MEDICO®
INSURANCE COMPANY

Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
Phone: 1-800-228-6080
Fax: 1-402-938-9459

CLAIMANT'S STATEMENT

CLAIM CANNOT BE PROCESSED UNTIL THESE QUESTIONS ARE CORRECTLY AND COMPLETELY ANSWERED. ITEMIZED HOSPITAL AND OTHER SUPPORTING BILLS MUST BE ATTACHED.

Notify us immediately if claiming accidental death or nursing home confinement. Do not complete this form. Sign both areas indicated below and return. A special form will be sent.

After both you and your doctor have answered all questions, send the completed form directly to Medico Insurance Company. Naturally, the furnishing of a claim form does not constitute an admission of liability.

PLEASE PRINT

POLICY NUMBER(S) REQUIRED:

Policy No._____

Policy No._____

1. Full Name of Policyholder ☐ MR. ☐ MRS. ☐ MISS _____

2. Full Name of Patient_____ Birth Date_____ Phone No._____

Address_____ City and State_____

Name and Address of Closest Relative_____ Phone No._____

Name of Person Holding ☐ Power of Attorney ☐ Guardianship (check one if applicable) _____

3. Describe sickness or injuries_____

4. If an illness, on what date did first symptoms of the sickness appear?_____

5. If an injury, when, where, and in what manner did it occur?_____

6. Date of first treatment_____ Physicians' names and addresses_____

7. Name of hospital_____ City_____ State_____

8. Date entered hospital_____ Date discharged_____(Attach Bill)

9. Are you filing claim under Workmen's Compensation? ☐ Yes ☐ No Under MEDICARE'S Voluntary Program? ☐ Yes ☐ No

10. Have you ever had the same or similar conditions in the past?_____

If so, when and by whom were you treated?_____

11. What other sicknesses or accidents have you had in the past 10 years? (Describe conditions, give dates, names and addresses of doctors)_____

12. Name and address of family physician_____

13. If confinement indoors after hospitalization was necessary, give:

a. Dates of confinement: FROM_____ TO_____
Month Day Year Month Day Year

b. Place of confinement:_____
(HOME, HOME OF RELATIVE, NAME OF REST HOME, CONVALESCENT HOME, ADDRESS, CITY, STATE)

IF YOUR CLAIM IS FOR LOSS OF TIME BENEFITS, THE FOLLOWING QUESTIONS MUST BE ANSWERED IN ADDITION TO THOSE OUTLINED ABOVE:

14. Last date worked prior to disability_____

15. Date you were or will be able to resume any of your work on a part-time basis_____

16. Date you were or will be able to resume work on a full-time basis_____

17. What other disability insurance do you carry? Name the Companies and state the monthly benefits_____

18. Occupation before disability_____

19. Names, addresses, and phone numbers of employers_____

20. What are your average earnings? $_____ ☐ per month ☐ per week ☐ other_____

ATTENDING PHYSICIAN'S STATEMENT

1. Patient's Name (First, Middle Initial, Last)	Date of Birth	Insured's Name, if patient is a dependent

DATE OF SERVICE	*PLACE OF SERVICE	PROCEDURE, SERVICE OR SUPPLY GIVEN	PROCEDURE CODE	DIAGNOSIS, CHIEF COMPLAINT	DIAGNOSIS CODE	DATE FIRST SYMPTOM APPEARED OR DATE OF ACCIDENT	DATE MEDICAL ATTENTION FIRST GIVEN	CHARGES

***PLACE OF SERVICE CODES**
1 – (IH) – INPATIENT HOSPITAL
2 – (OH) – OUTPATIENT HOSPITAL
3 – (O) – DOCTOR'S OFFICE
4 – (H) – PATIENT'S HOME
5 – DAY CARE FACILITY (PSY)
6 – NIGHT CARE FACILITY (PSY)
7 – (NH) – NURSING HOME
8 – (SNF) – SKILLED NURSING FACILITY
9 – AMBULANCE
10 – (IH) – CHEMICAL DEP. UNIT
11 – (OH) – CHEMICAL DEP. TREATMENT
0 – (OL) – OTHER LOCATIONS
A – (IL) – INDEPENDENT LABORATORY
B – OTHER MEDICAL/SURGICAL FACILITY

2. Has patient ever had same or similar conditions? ☐ Yes ☐ No Describe_____
_____ Date of first treatment_____ Date of first symptoms_____

3. Have you previously treated this patient? ☐ Yes ☐ No If yes, describe_____
_____ Date of first treatment_____

4. Name of facility where services rendered (if other than home or office)_____
City_____ State_____ If hospitalized, Admitted_____ Discharged_____

5. Was confinement indoors necessary after hospitalized? ☐ Yes ☐ No Place_____
Address_____ City_____ State_____

6. Is nursing home care involved or contemplated? ☐ Yes ☐ No
Name of nursing home_____ City_____ State_____

7. Date discharged from your care_____

8. Name and address of family doctor or referring physician_____

9. Dates of total disability: FROM_____ TO_____ Dates of partial disability: FROM_____ TO_____

10. Date patient able to return to work_____

11. What chronic diseases or impairments does patient have and when did they originate?_____
_____

12. Has disability been reported to Workmen's Compensation? ☐ Yes ☐ No

13. Does patient have other health insurance or coverage (if yes identify) ☐ Yes ☐ No _____
_____

14. **For cancer claims only:** Was a positive diagnosis of malignancy made by a pathologist based on microscopic tissue examination? ☐ Yes ☐ No
Morphologic (SNOP) No._____ Date of Pathology_____
Where located?_____

PLEASE ATTACH PATHOLOGY REPORT AND HOSPITAL DISCHARGE SUMMARY, IF AVAILABLE

Date_____ Signed X_____ M.D.
Month Day Year

IRS identification number or S.S. No._____ Physician's Name_____

Address_____ City_____ State_____ Telephone No._____

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Attention Residents of ALABAMA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Attention Residents of ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Attention Residents of ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Attention Residents of ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Residents of CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Residents of COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Residents of DELAWARE, IDAHO and INDIANA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Attention Residents of DISTRICT OF COLUMBIA: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Attention Residents of FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Attention Residents of KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Attention Residents of MAINE, TENNESSEE, VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Attention Residents of MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Effective January 1, 2013
Attention Residents of MARYLAND: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Residents of MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Attention Residents of NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

Attention Residents of NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Attention Residents of OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Attention Residents of OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Residents of PENNSYLVANIA: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Residents of RHODE ISLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Residents of TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Residents of VERMONT: Any person who knowingly, and with the intent to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information may be guilty of fraud and may be subject to criminal or civil penalties.

MEDICO®
INSURANCE COMPANY

Policy Numbers: _____

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HIPAA AUTHORIZATION

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to Medico Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; or the Medical Information Bureau (MIB).

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
- I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.
- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: Medico Insurance Company, P.O. Box 10386, Des Moines, Iowa 50306-0386.
- Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
- I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
- This Authorization expires 24 months from the date I sign it. (In AZ, 180 days for confidential HIV-related information.)
- I have the right to ask for and obtain a copy of any consumer report made about me to the Company. (In NC and VA, I may request to be interviewed in connection with the preparation of a consumer report and, upon written request, receive a copy of the report.)

I agree that a copy of this Authorization is as valid as the original.

Date_____

Your Name (Please print)

_____

Your Signature

X_____

Your Spouse's Name (if applying) (Please print)

_____

Your Spouse's Signature (if applying)

X_____

Your Child(ren)'s Name(s) if younger than 18 (Please print)

1._____

2._____

Your Child's Name (if 18 or older) (Please print)

_____

Your Child's Signature (if 18 or older)

X_____

Your Child's Name (if 18 or older) (Please print)

_____

Your Child's Signature (if 18 or older)

X_____

3._____

4._____

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Personal Representative (Please print)

_____

Person(s) to be Insured (Please print)	My relationship to applicant(s) (Please print)
1._____	1._____
2._____	2._____
3._____	3._____
4._____	4._____