P.O. Box 10386
Des Moines, IA 50306
Phone: 800-228-6080
www.GoMedico.com

Life Insurance Claim Form

Submitted to Medico Insurance Company and/or Medico Life and Health Insurance Company (the "Company").

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 Filing a Claim

1. Complete Parts 1, 2, and 4. 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 3.
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 for small estates, an affidavit form can be requested from the county clerk's office in the insured's county of residence. The form will need to meet the requirements for a small estate affidavit in the insured's state of residence. Complete the affidavit and return with the other required documents.
5. If a beneficiary is a minor or is legally incompetent, enclose certified copies of legal documents authorizing you to collect funds on behalf of the beneficiary.
6. If there is a claim for accidental death benefits, furnishing a newspaper account, police report, or coroner's verdict can facilitate the claim.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

Mail the completed claim form and all other necessary documents to:

Medico
Attn: Life Claims
P.O. Box 10386
Des Moines, IA 50306-0386

Claim Form
(Please print all information.)

Part 1 - The deceased

Full name - first	Middle	Last	
Address	City	State	ZIP code
Date of birth	Date of death		

Part 2 - Beneficiaries

Beneficiary's name	Relationship to insured		
Address	City	State	ZIP code
Telephone number	Social Security number	Date of birth	

Beneficiary's name	Relationship to insured		
Address	City	State	ZIP code
Telephone number	Social Security number	Date of birth	

Beneficiary's name	Relationship to insured		
Address	City	State	ZIP code
Telephone number	Social Security number	Date of birth	

If you need more room for the beneficiary information, please attach a separate sheet of paper.

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

Part 3 - 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 five years prior to his/her death. If you need more room for this information, please attach a separate sheet of paper.

Physician/Facility name	Telephone number		
Address	City	State	ZIP code
Disease or condition	Treatment dates		

Part 3 - Medical care, continued

Physician/Facility name			Telephone number
Address	**City**	**State**	**ZIP code**
Disease or condition			**Treatment dates**

Physician/Facility name			Telephone number
Address	**City**	**State**	**ZIP code**
Disease or condition			**Treatment dates**

Part 4 - Signature

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________________________ §

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: ____ (Affix Seal or Stamp, if any)

Notary Public in and for the state of ________________________

My commission expires: __________________________________

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.	

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.