Enrollment Application for Group Dental, Vision and Hearing (DVH) Insurance with Dental Preferred Provider Organization (DPPO) Option
DVA59

Corporate Office – Omaha, NE
Administrative Services – PO Box 10386
Des Moines, IA 50306
www.GoMedico.com
Toll-Free 1-800-228-6080

Part A: General Information – Please Print

Name ____
First MI Last Date of Birth (Mo./Day/Yr.) Age Sex

Address ____
Street Address City State ZIP Code

Social Security #________________________

Phone # ________________________ Email Address ________________________

Part B: Benefit – Check the Desired Options:

Certificate Year Maximum Benefit: ❒ $1,000 ❒ $1,500

Plan Selection: DVH Plus

Information regarding usual and customary fee determination is available from Medico Insurance Company upon request.

Part C: Payment Options

Make all checks payable to: Medico Insurance Company (do not make checks payable to the Producer or leave payee line blank).

Method of Payment:	**Frequency of Payment:**			
❒ Automatic Bank Withdrawal	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Direct Bill		❒ Quarterly	❒ Semi-Annually	❒ Annually
❒ Credit/Debit Card	❒ Monthly	❒ Quarterly	❒ Semi-Annually	❒ Annually

Amount Received with Application $________________

Requested Effective Date of New Policy (optional): __________

Effective Date can be any day from the 1st through the 28th of the month, and must be less than 90 days after the Application Date. If no Effective Date is requested, the Effective Date will be the day the application is approved by our Underwriting Department.

Part D: Application Agreement

I hereby apply to Medico Insurance Company for a **Group Dental, Vision and Hearing Insurance Certificate** to be issued solely and entirely in reliance on my answers. The answers, which I adopt as my own, are true, full and complete and have been accurately recorded. I agree that, except as provided in the Receipt for Initial Premium, no insurance will take effect unless the full first premium is paid and the certificate is delivered and accepted by me. I have received the Outline of Coverage for the certificate (in states where required by law).

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.

Certificate Delivery Options: Upon approval of this application, the certificate will be mailed to: ❒ Applicant ❒ Producer

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 certificate.

I am applying for this Group Dental, Vision and Hearing Insurance.

X ____
Applicant's Signature Date (MM/DD/YYYY)

____
Producer's Printed Name Producer's Number

____
Producer's Signature Date (MM/DD/YYYY)