MEDICO®
LIFE AND HEALTH INSURANCE COMPANY

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

EXTENDED LIFE INSURANCE (PREMIUM WAIVER) APPLICATION

This form should be completed in full by the employee, employer and physician; and mailed to above address.

All questions on this form should be fully answered by the Insured if competent to do so. If not, and if no guardian has been appointed, the form may be completed by the beneficiary or a close relative. If a guardian has been appointed, the form should be completed by the guardian and a certified copy of letters of guardianship forwarded. By furnishing this form the insurance company is not held to admit the validity of any claim or to waive the breach of any condition of the policy.

INSURED'S STATEMENT

I make the following statement in support of my claim for extended life insurance (premium waiver) benefits provided in the policy of insurance identified herein. Such information is submitted with the understanding that the insurance company may rely thereon, and I represent that all statements and answers are true and complete. I understand that the insurance company reserves the right to require, as proofs of disability, all documentary evidence, in addition to the items submitted, which it may reasonably deem necessary.

Name – Last First Middle | Address-Street City State Zip

Date you first became disabled: Month Day Year | Date you became totally disabled so as to be prevented from doing any work: Month Day Year | Last date worked: Month Day Year

Principle cause of disability: | Are you now totally disabled so as to be prevented from doing any work? ❑ Yes ❑ No

If not totally disabled, please state briefly the extent of your disability and present daily activities.

What physicians have you consulted during your present disability?

Name	Address	Date From	Date To

At what hospitals or institutions have you been confined or treated for this disability?

Name	Address	Date From	Date To

On what date do you expect to be able to return to work? _____

AUTHORIZATION

I hereby authorize any hospital, physician, insurance company, employer, or organization to furnish to the insurance company providing this form, or its representatives, any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original.

Date Employee Signature

EMPLOYER'S STATEMENT

Name of Insured | Social Security Number – – | Amount of Insurance $

Name of Employer | Group Number

Address of Employer (Street City State Zip) | Date of Birth Month Day Year

Was Insured in your employ at time disability began? ❑ Yes ❑ No | Date Employed? Month Day Year

Date on which Insured last worked full-time Month Day Year | When did Insured stop work? Month Day Year A.M. ❑ P.M. ❑

When did Insured return to work? Month Day Year A.M. ❑ P.M. ❑ | If not back at work, when do you expect Insured to return? Month Day Year

What is the Insured's job title and principle duties?

Other Remarks:

Name of Authorized Individual (Type or Print) _____

Title or Position _____

Signature _____ Date _____ Month Day Year

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ATTENDING PHYSICIAN'S STATEMENT

Patient Name _____ Age _____

1. Diagnosis

(a) Diagnosis (including any complications) _____

(b) Subjective symptoms _____

(c) Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

_____

2. Dates of Treatment

(a) Date of last visit — Month _____ Day _____ Year _____

(b) Frequency — Weekly ❑ Monthly ❑ Other (Specify) ❑

3. Nature of Treatment (including surgery and medications prescribed, if any)

4. Progress

(a) Has patient — Recovered? ❑ Improved? ❑ Unchanged? ❑ Regressed? ❑

(b) Is patient — Ambulatory? ❑ House confined? ❑ Bed confined? ❑ Hospital confined? ❑

(c) Has patient been hospital confined? Yes ❑ No ❑ If "Yes," give name and address of hospital

Confined from _____ through _____

5. Cardiac (if applicable)

(a) Functional capacity (American Heart Assn.) — Class 1 (No limitation) ❑ Class 2 (Slight limitation) ❑ Class 3 (Marked limitation) ❑ Class 4 (Complete limitation) ❑

(b) Blood pressure (last visit) — Systolic/Diastolic _____/_____

6. Physical Impairment (*as defined in the Federal Dictionary of Occupational Titles)

❑ Class 1 No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
❑ Class 2 Medium manual activity* (15-30%)
❑ Class 3 Slight limitation of functional capacity; capable of light work* (35-55%)
❑ Class 4 Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
❑ Class 5 Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)

Remarks:

7. Mental/Nervous Impairment (if applicable)

(a) Please define "stress" as it applies to this claimant.

(b) What stress and problems in interpersonal relations has claimant had on the job?

❑ Class 1 Patient is able to function under stress and engage in interpersonal relations (no limitations)
❑ Class 2 Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
❑ Class 3 Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
❑ Class 4 Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
❑ Class 5 Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks:

	Patient's Job	Any Other Work
8. Prognosis		
(a) Is patient now totally disabled?	Yes ❑ No ❑	Yes ❑ No ❑
(b) What duties of patient's job is he/she incapable of performing?	Yes ❑ No ❑	Yes ❑ No ❑
Do you expect a fundamental or marked change in the future?		
(1) If Yes, when will patient recover sufficiently to perform duties?	1 Mo. ❑ 1-3 Mos. ❑ 3-6 Mos. ❑ ____/____/____ Never ❑	1 Mo. ❑ 1-3 Mos. ❑ 3-6 Mos. ❑ ____/____/____ Never ❑
(2) If No, please explain		
	Patient's Job	**Any Other Work**
9. Rehabilitation		
(a) Is patient a suitable candidate for further rehabilitation services? (i.e. cardiopulmonary program, speech therapy, etc.)	Yes ❑ No ❑	Yes ❑ No ❑
(b) Can present job be modified to allow for handling with impairment?	Yes ❑ No ❑	Yes ❑ No ❑
(c) When could trial employment commence? ____/____/____	Full time ❑ Part time ❑	Full time ❑ Part time ❑
(d) Would vocational counseling and/or retraining be recommended?	Yes ❑ No ❑	Yes ❑ No ❑

10. Remarks:

Any person who knowingly and with intent to defraud or deceive an insurance company, files a statement of claim containing false, incomplete or misleading information, is in some states guilty of a felony.

Physician's Name (Print)		Date	Degree
Physician's Signature		Telephone	
Street Address	City	State	Zip