MEDICO®
INSURANCE COMPANY
P.O. Box 10386, Des Moines, Iowa 50306-0386

Critical Illness Claim Form

Please read and follow these instructions should there be a need to file a claim for a covered accident.

- The claim form must be completed and signed by the insured (or parent/guardian in the event of a dependent child).
- Please make sure the policy number is on the claim form.
- The "Authorization for Use and Disclosure of Information" must be signed, dated, and included with your submission.

Processing delays may result if we are not provided the above information

- Return the completed form and signed authorization to:

Medico Insurance Company
P.O. Box 10386
Des Moines, IA 50306-0386

- One claim form needs to be completed when the insured has been diagnosed with a critical illness.
- We suggest you make photocopies of any correspondence sent to our office to keep for your own records.

If you have any questions,
please contact our Customer Care Department.
800-228-6080

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Critical Illness Claim Form - Insured/Patient Information

Section A

Insured/Patient Name _____ Date of Birth ___/___/___

Address _____
Street City State ZIP

Telephone Number _____ Policy Number _____

Section B

Diagnosed Condition _____ Date of Diagnosis ___/___/___

Has the insured been diagnosed with this condition before? ☐ Yes ☐ No

If Yes, please list the date first diagnosed: _____

List the names, addresses, and telephone numbers of the physicians treating you for this condition. Attach a separate sheet of paper if additional space is needed.

Physician's Name _____

Address _____
Street City State ZIP

Telephone Number _____

Physician's Name _____

Address _____
Street City State ZIP

Telephone Number _____

Section C

If Insured has been hospitalized, complete the following:

Date of Confinement	Hospital	Address/Telephone	Diagnosis

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I understand that this information will be used by Medico Insurance Company for the purpose of evaluating my claim for insurance benefits. I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief. I understand that I or my authorized representative is entitled to receive a copy of this authorization upon request.

Insured Signature_____ Date____/____/_____

Print Name _____

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P.O. Box 10386, Des Moines, Iowa 50306-0386

Critical Illness Claim Form - Physician Statement

To be completed by the Attending Physician providing care for this condition (PLEASE PRINT)

Diagnosis of Cancer

Diagnosis _____

Date of Diagnosis ____/____/____

Diagnostic Codes _____

Is metastatic disease present? ☐ Yes ☐ No

Please describe _____

_____

Please include a copy of diagnostic test results or operative pathology result reports that support this diagnosis. If no supporting pathology report exists, please provide documentation of diagnosis, supporting information and current plan of treatment.

Has patient ever had same or similar symptoms/conditions? ☐ Yes ☐ No

If Yes, please provide the date of other conditions and symptoms ____/____/____

I certify that the above information is complete and accurate to the best of my knowledge.

_____ ____/____/____
Signature of Physician Date

_____ (____)_____
Printed Name Telephone Number

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Critical Illness Claim Form - Physician Statement
Continued

To be completed by the Attending Physician providing care for this condition (PLEASE PRINT)

Diagnosis of Myocardial Infarction (Heart Attack)

Diagnosis _____

Date of Diagnosis ____/____/____

Diagnostic Codes _____

Electrocardiogram Evaluation (Please include a copy of the EKG report)

EKG done? ☐ Yes ☐ No Date: ____/____/____

Cardiac Enzyme Evaluation (Please include a copy of the cardiac enzyme report)

Evaluation done? ☐ Yes ☐ No Date: ____/____/____

Has patient ever had same or similar symptoms/conditions? ☐ Yes ☐ No

If Yes, please provide the date of other conditions and symptoms ____/____/____

I certify that the above information is complete and accurate to the best of my knowledge.

_____ ____/____/____
Signature of Physician Date

_____ (____)_____
Printed Name Telephone Number

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P.O. Box 10386, Des Moines, Iowa 50306-0386

Critical Illness Claim Form - Physician Statement
Continued

To be completed by the Attending Physician providing care for this condition (PLEASE PRINT)

Diagnosis of Cerebro-Vascular Accident or 'Stroke'

When did symptoms first appear? ____/____/____

Date of Diagnosis ____/____/____

Diagnostic Codes _____

Were neuro-imaging studies done? ☐ Yes ☐ No

If Yes, please include a copy of the diagnostic imaging results.

Please describe neurological deficits _____

_____

_____

Have neurological deficits been present for at least 48 hours following the occurrence of the stroke? ☐ Yes ☐ No

Has patient ever had same or similar symptoms/conditions? ☐ Yes ☐ No

If Yes, please provide the date of other conditions and symptoms ____/____/____

I certify that the above information is complete and accurate to the best of my knowledge.

_____ ____/____/____
Signature of Physician Date

_____ ( ) _____
Printed Name Telephone Number

For your protection state law requires the following statements to appear on this form.	
FRAUD WARNING STATEMENT	
Alabama	Any person who knowingly presents 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.
California	For your protection California law requires the following to appear on this form. 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.
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.
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.
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.
Minnesota	A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.
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."
New York	Any person who knowingly and with 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
Pennsylvania	Any person who knowingly and with 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.
Rhode Island	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.
Tennessee	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.
Residents of All Other States	WARNING: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive is guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
The furnishing of forms does not constitute an admission of liability on the part of the Company.	

American Republic Insurance Company
American Republic Corp Insurance Company
Medico Insurance Company
Medico Corp Life Insurance Company
Medico Life and Health Insurance Company

Authorization for the Use and Disclosure of Information

I hereby authorize American Enterprise Group, Inc. (the "Company") to use and/or disclose the following information about me as described below. I understand that the information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.

1. Your Information

Policy/Certificate Number		
First Name	Last Name	Date of Birth (mm/dd/yyyy)

2. Name and address of persons/class of persons authorized to receive the information:

Person or Company Name	Phone Number
Street Address	City, State, and ZIP Code

3. Specific description of information that may be used/disclosed:

- ☐ **Medical Information** (Examples include: Explanation of benefits, medical records, dates of service, amounts payable, health care provider information, services rendered, claim information, etc.) This will include information relating to communicable diseases, including HIV or AIDS, mental health and alcohol or drug use treatment. This will not authorize the disclosure of psychotherapy notes.
- ☐ **Personal Information** (Examples include: Names of insured member(s), address, social security numbers, policy/certificate numbers, date of birth, prior insurance information, etc.)
- ☐ **Bank Information** (Examples include: Name and address of financial institution, routing/account number, depositor name, withdrawal information such as dates, amounts, and history, etc.)
- ☐ **Coverage Information** (Examples include: Effective date, covered person(s), premium information, policy/certificate provisions, policy/certificate numbers, insured member(s) date of birth(s), explanation of benefits, claim information, etc.)
- ☐ **Other,** please specify:

4. The information will be used/disclosed for the following purposes (all purposes must be listed and described):

- ☐ **Benefit/Payment Purposes** (Examples include: For processing my claims and servicing my coverage, for coordination of benefits, explanation of benefits, assessment of coverage needs, etc.)
- ☐ **Coverage Maintenance** (Examples include: Perform maintenance such as changing banks/account numbers/depositor, premium payments, changes to mode of payment, etc.)
- ☐ **Coverage Changes** (Examples include: To add or remove insured members from coverage, increase/decrease coverage deductibles, replacement coverage, name changes of insured member(s), termination of coverage, address changes, etc.)
- ☐ **Life Insurance Cash Value Amounts, Beneficiary Information, or Owner Information**
- ☐ **Other,** please specify:

(Continued on back)

5. By signing this Authorization, I understand and agree that:

- The information I authorize a person or entity to receive may potentially be re-disclosed and no longer protected by federal privacy regulations.
- The Company will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization.
- I may request a copy of this signed Authorization by sending a request to the Company at the address provided below.
- I may revoke this Authorization at any time by notifying the person/organization providing the information in writing. However, the revocation will not be valid if:
    a. the Company or another third party has taken action in reliance on this Authorization; or
    b. this Authorization is obtained as a condition for obtaining insurance coverage, other law may provide the Company with the right to contest a claim under the policy/certificate or the policy/certificate itself.
- This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date it was signed.

You may mail written correspondence to: American Enterprise Group, Inc; Attn: Customer Service; P.O. Box 1; Des Moines, Iowa 50306-0001.

6. If you are completing this Authorization as a personal representative of the policy/certificate holder, please complete this section.

If you have legal documentation that shows you are a personal representative for the policy/certificate holder, please enclose a copy when you return this form. I hereby certify and attest that I am authorized to complete this Authorization due to my relationship to the policy/certificate holder as a:

☐ Parent
☐ Legal Guardian
☐ Power of Attorney
☐ Personal Representative
☐ Other, please specify: _____

_____

I agree that the Company may use and/or disclose the aforementioned information for the purposes set forth herein.

_____ _____

Signature of Individual or Personal Representative *Date (MM/DD/YYYY)*

_____

Printed Name of Individual or Personal Representative

* The Company includes, but is not limited to, American Republic Insurance Company, American Republic Corp Insurance Company, Medico Insurance Company, Medico Corp Life Insurance Company, and/or Medico Life and Health Insurance Company. American Republic Insurance Company administers for American Family Mutual Insurance Company, S.I., American Family Insurance Company, Continental General Insurance Company, Central Reserve Life Insurance Company, and Provident American Life Insurance Company. Medico Insurance Company administers for Ability Insurance Company and Knights of Columbus Health and Accident Division. Medico Life and Health Insurance Company administers for Pioneer Mutual Life Insurance Company.