

Application for Dental, Vision and Hearing Insurance

Part A: General Information – Please Print
Applicant Information

Name _____ Date of Birth (Mo./Day/Yr.) _____ Age _____ Sex _____

Address _____
 Street Address _____ City _____ State _____ Zip _____

Social Security # _____

Phone # _____ E-mail Address _____

Beneficiary _____ Relationship _____ Address _____

Co-Applicant Information

Name _____ Date of Birth (Mo./Day/Yr.) _____ Age _____ Sex _____

Social Security # _____ E-mail Address _____

Beneficiary _____ Relationship _____ Address _____

Part B: Medical Information

	Applicant		Co-Applicant	
	Yes	No	Yes	No
1. (a) Do you currently wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you been advised to have any dental work which has not been completed? If "Yes," provide details: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. (a) Do you currently wear eyeglasses or contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you received advice or treatment within the past nine months for correction of a vision problem? If "Yes," provide details: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. (a) Do you currently wear a hearing aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Have you been treated for hearing loss within the past nine months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Has a physician recommended the purchase of a hearing aid to correct a hearing deficiency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part C: Applicant Information

1. (a) Do you have any dental, vision or hearing insurance currently in force?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company? If "Yes," provide type of contract or policy number, and name of company: Applicant: _____ Co-Applicant: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) If replacement is involved, have you received a replacement form (in states where required by law)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part D: Benefit Option
Applicant: Check the Benefit you prefer:

 Policy Year Maximum: \$1,000 \$1,500

Co-Applicant: Check the Benefit you prefer:

 Policy Year Maximum: \$1,000 \$1,500

Part E: Payment Options

Applicant: Provide the following information:

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

Method of Payment:

Automatic Bank Withdrawal

Direct Bill

Frequency of Payment:

Monthly*

Bi-Monthly

Quarterly

Semi-Annually

Annually

*Monthly is not a payment option for Direct Bill.

Amount Received

Renewal

with Application \$ _____

Premium \$ _____

Requested Effective Date of Policy (optional) _____

(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Co-Applicant: Provide the following information:

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

Method of Payment:

Automatic Bank Withdrawal

Direct Bill

Frequency of Payment:

Monthly*

Bi-Monthly

Quarterly

Semi-Annually

Annually

*Monthly is not a payment option for Direct Bill.

Amount Received

Renewal

with Application \$ _____

Premium \$ _____

Requested Effective Date of Policy (optional) _____

(The issued policy will be effective on the day after the applicant signs the application unless a special effective date is requested.)

Part F: Application Agreement

I hereby apply to Medico™ Insurance Company for a **Dental, Vision and Hearing Insurance Policy** to be issued solely and entirely in reliance on my written answers to the above questions. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. These statements will become a part of any policy to which this form is attached. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid by the time the policy is delivered, and unless the policy is delivered and accepted by me.

I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, the Medical Information Bureau or other organization, institution or person, or prescription/pharmaceutical database that has any record or knowledge of me or my health, to give to Medico™ Insurance Company any such information. I understand that a photocopy of this authorization shall be as valid as the original and that this authorization shall remain valid for 24 months unless revoked by me in writing to the Home Office of Medico™ Insurance Company.

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

Check one of the following if you are eligible for Medicare and "A Guide to Health Insurance for People With Medicare" is required in your state:

Applicant Co-Applicant

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. I have agreed to accept a link to the Medicare Buyers Guide on the Company website at gomedico.com/products . |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. I have received a hard copy of the Medicare Buyers Guide. |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. I am not eligible for Medicare. |

CAUTION: If your answers on this application are incorrect or untrue, the Company may have the right to deny benefits or if the misrepresentation was material to our acceptance of the risk, rescind your policy.

I acknowledge that in states where it is required, the producer met with me on this date, 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 Dental, Vision and Hearing insurance.

Applicant's Signature _____ Date _____

Co-Applicant's Signature _____ Dated at _____
City State

Producer's Name _____
(Please print)

Producer's Signature _____ Date _____