



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, Age, Sex), Address (Street, 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?
(b) Is the insurance applied for intended to replace any existing insurance with this or any other company?
(c) If replacement is involved, have you received a replacement form (in states where required by law)?

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: Automatic Bank Withdrawal, Direct Bill; Frequency of Payment: Monthly, 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Automatic Bank Withdrawal method of payment and we receive no money with your application, your first premium will be withdrawn from your account on the day we issue your policy.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.

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, Dated at (City, State), Producer's Name (Please print), Producer's License Number, Producer's Signature, Date