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

Accidental Dismemberment Claim Form

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

- Your policy says you must notify us of your claim for a covered loss due to an accidental injury. Your plan requires treatment must be sought within a specific time frame. Please refer to the Benefits section in your policy for the initial treatment period.
- 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.
- Please attach the itemized bills to the claim form. A balance due bill from your provider is not sufficient. An itemized bill is a statement that includes:
    1. Your, and/or the Covered Person's name and policy number.
    2. Health care provider's name, address and phone number.
    3. Place where service was received.
    4. Date service was received.
    5. Diagnosis of Injury using ICD-CM codes (including date of injury), and the description of the service received using CPT and/or HCPCS procedure codes.
    6. Charges for each service received.

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

- Return the completed form, signed authorization, and itemized bills to:

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

- A claim form needs to be completed only at the beginning of treatment for each accident.
- 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 Center.

800-228-6080

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Accident Medical Claim Form

To Be Completed By Insured

Name of Patient _____ Policy Number _____

Phone Number _____ Patient Date of Birth ____/____/____

Relationship of Patient to Insured _____

Address _____
Street City State ZIP

Please check the policy benefit for which you are making a claim:

☐ Dismemberment (please circle the appropriate description(s))
(severance through or above wrist, elbow, ankle, or knee; vision loss total & irrecoverable):

Both Hands	Both Arms	Both Feet	Both Legs	Sight both eyes
One Hand	One Arm	One Foot	One Leg	Sight one eye

☐ Paralysis (please circle the appropriate description):

Quadriplegia Paraplegia Hemiplegia

☐ Loss of Hearing (hearing loss above 90 decibels in both ears)

☐ Severe Burn (treatment within 72 hours of covered accident and full-thickness or third degree burn covering at least 20% of the body surface)

Date of Accident ____/____/____ Time of Accident _____ AM ☐ PM ☐

Description of Accident

a. How did it occur? _____

_____

b. Where did it occur? City_____ State_____ Location _____

Date of Initial Treatment of Injury (if different than date of accident ____/____/____

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 ( ) _____

Continued on next page

If you received treatment at a hospital for your injury, please list the hospital name, address, and phone number:

Hospital Name _____

Address _____
Street City State ZIP

Telephone Number ( ) _____

PLEASE NOTE: Incomplete claim forms will result in processing delays.

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 _____

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.
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.
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.
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.
Kansas	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be guilty of insurance fraud as determined by a court of law. Use of the mail to defraud is a violation of federal law.
Kentucky	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
Maine, Tennessee, Virginia, and Washington	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.
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.
Ohio	Any person who, with intent to defraud or knowing that he or she 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.
Oklahoma	Any person who knowingly, and with intent to injure, defraud or deceive, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Oregon	Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud may be a violation of federal law.
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.
Residents of All Other States	**NOTICE: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.**
The furnishing of forms does not constitute an admission of liability on the part of the Company.	

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

Authorization for the Use and Disclosure of Medical Information

I hereby authorize Medico® Insurance 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.**

Policy Number: _____ ____ /____ /____
Date of Birth

_____
Full name of insured whose information is being requested for use/disclosure

1. Persons/class of persons authorized to use or make disclosure of the information: **Any health care providers from whom you sought treatment or received consultation.**

2. Name and address of persons/class of persons authorized to receive the information: **Medico Insurance Company staff with appropriate access clearance to use and disclose the applicable information.**

3. Specific description of information that may be used/disclosed:
   - ☐ **Medical Information** (such examples may include, but is not limited to, the following: Explanation of Benefits, medical records, dates of services, amounts payable, health care provider information, services rendered, 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, but are not limited to, the following: for processing my claims and servicing my coverage, explanation of benefits, assessment of coverage needs)
   - ☐ **Other,** please specify: _____

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I further understand as a consequence of my failure to sign this authorization, Medico Insurance Company may not be able to process my claim for insurance benefits, resulting in a claim denial. I understand that Medico Insurance Company requires the information sought through this authorization to determine claim eligibility under the policy contract.

(Continued)

6. I understand that 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. Medico Insurance 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 Medico Insurance Company with the right to contest a claim under the policy or the policy itself.

   I understand to revoke my authorization I should send my written revocation request to:

Medico Insurance Company
P. O. Box 21660
Eagan, MN 55121-0660
Fax: 402-496-8199

7. This Authorization will expire 24 months (180 days in Arizona and 12 months in Maryland) from the date of signature.

If you are signing as a personal representative for the policyholder, please read and sign below.

I, _____, hereby certify and attest that I am the duly authorized personal representative of _____, that my relationship to the policyholder is _____, and that I have the lawful authority to enter into this authorization on behalf of the policyholder. I have read the provisions set forth in this authorization, and agree that Medico Insurance Company may use and/or disclose the aforementioned information for the purposes set forth herein.

_____ _____
*Signature of Individual or Personal Representative** *Date*

_____ _____
*Printed Name of Individual or Personal Representative** *Relationship of Personal Representative or Authority to Act for the Individual**

You will be provided a copy of this signed Authorization.

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Proof of Death

(For Accidental Death Indemnity Benefit Only)

The furnishing of this form and investigation of the claim is not to be construed as an admission of the validity of any claim or as a waiver of any condition of the policy by the Company.

Instructions for Furnishing Proof of Death

1. Complete **Parts I, II and IV**. If the policy has been in force less than two years or has lapsed within two years from the date of death, you must also complete **Part III.**

2. Enclose a certified copy of the Insured's Certificate of Death that includes the cause and manner of death.

3. If any primary beneficiary has died before the Insured, enclose proof of the beneficiary's death: a copy of the beneficiary's death certificate or obituary or a copy of the Insured's obituary if it mentions the beneficiary predeceased the Insured. In such case, the claim should be made by the other beneficiary(ies), or if there are none, by the duly appointed Personal Representative (Executor or Administrator) of the Insured's estate.

4. If the claim is made on behalf of the Insured's estate, enclose a certified copy of the Letters of Administration or the Letters Testamentary, whichever is applicable, and a completed W-9 for the estate. If the Insured's estate will not be probated and the Insured's state of residence permits payment by affidavit in small estates, enclose the completed affidavit. (The affidavit form can be requested from our office.)

5. If any beneficiary is a minor or legally incompetent, enclose a certified copy of the Letters of Guardianship or the Letters of Conservatorship, whichever is applicable.

6. Furnishing a newspaper account, police report, or coroner's verdict can facilitate the claim.

Mail the completed Proof of Death form and all other necessary documents to:

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

Claimant's Statement

(Please Print All Information)

PART I – The Deceased

Full name _____
First Middle Last

Residence address _____
Street City State ZIP

Date of birth _____ Date of death _____
Month Date Year Month Date Year

PART II – Beneficiaries

Additional beneficiaries can be listed on the back of this form.

Name _____ Relationship to insured _____
First Middle Last

Residence address _____
Street City State Zip

Social Security # _____ Date of birth _____
Month Date Year

Name _____ Relationship to insured _____
First Middle Last

Residence address _____
Street City State Zip

Social Security # _____ Date of birth _____
Month Date Year

Name _____ Relationship to insured _____
First Middle Last

Residence address _____
Street City State Zip

Social Security # _____ Date of birth _____
Month Date Year

Each beneficiary must complete a W-9 Request for Taxpayer Identification Number and Certification form. The W-9s should be returned with this Proof of Death form. A W-9 form is enclosed. If more forms are needed, copy the W-9 form so each beneficiary has one.

Part III – Medical Care

Complete this part ONLY if the policy is less than two years old or has lapsed within two years from the date of death.

List the names and addresses of all physicians who attended the deceased and all hospitals and institutions where he/she was treated during the last illness and during five years prior to his/her death. If you need more room for this information, you can use the back of this form.

Physician/facility name _____

Address _____
Street City State Zip

Treatment date _____ Disease or condition _____
Month Day Year

_____

Physician/facility name _____

Address _____
Street City State Zip

Treatment date _____ Disease or condition _____
Month Day Year

_____

Physician/facility name _____

Address _____
Street City State Zip

Treatment date _____ Disease or condition _____
Month Day Year

_____

Part IV – Signature and Authorization

These statements are true and complete to the best of my knowledge and belief. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance in force.

I authorize every doctor or practitioner who examined or attended _____, deceased, and every hospital or any other institution in which the deceased received treatment to fully disclose to the Company or its duly authorized representative any knowledge or information thereby acquired.

Date _____ , 20 _____

Signature of claimant or beneficiary – **PLEASE NOTE: Signature must be notarized.**

Printed name _____

Signature _____

STATE OF _____)
) ss
COUNTY OF _____)

On this the _____ day of _____, 20 _____, before me, the undersigned Notary Public, personally appeared _____, known to me to be the person(s) named in and who executed the foregoing instrument, and acknowledged to me that he/she/they executed said instrument as his/her/their free and voluntary act and deed for the uses and purposes therein mentioned.

_____

Print name: _____

Notary Public in and for the state of _____

My commission expires: _____

(Affix Seal or Stamp, if any)

Substitute Form W-9 Request for Taxpayer Identification Number and Certification (2018)

Return to: **Insurance Processing Center**
P.O. Box 1, Des Moines, Iowa 50306-0001 *(Home Office Use Only)* Acct: Dept:

We are required by law to obtain this information when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 28% Federal income tax backup withholding and you may be subject to a $50 penalty imposed by the Internal Revenue Service under Section 6723.

Complete & return THIS form. DO NOT use or photocopy an IRS W-9.

Please Print

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership): _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other

4 Exemptions (codes apply only to certain entities, not individuals.

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state and ZIP code

7 Policy number(s)

Part 1: Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see How to get a TIN, later.

Note: If the account is in more than one name, see the instructions for line 1 on www.IRS.gov. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social Security Number

			—			—				

or

Employer Identification Number

		—							

Part 2: Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN.

Signature of U.S person ▶ **Date ▶**

Please complete the following areas so we may contact you if we have questions regarding the information you provided.

Person completing this form (Print): _____ Phone: (_____) _____

E-mail Address: _____ Fax #: (_____) _____

For more information or instructions, please refer to www.IRS.gov or contact our office at the number on the accompanying letter.