INSTRUCTIONS — VOLUNTARY LIFE and AD&D ENROLLMENT FORM

PLEASE USE BLACK BALL POINT PEN

Complete the attached application and return it to your employer within 10 days of receipt. Before you begin, be sure to check the reason you are submitting this application (see top of enrollment form). Complete each section which applies to you and refer to these instructions if you have any questions.

Section 1 - APPLICANT(S)

- Complete this section for ALL Voluntary Life and AD&D applications (new enrollment, changes to a benefit amount or AD&D plan, delete coverage, etc.).
- If you are increasing coverage, be sure to fill in the amount you currently have in force in the Reason for Application section at the top of the form.
- COMPLETE ALL SHADED AREAS IF YOU ENROLL FOR LIFE INSURANCE FOR YOUR SPOUSE.

Section 2 - PLAN OPTIONS

- Answer all choices either YES or NO.
- Fill in the amount of insurance you desire and, if applicable, which AD&D plan you are selecting.
- If you are increasing your insurance amount(s), fill in ONLY the amount of coverage you are currently requesting.
- The amount of life insurance permitted on the life of your spouse is limited in some states; refer to your enrollment booklet for a list of states with such limitations.

Section 3 - BENEFICIARY

- ***To be completed by employee applicant only*** - the beneficiary of spouse and dependent life insurance is automatically the insured employee.

Primary Beneficiary

- The primary beneficiary is the person(s) you name to receive death benefits. You may name more than one beneficiary.
- If you specify benefit percentages, the total must equal 100%. If you name two primary beneficiaries and you do not specify benefit percentages, proceeds will be paid in equal shares to the primary beneficiaries who survive you.

Contingent Beneficiary

- The contingent beneficiary is the person(s) you name to receive death benefits if no primary beneficiary survives you. You may name more than one contingent beneficiary.
- If you specify benefit percentages, the total must equal 100%; If you do not specify benefit percentages, proceeds will be paid in equal shares.

No Beneficiary: If you do not name a beneficiary, or if no beneficiary survives you, we will pay death benefits in the following order of survivorship: spouse, children, father and/or mother, brothers and/or sister(s), or to your estate.

Sections 4 and 5 - INSURABILITY QUESTIONNAIRE/EXPLANATIONS

- Answer these sections ONLY if you or your spouse are applying for life insurance.
- Answer ALL questions in the Insurability Questionnaire for employee and, if applicable, for spouse.
- If you or your spouse answer YES to Question 4, circle all conditions which apply.
- If you or your spouse answer YES to any health questions, provide details in the Explanations section. If you need more space, attach a signed, dated sheet with details.

NOTE: We may need additional information about you or your spouse's health before we can approve or deny your application for coverage, based on our underwriting guidelines. This additional information could include statement(s) from your doctor, a blood profile, urinalysis, an EKG and/or a Para-Med exam.

DISCLOSURE

(retain with your insurance records)

Information regarding your insurability will be treated as confidential. Medico Life and Health Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates as an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such company, the MIB, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the MIB file, you may contact the MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB information office is P.O. Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

Medico Life and Health Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Voluntary LIFE and AD&D Enrollment Form

(Use black ball point pen)

MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386
Des Moines, IA 50306-0386
Toll Free 1-800-228-6080

Reason for Application (Check all that apply):

Life: ☐ Add ☐ Change Amount* ☐ Delete
*amount currently in force: Employee: $_____
Spouse: $_____

AD&D: ☐ Add ☐ Change* ☐ Delete
*amount and Plan currently in force: $_____
☐ Individual ☐ Family

FOR MLHIC USE ONLY

Notice of Action: The following action has been taken with respect to the life insurance application(s) submitted:
Employee: ☐ Approved ☐ Declined
Spouse: ☐ Approved ☐ Declined Agent_____ %_____
Dep. Child: ☐ Approved ☐ Declined Agent_____ %_____
Effective Date: _____ /_____ /_____ Action Taken By: _____
Initial Monthly Premium: $_____

1. APPLICANT(S)

Employer	Location	Group No./Division No.
Employee Name	Date of Birth / /	Age	Sex ☐M ☐F	State of Birth
Address	City	State	Zip code	Telephone Number at Work ( )
Social Security Number	Job Title	Date of Hire (full-time)
Spouse First MI Last	SSN	Date of Birth / /	Age	State of Birth

2. PLAN OPTIONS

Term Life Insurance:
Employee ☐ Yes ☐ No
Spouse ☐ Yes ☐ No
Children ☐ Yes ☐ No
} *No spouse or child coverage will be issued unless employee application is approved.*
Employee $ _____ Spouse $ _____*
- select new or additional amounts in $10,000 increments to a maximum of $300,000
- complete sections 4 and 5

* spouse benefit limited in some states

AD&D:
☐ Yes ☐ No (If yes, select one plan)
☐ Individual Plan ☐ Family Plan
$_____ (select new or additional amount in $10,000 increments to a maximum of $300,000)
You do not have to complete sections 4 and 5 if you are applying ONLY for AD&D.

3. BENEFICIARY

	FIRST NAME LAST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
(Primary)	/	/		%
(Primary)	/	/		%
(Contingent)	/	/		%
(Contingent)	/	/		%

4. INSURABILITY QUESTIONNAIRE (Life Only)

ANSWER YES OR NO FOR YOURSELF AND YOUR SPOUSE; CIRCLE ALL CONDITIONS WHICH APPLY AND PROVIDE DETAILS BELOW.

	Employee	Spouse
1. Employee Height ft. in. Weight: lbs. 2. Spouse Height: ft. in. Weight: lbs.		
3. Have you used cigarettes or other tobacco products in the last 2 years?	☐Y ☐N	☐Y ☐N
4. Within the past 5 years, have you been medically counselled or treated for, or been told by a medical practitioner that you had: heart murmur; high blood pressure; heart attack; any disease of the heart or blood vessels; diabetes; albumin; blood or sugar in urine; any kidney disorder; tumor; cancer; asthma; lung or respiratory disorder; any disease of the stomach, liver or intestines; back, spine or bone disease or disorder; epilepsy; any mental or nervous system disorder?	☐Y ☐N	☐Y ☐N
5. Within the past 5 years have you been diagnosed by or received treatment from a member of the medical profession for AIDS or ARC (AIDS Related Complex) or other immunological disorders?	☐Y ☐N	☐Y ☐N
6. Within the past 5 years have you consulted or been attended by a doctor, psychiatrist, psychologist or medical practitioner for any health reason or condition not disclosed in the preceding questions?	☐Y ☐N	☐Y ☐N
7. Are you presently receiving any treatment by a medical practitioner or taking any medication?	☐Y ☐N	☐Y ☐N
8. Have you ever had or been told by a medical practitioner that you had (or still have) a problem with substance abuse?	☐Y ☐N	☐Y ☐N
9. Have you ever been rated, declined, postponed or limited in any way for life, health, accident or sickness insurance?	☐Y ☐N	☐Y ☐N

10. Name & address of your personal physician:	11. Name & address of spouse's personal physician:
Date last seen and reason:	Date last seen and reason:

5. EXPLANATIONS

Provide details of all "YES" answers given to questions in Insurability Questionnaire.—If additional space is required, attach a separate signed and dated sheet.

Question Number & Individual	Illness/Reason for Checkup or Doctor's Treatment/Consultation	Dates From To	Full Name & Complete Address of Attending Physician or Other Practitioner

6. SIGNATURE(S)

I request to be insured and authorized payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that: (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) I must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my (our) coverage would become effective, my coverage will not begin until the day I return to work.

Authorization to Release Information: I (We) authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB) or other organization, institution or person that has any records or knowledge of me or my (our) health to give the Medico Life and Health Insurance Company or its reinsurers any such information (including information about drug or alcohol use or abuse, mental illness, HIV (AIDS virus) or other sexually transmitted diseases.) This authorization is valid for 24 months from the date it is signed. I (We) agree that a photocopy of this authorization shall be as valid as the original. I (We) acknowledge that I (we) have read and retained the DISCLOSURE (located at bottom of instruction sheet).

If your answers on this application are incorrect or untrue, Medico Life and Health Insurance Company has the right to deny benefits or rescind your coverage.

Employee Signature Date Spouse Signature (if applicant) Date

EMPLOYER: **DO NOT REMOVE ANY PAGES.** *Return enrollment forms for Voluntary Life Insurance intact.* If you have already been assigned a group number, please include that number in the Applicant(s) section above.