MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

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

PORTABILITY APPLICATION FOR VOLUNTARY GROUP TERM LIFE

Upon leaving your employment or otherwise becoming ineligible for Voluntary Group Term Life (VGTL) insurance you are eligible to continue your VGTL coverage. This can be done at the group rate for your attained age, regardless of your physical condition, provided you apply for portability within 31 days of the date your VGTL insurance terminates. For further information see either your certificate or group policy and contact Medico Life and Health Insurance Company at 800-228-6080.

To apply for Portability:

1. Read and complete all sections of this application.
2. Mail the completed application within 31 days to the above address. Note that the applicable premium is determined by your attained age on the date that your VGTL eligibility terminates and increases as you move into new age brackets.
3. Premium rates are contained in the master policy issued to your employer. (Future premium billings will be on a monthly, quarterly, semi-annual, or annual basis)

Coverage under Portability terminates upon cancellation of your employer's master contract. A conversion privilege to an individual whole life plan is available as indicated in your certificate.

In accordance with and subject to all the terms and conditions of the Portability Provision contained therein, I make application to continue my insurance under said VGTL policy. Such policy to be used in accordance with the following requests and statements of fact.

Name of Employer Providing Group Policy:	
VGTL Policy No.:	Phone Number:
Your name in Full:	
Your Social Security Number:	Date of Birth:

Resident mailing address for billing purposes:

Street/Box No.	City	State	Zip
Last Date of Active Work / /	Reason for termination:		

Coverage Information: **Coverage cannot exceed amount in force at time of termination**

❒ Continue the same coverage as in force prior to termination. *OR*

❒ Life Amount of $_____

❒ Spouse Amount of $_____

❒ Dependent coverage (only available if employee coverage continued)

❒ AD&D Amount of $_____ Single ____ Family ____

Please bill me: (check one) ❒ Monthly EFT *(complete reverse side)* ❒ Quarterly ❒ Semi-annual ❒ Annual

I understand that semi-annual or annual premium statements will be mailed to my home address and payment must be remitted to Medico Life and Health Insurance Company within 30 days of receipt in order to keep coverage in force. I understand that I may terminate this coverage at the end of any billing period by giving Medico Life and Health Insurance Company at least 31 days prior written notice. Medico Life and Health Insurance Company may terminate this coverage at the end of any billing period by giving me at least 31 days prior written notice.

Home Office Use

_____ _____

Date Signature of Applicant

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PAYMENT ELECTION FORM

Policyholder's Name _____ Policy Number _____

_____I elect to make my monthly insurance premium payments electronically. **I have enclosed a voided check for my account and the address of the bank.**

I authorize Medico Life and Health Republic Insurance Company to change the billing mode for mailing in my premium or to initiate the electronic payment of my monthly insurance premium from my checking/savings account.

_____ _____
Authorized Signature Date

THIS FORM MUST BE SIGNED AND DATED IN ORDER TO PROCESS YOUR PAYMENT ELECTION

PLEASE ENCLOSE A VOIDED CHECK IF YOU WISH TO PAY YOUR MONTHLY PREMIUM ELECTRONICALLY.

Contact Medico Life and Health Insurance at 1-800-228-6080 with any questions.