplement 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.

There are three options for submitting enrollment materials:

MyEnroller
Electronic Application Submission Tool
Website: mic.GoMedico.com

Mail
Medico Corp Life Insurance Company
PO Box 10482
Des Moines, IA 50306

Fax
1-844-850-2550

If you need assistance, please call 1-800-547-2401-Option 3.

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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) Are you within 6 months of your 65th birthday? ❒ 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? (NOTE TO APPLICANT: 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

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Part B Insurance Information (continued)

5. (a) Do you have another Medicare supplement policy in force? ❒ Yes ❒ No
   (b) If "Yes", please indicate company and plan.

Company	Plan

   (c) If so, do you intend to replace your current Medicare supplement policy with this policy? ❒ Yes ❒ No

Producer: If replacing another Medicare plan or a Medicare Supplement, please complete and submit NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE.

6. Are you eligible for Guaranteed Issue? ❒ Yes ❒ No
   If "Yes", please provide documentation and skip Parts C, D and E.
7. Have you had coverage under any other health insurance within the past 63 days?
   (For example, an employer, union or individual plan.) ❒ Yes ❒ No
   (a) If "Yes", please indicate company and kind of policy.

Company	Kind of Policy

   (b) What are your dates of coverage under the other policy?
   (If you are still covered under the other policy, leave "END" blank.)

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

8. If you have lost or are losing other health insurance coverage, did you receive notice from that insurance company stating you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy a policy? If you answered, "Yes," and you are unable to provide a termination notice please complete all sections of this form ❒ Yes ❒ No
   If "No," Please provide an explanation.

Part C General Health Information

Note: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a Guaranteed Issue.

Please indicate your current height and weight.

Height		Weight	

QUALIFYING INFORMATION

(If any answer to questions 1 through 4 is "Yes," you are not eligible for coverage.)

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

1. Within the past 5 years, have you:
   (a) had or been treated for or diagnosed as having diabetes requiring insulin or with complications? ❒ Yes ❒ No
   (b) had or been treated for or advised to have a bone marrow or organ transplant? ❒ Yes ❒ No
   (c) had or been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? ❒ Yes ❒ No
2. Within the past 2 years have you:
   (a) had or been treated for or diagnosed as having internal cancer, leukemia, melanoma, Hodgkin's Disease or lymphoma? ❒ Yes ❒ No
   (b) had or been treated for or diagnosed as having Amyotrophic Lateral Sclerosis (ALS), Parkinson's or Multiple or Lateral Sclerosis? ❒ Yes ❒ No
   (c) had or been treated for or diagnosed as having cirrhosis of the liver, Hepatitis C, chronic renal failure, kidney failure or had dialysis? ❒ Yes ❒ No
   (d) had or been treated for or diagnosed as having had a stroke or Transient Ischemic Attack (TIA)? ❒ Yes ❒ No
   (e) had heart surgery, including bypass, angioplasty or stent placement? ❒ Yes ❒ No
   (f) had or been treated for or diagnosed as having peripheral vascular disease (poor circulation in your extremities), had angioplasty or stent placement of any vessel, congestive heart failure or a heart attack? ❒ Yes ❒ No
   (g) had or been treated for or diagnosed as having emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disease? ❒ Yes ❒ No
   (h) had or been treated for or diagnosed as having connective tissue disease, (for example, lupus), degenerative bone disease or disabling or rheumatoid arthritis? ❒ Yes ❒ No
   (i) had fractures due to osteoporosis or amputation due to disease? ❒ Yes ❒ No

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Part C General Health Information (continued)

(j) been or are you now bedridden or confined to a wheelchair? ❒ Yes ❒ No

(k) had or been treated for or diagnosed as having schizophrenia or bipolar disease? ❒ Yes ❒ No

(l) been hospitalized for a mental or nervous condition? ❒ Yes ❒ No

(m)been treated for or diagnosed as having alcohol or drug abuse? ❒ Yes ❒ No

3. Do you have, or have you been told by a medical professional, that you have Alzheimer's Disease, senile dementia or organic brain disorder? ❒ Yes ❒ No
4. Are you currently using oxygen? ❒ Yes ❒ No

Part D Medical Health Information

Note: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a Guaranteed Issue.

If you answer "Yes" to any of the following questions, please provide details in the space allotted following question D. If you need additional space, attach a separate page that you have signed and dated.

A. Do you require assistance or supervision to perform any of the following everyday living activities; dressing, eating, bathing, toileting (including use of a catheter), or walking (including use of cane, walker, motorized scooter or wheelchair)? ❒ Yes ❒ No

B. Has a member of the medical profession recommended that you have medical tests, treatment or therapy, or surgery, including cataract surgery or joint replacement, that has not yet been performed? ❒ Yes ❒ No

C. Have you been, or has a member of the medical profession recommended that you be hospitalized or confined to a nursing facility within the last 60 days, or have you been hospitalized 3 or more times within the past 2 years? ❒ Yes ❒ No

D. Have you had a seizure within the last 2 years? ❒ Yes ❒ No

Question (list A, B, C, or D)	Details

Have you taken any medication in the last 12 months? ❒ Yes ❒ No

If "Yes", please provide the name and diagnosis or condition for which they were prescribed.

Medication	Diagnosis/Condition

Please provide the date and reason for your last visit to a physician.

Your Physician's Name

Physician's Phone Number

Date of Last Visit MM/DD/YYYY

Reason for Last Visit

Part E Preferred Rate Information

Note: These questions should not be answered if you apply during "Open Enrollment" or if you are eligible for a Guaranteed Issue.

To qualify for preferred rates you must be able to answer "No," to the following question.

Have you used tobacco in any form in the past 2 years? ❒ Yes ❒ No

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Part F Definitions of Eligible Person for Guaranteed Issue

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

1. The individual is enrolled under an employee welfare benefit plan that either: (a) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or (b) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.
2. The individual is enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual.
3. The individual is enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan , or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual.
4. The individual is enrolled in a Medicare supplement policy and coverage discontinues due to insolvency, substantial violation of material policy provision, or material misrepresentation or of other involuntary termination of coverage or enrollment under the policy.
5. The individual was enrolled under a Medicare supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment,
6. The individual, upon first becoming eligible for benefits under Part B at age 65 or older, enrolls in a Medicare Advantage or PACE provider and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.
7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and terminates enrollment in the Medicare supplement policy.
8. The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).
9. The individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013 and the individual's Pool coverage terminated on or after December 31, 2013.

Part G Notices

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages in addition to your Medicare benefits.

You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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Part H Benefit Options

Choose Your Plan:

- ❒ Policy Form MSM70A – Plan A
- ❒ Policy Form MSM70DISA – Plan A (Underage 65)
- ❒ Policy Form MSM70F – Plan F
- ❒ Policy Form MSM70G – Plan G
- ❒ Policy Form MSM70N – Plan N

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 Corp Life 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

First Name M.I. Last Name

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 $

Make all checks payable to: Medico Corp Life Insurance Company (do not make checks payable to the producer or leave payee line blank).

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Part I Application Agreement

I hereby apply to Medico Corp Life Insurance Company for a **Medicare Supplement Insurance Policy** to be issued solely and entirely in reliance on my answers to the questions. This application will become a part of any policy to which this form is attached. If I am not applying during "Open Enrollment" or not eligible for a Guaranteed Issue, I do not have a right to have this policy issued to me if I have answered "Yes" to any of questions 1 through 4 in the General Health Information Part above. I also may not have a right to have this policy issued to me if I have answered "Yes" to any of questions A through D in the Medical Health Information Part if I am not applying during "Open Enrollment" or not eligible for a Guaranteed Issue. I have read, or had read to me, the complete application.

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 delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.

I have received the Notice of Privacy Practices and the Outline of Coverage for the policy.

Check one of the following if "A Guide to Health Insurance for People With Medicare" is required in the applicant's state:

❒ 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at www.GoMedico.com/products.

❒ 2. I have received a hard copy of the Medicare Buyers Guide.

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.

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.

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 Medicare Supplement Insurance Policy.

X _____

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

Part J Producer's Section

Have any other health insurance policies been sold to the proposed insured that are still in force OR have any policies been sold that are no longer in force in the past 5 years? ..... ❒ Yes ❒ No

If "Yes", please list policies.

Policy Type and Policy Number	In Force?
	❒ Yes ❒ No
	❒ Yes ❒ No

Producer: Is the insurance applied for intended to replace any medical or health insurance coverage? ..... ❒ Yes ❒ No

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. 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 (9 digit Number)

X _____

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

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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.

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MEDICO® CORP
LIFE INSURANCE COMPANY

PO Box 10482
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-822-9993

REPLACEMENT NOTICE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Corp Life Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. (Check One):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

☐ Other. (please specify)

_____

_____

_____

I call to your attention the following items for your consideration:

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer	Typed Name and Address of Issuer or Producer
Applicant's Signature	Date

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REPLACEMENT NOTICE

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SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Medico Corp Life Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY ISSUER OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason. (Check One):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

☐ Other. (please specify)

_____

_____

_____

I call to your attention the following items for your consideration:

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Producer	Typed Name and Address of Issuer or Producer
Applicant's Signature	Date

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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

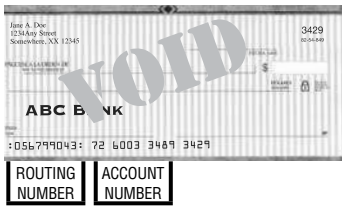
☐ Checking ☐ Savings

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® CORP
LIFE INSURANCE COMPANY

PO Box 10482
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-822-9993

RECEIPT

Medicare Supplement Policy Receipt

The applicant has applied for Medicare Supplement Policy:

❒ M70A ❒ M70DISA (Disability Plan A) ❒ M70F ❒ M70G ❒ M70N

Received of _____
(Applicant's Name)

an application for insurance as shown above and $ _____ Dollars.
(includes policy fee, if any)

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 CORP LIFE 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 the following methods:

Write to:
Medico Corp Life Insurance Company
P.O. Box 10482 • Des Moines, Iowa 50306

Call:
Customer Service at 1-800-822-9993

E-mail:
customerservice@GoMedico.com

_____ _____
Producer's Printed Name Date

_____
Producer's Signature

MEDICO® CORP
LIFE INSURANCE COMPANY

PO Box 10482
Des Moines, IA 50306

www.GoMedico.com
Toll-Free 1-800-822-9993

Benefit Charts of Medicare Supplement Plans Sold on or after January 1, 2020

Available Plans: A, F, G, and N

This chart shows the benefits included in each of the standard Medicare Supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. **Only applicants first eligible for Medicare before 2020 may purchase Plans C, F, and High Deductible F.**

A ✓ means 100% of the benefit is paid. Highlighted plans are available from Medico Corp Life Insurance Company.

Benefits	Plans Available to All Applicants								Medicare first eligible before 2020 only	
	A	B	D	G[1]	K	L	M	N	C	F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓ copays apply[3]	✓	✓
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in 2020[2]					$5,880	$2,940				

[1] Plans F and G also have a high deductible option which require first paying a plan deductible of $2,340 before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2] Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3] Plan N pays 100% of the Part B coinsurance, except for a co-payment of up to $20 for some office visits and up to a $50 co-payment for emergency room visits that do not result in an inpatient admission.

Premium Information

We guarantee to renew your policy for life as long as the premium is paid when due.

We can only raise your premium if we raise the premium for all policies like yours in this state. If it is necessary to change the premium for your policy, we will notify you in advance of the change in premium. Premiums are based on your attained age and will increase annually. Any rate increases are subject to approval by the Texas Department of Insurance.

Although these policy types are issued individually, when you live in the same household with another person over 18 years of age, regardless of whether they sign up for coverage with us, a discount is applied to your premium rates.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

Right To Return Policy

When you receive your policy, please review it along with the attached application. If you find that you are not satisfied with your policy, you may return it to us at PO Box 10482, Des Moines, IA 50306. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments, less any claims paid.

Policy Replacement

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Notice

This policy may not fully cover all of your medical costs.

Neither Medico Corp Life Insurance Company nor its producers are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

Limitations and Exclusions

We will NOT pay benefits for:

1. any expense incurred for outpatient prescription drugs, other than drugs covered by Medicare Parts A and B;
2. non-Medicare Eligible Expenses, including, but not limited to: routine exams, take-home drugs and eye refractions;
3. services for which you are not liable or for which no charge normally is made in the absence of insurance; and
4. loss that occurs while this policy is not in force.

Refund of Premium

We will refund any unearned premium in the event of your death or policy cancellation.

Complete Answers Are Very Important

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. Medical and health history questions are not required to be answered on the application if you apply during Open Enrollment or if you are eligible for a Guaranteed Issue.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$0	$1,408 (Part A deductible)
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	$0	Up to $176 a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed for $198 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed for $198 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts* (Part B deductible)	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts* (Part B deductible)	$0	$198 (Part B deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $198 of Medicare Approved Amounts*	$0	$198 (Part B deductible)	$0
• Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN F (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN G (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed for $198 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT Such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$198 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$198 (Unless Part B deductible has been met)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $198 of Medicare Approved Amounts*	$0	$0	$198 (Unless Part B deductible has been met)
• Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN G (continued)

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN N

MEDICARE (PART A) - HOSPITAL SERVICES - PER BENEFIT PERIOD*

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,408	$1,408 (Part A deductible)	$0
61st thru 90th day	All but $352 a day	$352 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $704 a day	$704 a day	$0
• Once lifetime reserve days are used: • Additional 365 days	$0	100% of Medicare Eligible expenses	$0**
• Beyond the additional 365 days	$0	$0	All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare Approved Facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $176 a day	Up to $176 a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE			
You must meet Medicare's requirements, including a physician's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	$0

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits". During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN N (continued)

MEDICARE (PART B) - MEDICAL SERVICES - PER CALENDAR YEAR

* Once you have been billed for $198 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES - IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $198 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	Generally 80%	Balance, other than up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to $20 per office visit and up to $50 per emergency room visit. The copayment of up to $50 is waived if you are admitted to any hospital and the emergency visit is covered as a Medicare Part A expense
PART B EXCESS CHARGES			
Above Medicare Approved Amounts	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $198 of Medicare Approved Amounts* (Part B deductible)	$0	$0	$198 (Part B deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES			
Tests for Diagnostic Services	100%	$0	$0

PLAN N (continued)

* Once you have been billed for $198 of Medicare Approved Amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

MEDICARE (PARTS A AND B) - HOME HEALTH CARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE - MEDICARE APPROVED SERVICES			
Medically necessary skilled care services and medical supplies	100%	$0	$0
Durable medical equipment			
• First $198 of Medicare Approved Amounts*	$0	$0	$198 (Part B deductible)
• Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS - NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a Lifetime Maximum Benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

MEDICO® CORP
LIFE INSURANCE COMPANY

Texas

Medicare Supplement Rates

Plans A, F, G, and N

Effective 11-1-2020

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

36 114 3820 1 1120 TX

How to Calculate the Premium

Step 1 - Find the Monthly Base Premium Rate
Find the monthly premium rate on the following tables based on the plan, preferred/standard, household/individual, applicant's gender, and age. If 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 Corp Life Insurance Company, a discount is applied to the premium rates. Write the monthly base premium rate on Line 1 below.

Step 2 - Find the Area Factor
Use the first 3 digits of the applicant's ZIP code to determine the area factor. Write the Area Factor on Line 2 below.

Area Factors			
ZIP Code	Factor	ZIP Code	Factor
767, 769, 798, 799, 885	0.865	733, 756, 760, 761, 776, 778, 787, 789, 790, 793, 794	0.995
788, 796	0.9	752, 753, 779	1.015
768, 781, 782, 791, 795	0.925	757, 758, 759, 762, 783, 785	1.03
755, 780, 797	0.94	750, 751, 774, 775	1.045
765, 766	0.95	754, 770, 772, 773	1.065
784	0.965	792	1.08
763, 764, 777, 786	0.98	All others	1

Step 3 - Find the Mode Factor
Determine the Mode Factor for the method of premium payment requested by the Applicant. Write the Mode Factor on Line 3 below.

Note: If a mode is not listed here, it is not available.

Mode Factors	
Automatic Bank Withdrawal - Monthly	1
Automatic Bank Withdrawal - Quarterly	3
Automatic Bank Withdrawal - Semi-annual	6
Automatic Bank Withdrawal - Annual	12
Direct Billed - Quarterly	3.24
Direct Billed - Semi-annual	6.24
Direct Billed - Annual	12
Credit/Debit Card - Monthly	1.032
Credit/Debit Card - Quarterly	3.096
Credit/Debit Card - Semi-annual	6.180
Credit/Debit Card - Annual	12.360

Step 4 - Calculate the Premium

Multiply to determine the premium and round to the nearest cent:

$_____ X _____ X _____ = $_____

Line 1 Monthly Base Premium Rate		Line 2 Area Factor		Line 3 Mode Factor		Final Premium

Please Note: Open Enrollee and Guaranteed Issue applicants will be rated as Preferred Risks. Due to rounding, premium amounts you calculate may differ by a few cents from the final premium.

Texas

Medicare Supplement Plan A Monthly Base Rates
Effective November 1, 2020

PLAN A	Preferred				Standard			
	Household		Individual		Household		Individual	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female
65	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
66	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
67	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
68	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
69	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
70	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
71	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
72	166.15	151.04	188.81	171.64	195.48	177.69	222.13	201.92
73	169.73	151.04	192.87	171.64	199.68	177.69	226.90	201.92
74	176.22	154.23	200.25	175.26	207.32	181.45	235.59	206.19
75	183.25	161.37	208.23	183.38	215.58	189.85	244.98	215.74
76	190.05	168.61	215.96	191.61	223.58	198.37	254.07	225.42
77	196.70	175.91	223.52	199.90	231.41	206.96	262.97	235.18
78	203.31	183.23	231.03	208.22	239.19	215.57	271.80	244.96
79	209.95	190.58	238.58	216.56	247.00	224.21	280.68	254.78
80	217.45	195.69	247.11	222.37	255.83	230.22	290.71	261.61
81	225.02	200.67	255.71	228.03	264.73	236.08	300.83	268.28
82	232.59	205.47	264.31	233.49	273.64	241.73	310.95	274.69
83	240.05	210.12	272.78	238.77	282.41	247.20	320.92	280.91
84	247.28	214.58	281.00	243.84	290.92	252.45	330.59	286.87
85	253.65	219.37	288.24	249.28	298.41	258.08	339.10	293.27
86	259.73	223.99	295.14	254.53	305.56	263.51	347.23	299.45
87	265.57	228.42	301.78	259.57	312.43	268.73	355.04	305.38
88	271.20	232.69	308.18	264.42	319.06	273.76	362.56	311.09
89	276.68	236.77	314.41	269.06	325.51	278.55	369.89	316.54
90 & over	282.05	240.66	320.51	273.47	331.83	283.13	377.07	321.73

Note: These are the monthly base rates. Please refer to the "How to Calculate the Premium" instructions on page 2 to find any applicable Area and Mode Factors.

Texas

Medicare Supplement Plan F Monthly Base Rates
Effective November 1, 2020

PLAN F	Preferred				Standard			
	Household		Individual		Household		Individual	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female
65	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
66	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
67	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
68	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
69	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
70	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
71	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
72	225.96	205.40	256.77	233.41	265.83	241.65	302.08	274.60
73	230.81	205.40	262.29	233.41	271.54	241.65	308.57	274.60
74	239.65	209.74	272.33	238.34	281.94	246.75	320.39	280.40
75	249.20	219.46	283.18	249.38	293.18	258.18	333.15	293.39
76	258.45	229.30	293.69	260.57	304.06	269.77	345.52	306.56
77	267.50	239.23	303.97	271.85	314.70	281.44	357.62	319.82
78	276.48	249.18	314.19	283.16	325.28	293.15	369.63	333.13
79	285.52	259.17	324.45	294.51	335.90	304.91	381.71	346.49
80	295.72	266.12	336.05	302.41	347.91	313.08	395.35	355.77
81	306.02	272.90	347.75	310.11	360.02	321.05	409.11	364.83
82	316.31	279.42	359.44	317.53	372.13	328.73	422.87	373.56
83	326.44	285.75	370.96	324.71	384.05	336.17	436.42	382.01
84	336.28	291.81	382.14	331.61	395.63	343.31	449.58	390.12
85	344.94	298.32	391.98	339.00	405.81	350.97	461.15	398.83
86	353.21	304.60	401.37	346.14	415.54	358.36	472.20	407.23
87	361.15	310.64	410.40	353.00	424.89	365.46	482.83	415.29
88	368.81	316.45	419.10	359.60	433.89	372.29	493.06	423.06
89	376.26	321.99	427.57	365.90	442.66	378.81	503.03	430.47
90 & over	383.57	327.28	435.87	371.90	451.26	385.03	512.79	437.53

Note: These are the monthly base rates. Please refer to the "How to Calculate the Premium" instructions on page 2 to find any applicable Area and Mode Factors.

Texas

Medicare Supplement Plan G Monthly Base Rates
Effective November 1, 2020

PLAN G	Preferred				Standard			
	Household		Individual		Household		Individual	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female
65	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
66	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
67	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
68	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
69	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
70	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
71	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
72	155.38	141.24	176.56	160.50	182.80	166.17	207.72	188.83
73	158.72	141.24	180.36	160.50	186.72	166.17	212.19	188.83
74	164.79	144.23	187.26	163.89	193.87	169.68	220.31	192.82
75	171.36	150.91	194.73	171.48	201.60	177.54	229.09	201.75
76	177.72	157.68	201.95	179.18	209.08	185.50	237.59	210.80
77	183.94	164.50	209.02	186.93	216.40	193.53	245.91	219.92
78	190.12	171.35	216.05	194.71	223.67	201.58	254.17	229.07
79	196.33	178.22	223.11	202.52	230.98	209.67	262.48	238.26
80	203.35	182.99	231.08	207.95	239.23	215.29	271.86	244.64
81	210.43	187.65	239.12	213.24	247.56	220.77	281.32	250.87
82	217.51	192.14	247.17	218.34	255.89	226.05	290.78	256.87
83	224.48	196.49	255.09	223.28	264.09	231.17	300.10	262.69
84	231.24	200.66	262.77	228.02	272.05	236.07	309.15	268.26
85	237.19	205.14	269.54	233.11	279.05	241.34	317.11	274.25
86	242.88	209.46	276.00	238.02	285.74	246.42	324.71	280.02
87	248.34	213.61	282.21	242.74	292.17	251.30	332.01	285.57
88	253.61	217.60	288.19	247.27	298.36	256.00	339.05	290.91
89	258.73	221.41	294.02	251.61	304.39	260.49	345.90	296.01
90 & over	263.76	225.05	299.72	255.74	310.30	264.76	352.62	300.87

Note: These are the monthly base rates. Please refer to the "How to Calculate the Premium" instructions on page 2 to find any applicable Area and Mode Factors.

Texas

Medicare Supplement Plan N Monthly Base Rates
Effective November 1, 2020

PLAN N	Preferred				Standard			
	Household		Individual		Household		Individual	
Attained Age	Male	Female	Male	Female	Male	Female	Male	Female
65	134.88	121.90	153.28	138.52	158.69	143.41	180.33	162.96
66	134.88	121.90	153.28	138.52	158.69	143.41	180.33	162.96
67	134.88	121.90	153.28	138.52	158.69	143.41	180.33	162.96
68	134.88	121.90	153.28	138.52	158.69	143.41	180.33	162.96
69	134.88	121.90	153.28	138.52	158.69	143.41	180.33	162.96
70	135.42	122.24	153.89	138.90	159.32	143.81	181.05	163.42
71	135.87	122.55	154.40	139.26	159.85	144.18	181.65	163.84
72	136.25	122.85	154.83	139.60	160.29	144.53	182.15	164.23
73	139.51	123.12	158.53	139.91	164.13	144.85	186.51	164.60
74	145.14	125.99	164.94	143.17	170.76	148.22	194.04	168.43
75	151.20	132.08	171.82	150.09	177.89	155.38	202.14	176.57
76	157.07	138.25	178.49	157.10	184.79	162.65	209.99	184.82
77	162.81	144.47	185.01	164.17	191.54	169.96	217.66	193.14
78	168.51	150.71	191.49	171.26	198.25	177.31	225.28	201.49
79	174.24	156.98	198.00	178.38	204.99	184.68	232.94	209.86
80	180.69	161.39	205.33	183.40	212.58	189.87	241.56	215.77
81	187.20	165.70	212.72	188.30	220.23	194.94	250.26	221.53
82	193.70	169.85	220.12	193.02	227.88	199.83	258.96	227.08
83	200.11	173.88	227.39	197.59	235.42	204.56	267.52	232.46
84	206.33	177.74	234.46	201.97	242.74	209.10	275.84	237.61
85	211.81	181.86	240.69	206.66	249.19	213.95	283.17	243.13
86	217.05	185.84	246.64	211.18	255.35	218.64	290.17	248.45
87	222.08	189.66	252.36	215.53	261.27	223.13	296.90	253.56
88	226.93	193.34	257.88	219.71	266.98	227.46	303.38	258.48
89	231.65	196.85	263.24	223.70	272.53	231.59	309.70	263.17
90 & over	236.28	200.20	268.50	227.50	277.98	235.53	315.88	267.65

Note: These are the monthly base rates. Please refer to the "How to Calculate the Premium" instructions on page 2 to find any applicable Area and Mode Factors.

Texas

Medicare Supplement Disability Plan A Monthly Base Rates
Effective November 1, 2020

PLAN DISABILITY A	Preferred			
	Household		Individual	
Attained Age	Male	Female	Male	Female
0-99	604.53	604.53	686.96	686.96

Note: These are the monthly base rates. Please refer to the "How to Calculate the Premium" instructions on page 2 to find any applicable Area and Mode Factors.

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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