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 illness.

- 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 Center.

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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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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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.
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.	

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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.