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 Department.

800-228-6080

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

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.
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.	

AmericanEnterprise GROUP INC.

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.

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)

<u>PART I</u> – 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

<u>PART II</u> – 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)

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

Substitute Form W-9 Request for Taxpayer Identification Number & Certification (2014)

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 and return this form. Do not use or photocopy an IRS W-9.

Please Print

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification:

❒ Individual/sole proprietor ❒ C Corporation ❒ S Corporation ❒ Partnership ❒ Trust/estate

❒ Limited liability company. Enter the tax classification (C=C Corporation, S=S Corporation, P=Partnership) ___________

❒ Other (see instructions) ____

Exemptions (see instructions):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _________________

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

Requester's name and address (optional)

City, State, and ZIP code

Policy number(s)

Part 1: Taxpayer Identification Number (TIN):

Enter your TIN on the appropriate line. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). For a resident alien who is not eligible to get a SSN, your TIN is your IRS individual taxpayer identification number (ITIN). If you are a sole proprietor and you have an employer identification number (EIN), you may enter either your SSN or your EIN, but the IRS prefers that you use your SSN. If you are a single member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). For other entities, it is your employer identification number (EIN).

_ _ _ – _ _ – _ _ _ _

_ _ – _ _ _ _ _ _ _

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 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 in the instructions.
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. **The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.**

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.