



1515 South 75th Street
Omaha, Nebraska 68124

www.gomedico.com

Toll-Free 1-800-228-6080

Application for Dental, Vision and Hearing Insurance

Part A: General Information – Please Print

Name _____
First MI Last Date of Birth (Mo./Day/Yr.) Age Sex
Address _____
Street Address City State Zip
Social Security # _____
Phone # _____ E-mail Address _____
Beneficiary _____ Relationship _____ Address _____

Part B: Applicant Information

- 1. (a) Do you have any dental, vision or hearing insurance currently in force? Yes No
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company? Yes No
If "Yes," provide type of contract or policy number, and name of company:

(c) If replacement is involved, have you received a replacement form (in states where required by law)? Yes No

Part C: Benefit Option – Check the Desired Benefit: Policy Year Maximum: \$1,000 \$1,500

Part D: Payment Options

Household Discount – If eligible, list name(s) of the other person or persons in your household who is/are also applying for this policy: _____

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

Method of Payment:

Frequency of Payment:

- Automatic Bank Withdrawal Monthly Quarterly
 Direct Bill Quarterly Semi-Annually Annually

Note: If you select the Automatic Bank Withdrawal method of payment and we receive no money with your application, your first premium will be withdrawn from your account on the day we issue your policy.

Amount Received with Application \$ _____ Renewal 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 E: 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 have received the Outline of Coverage for the policy (in states where required by law).

Check one of the following regarding your eligibility for Medicare and "A Guide to Health Insurance for People With Medicare."

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

Policy Delivery Options: Upon approval of this application, the policy will be mailed to: Applicant Producer
Note: Policy will be mailed to Producer in states where a policy delivery receipt is required by law.

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 am applying for this Dental, Vision and Hearing insurance.

Applicant's Signature _____ Date _____

Dated at _____
City State

Producer's Name _____ (Please print) Producer's License Number _____

Producer's Signature _____ Date _____



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Bank Withdrawal Authorization

Bank Withdrawal Authorization (For New Applications)

Applicant's Name _____
First Name MI Last Name

Payor's Name (as it appears on bank records) _____
First Name MI Last Name

Address _____
Street Address City State Zip

By signing the authorization below and attaching a voided check (if a checking account is selected for the withdrawal) for proper encoding of your personal account number, we will start you on your Bank Draft service. **Remember to attach a voided check.**

Checking Account Savings Account

Routing #

--	--	--	--	--	--	--	--	--	--

Account #

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Date for premiums to be withdrawn (select a date from the 1st to the 28th of the month) _____

I (We) give permission to my (our) financial institution to automatically make payments to Medico Insurance Company in Omaha, Nebraska. This authorization will remain in force unless I (we) cancel it, or unless the insurance policy/certificate is cancelled or my (our) bank account is closed.

Payor's Signature _____ Date _____
(As it appears on bank records)

Signature _____ Date _____
(If a joint account)

If payor is different than applicant, please provide payor's phone number _____

If payment is not received with this application, the first premium will be withdrawn from your bank account upon approval of your application.

Automatic Bank Withdrawal

Please leave this form with any applicant signed up for the Automatic Bank Withdrawal.

Since no premium was submitted with your application, the first premium will be immediately withdrawn from your bank account upon approval of your application.

We suggest that you take a moment now to deduct the premium from your account register in order to eliminate confusion and avoid unnecessary bank fees.

If you do not receive your policy within 30 days, please contact us by one of the following methods:

Write to: Medico Insurance Company
1515 South 75th Street • Omaha, Nebraska 68124

Call: Client Services at 1-800-228-6080

E-mail: clientservices@gomedico.com

If you are eligible for Medicare, the Medicare Buyers Guide, "Choosing a Medigap Policy: A Guide to Health Insurance for People With Medicare," can be found on our website at www.gomedico.com/products.