Medico® Insurance Company
A Wellabe® Company
601 Sixth Ave., Des Moines, IA 50309
P.O. Box 10386, Des Moines, IA 50306
www.wellabe.com
Phone (toll-free): 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 the company.

Policy delivery options

Upon approval of this application, the policy will be delivered to the applicant by mail.

Part A: General information (please print)

Applicant information

Full name of applicant: *first, middle, last, suffix* | Date of birth (MM/DD/YYYY) | Age | Gender

Social Security number | Phone number | Email address

Residence address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

Mailing address *(if different than residence address)* | City | State | ZIP code

Beneficiary information

Full name of beneficiary: *first, middle, last, suffix* | Relationship to applicant

Address *(include Apt/Bldg/Unit Nbr if applicable)* | City | State | ZIP code

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

Part B: Medical information

Note: If you are between the ages of 60 and 79 on the date the application is signed, skip to Part C.

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 3 months have you received home health care, been bedridden, been confined to a wheelchair, or been confined to a nursing home or a hospital as an inpatient (other than for childbirth)? ❒ Yes ❒ No

Part B: Medical information (continued)

3. In the past 12 months have you had, been treated for, or diagnosed by a member of the medical profession with:
   a. Chronic obstructive lung disease, COPD, emphysema, chronic bronchitis, or required the use of oxygen? ❒ 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 12 months have you had, been treated for, or diagnosed by a member of the medical profession with diabetes:
   a. Requiring more than 50 units insulin per day; ❒ Yes ❒ No
   b. Requiring more than two diabetic medications; ❒ Yes ❒ No
   c. That involved any complication, including, but not limited to, peripheral neuropathy, nephropathy, peripheral vascular disease, or diabetic retinopathy? ❒ Yes ❒ No
6. In the past 12 months have you had, been treated for, 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 (excluding basal cell or squamous cell skin cancer), malignancy, leukemia, melanoma, or Hodgkin's disease? ❒ Yes ❒ No
7. In the past 12 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 12 months:
   a. Have you been advised or recommended by a member of the medical profession to have treatment, testing or examinations which have not yet been completed, results have not been received, and/or follow-up or treatment has not 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 abnormal laboratory or diagnostic test results that were not later confirmed normal through follow-up? ❒ Yes ❒ No
9. 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

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:
(3, 6, 7, 8, 9, 10, 21, or 31 days) _____ days

In addition to the Benefit selected above, an additional benefit of $15 a day for a maximum of 31 days will be provided.

Part C: Benefit options (continued)

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 age 18 or older? ❒ Yes ❒ No

_____

Full name: *first, middle, last, suffix*

Method and frequency of payment

Method of payment:	**Frequency of payment:**			
❒ Automatic bank withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually
❒ Credit/Debit card	❒ Monthly	❒ Quarterly	❒ Semi-annually	❒ Annually

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.

Part E: Application agreement (continued)

- 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).

NOTICE: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 (MM/DD/YYYY)

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 Supplement Buyers Guide at wellabe.com/products.

Producer's printed name | Producer's number

X _____

Producer's signature | Date (MM/DD/YYYY)