

FILED

2011 MAY 23 P 2:19

Hearings Unit, DIC  
Patricia D. Petersen  
Chief Hearing Officer

STATE OF WASHINGTON  
OFFICE OF  
INSURANCE COMMISSIONER

In the Matter of

No. 11-0088

ABILITY INSURANCE COMPANY,

DECLARATION OF VIRGINIA  
NICHOLSON IN SUPPORT OF MOTION  
TO STAY CEASE AND DESIST ORDER

Respondent.

Virginia Nicholson, being over the age of eighteen and fully competent to testify hereto, declares and states as follows:

1. To avoid faxing excess paper, attached as **Exhibit A** are true and correct excerpts of the provisions from Gladys Whites' policy referenced in the Motion for Stay of Cease and Desist Order. A full copy of Gladys Whites' policy will be included in the mailed copy of this declaration.

2. I am one of the attorneys for Respondent Ability Insurance Company ("Ability") in this action and make this affidavit for and on behalf of Ability based upon my review of the file in this matter.

3. Attached as **Exhibit B** is a true and correct copy of Gladys White's designation of her daughter, Cheryl Silvernail, to receive notice of lapse or termination of the policy for nonpayment of premium, dated September 16, 2007.

4. Attached as **Exhibit C** are true and correct copies of notices sent to Gladys White and Cheryl Silvernail regarding the premium due.

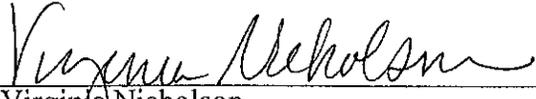
DECLARATION OF VIRGINIA NICHOLSON IN  
SUPPORT OF MOTION TO STAY CEASE AND DESIST  
ORDER - 1

PDX/122574/181300/VNI/7541019.1

SCHWABE, WILLIAMSON & WYATT, P.C.  
Attorneys at Law  
U.S. Bank Centre  
1420 5th Avenue, Suite 3400  
Seattle, WA 98101-4010  
Telephone 206.622.1711 Fax 206.292.0460

1  
2 I declare under penalty of perjury under the laws of the State of Washington that the  
3 foregoing statements are true and correct.

4 Dated this 20th day of May, 2011, at Seattle, Washington.

5   
6 Virginia Nicholson

7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26  
DECLARATION OF VIRGINIA NICHOLSON IN  
SUPPORT OF MOTION TO STAY CEASE AND DESIST  
ORDER - 2

PDX/122574/181300/VNI/7541019.1

SCHWABE, WILLIAMSON & WYATT, P.C.  
Attorneys at Law  
U.S. Bank Centre  
1420 5th Avenue, Suite 3400  
Seattle, WA 98101-4010  
Telephone 206.622.1711 Fax 206.292.0460

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22  
23  
24  
25  
26

CERTIFICATE OF SERVICE

I hereby certify that on the 20th day of May, 2011, I caused to be served the foregoing DECLARATION OF VIRGINIA NICHOLSON IN SUPPORT OF MOTION TO STAY CEASE AND DESIST ORDER on the following party at the following address:

Alan Michael Singer  
Staff Attorney, Legal Affairs Division  
Office of the Insurance Commissioner  
State of Washington  
PO Box 40255  
Olympia WA 98504-0255

by:

U.S. Postal Service, ordinary first class mail  
U.S. Postal Service, certified or registered mail,  
return receipt requested  
hand delivery  
facsimile  
electronic service  
other (specify) \_\_\_\_\_

Chante Tayler  
Chante Tayler

**EXHIBIT A**

DUPLICATE



## MUTUAL PROTECTIVE INSURANCE COMPANY

1515 SOUTH 75TH STREET • OMAHA, NEBRASKA 68124

A Mutual Company

**CAUTION:** The issuance of this long-term care insurance policy is based upon your responses to the questions on your application. A copy of your application is attached to the policy. If your answers are incorrect or untrue, the Company has the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact the Company at the address shown above.

**THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company.

**Insuring Clause:** We agree to provide the benefits set out in this policy for any insured loss. This agreement is subject to all of the provisions of the policy. A "loss" is an expense you incur for care or services this policy covers and that you receive after the Policy Date and while the policy is in force.

This policy is a legal contract between you and us. **READ YOUR POLICY CAREFULLY.** Also, read the copy of your application and the policy Schedule. If there is any error or omission, tell us. We will make any needed change.

The first premium you, the Insured, paid before the Policy Date (and the copy of your application, attached hereto), put this policy in force as of the Policy Date. That date is shown in the Schedule. The Schedule is attached and is a part of this policy.

### **PART A PLEASE READ -- 30-DAY RIGHT TO RETURN**

Please read your policy. If you are not satisfied, send it back to us, or to the agent who sold it to you, within 30 days after you receive it. We will return your money. That will mean your policy was never in force. We will pay a 10% penalty if the requested premium refund is not made within 30 days of our receipt of the returned policy.

### **PART B GUARANTEED RENEWABLE FOR LIFE SUBJECT TO OUR LIMITED RIGHT TO CHANGE PREMIUMS**

We guarantee to renew your policy for life, subject to the Lifetime Maximum Benefits provision, as long as the premium is paid within the allowable time; but, we do have the right to change your premium as stated below.

We can change your premium only if we do the same to all policies of this form and any similar form issued to persons of your class in your state. If a change is made, it will not be based on any physical impairment you might have or any claims you have incurred under this policy, and it will be consistent with the Rate Guarantee provision on page 2. If it is necessary to change the premium for your policy, we will send you notice at least 30 days before your premium is due.

**NOTICE TO BUYER:** This policy may not cover all of the costs associated with long-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations.

### **A QUALIFIED LONG-TERM CARE POLICY FOR FEDERAL TAX PURPOSES**

**Rate Guarantee:** The premium we charge for this policy is based on the benefit amounts shown in the policy Schedule and the disclosures made in your application. That premium rate is guaranteed for at least a three year period measured from the Policy Date. If subsequent rate increases are needed after that initial three year period, each new rate will be guaranteed for an additional two year period.

**ALPHABETICAL GUIDE TO YOUR POLICY**

	Part		Part
Benefits . . . . .	H, I, J, K, L & M	Other Important Provisions . . . . .	S
Deferred Inflation Protection . . . . .	N	Payment Of Claims . . . . .	R
Definitions . . . . .	E	Renewal Agreement And Premium Change . . . . .	B
Eligibility For Benefits . . . . .	G	Restoration Of Benefits . . . . .	M
Exceptions . . . . .	C	Right To Reduce Coverage . . . . .	P
General Benefit Information . . . . .	F	Right To Return . . . . .	A
How To File A Claim . . . . .	Q	Schedule . . . . .	Last Page
Lifetime Maximum Benefits . . . . .	D	Waiver Of Premium . . . . .	O

**PART C EXCEPTIONS**

We will NOT pay benefits for:

- (1) loss that occurs while this policy is not in force;
- (2) intentional, self-inflicted injury or attempted suicide;
- (3) alcoholism or drug addiction, unless addiction resulted from narcotics prescribed by a Physician;
- (4) care provided by a member of your immediate family;
- (5) services for which you are not liable or for which no charge normally is made in the absence of insurance; and
- (6) loss that occurs outside the United States.

**Non-Duplication:** This contract will not pay or reimburse expenses incurred for services or items to the extent that such expenses are reimbursable under Title XVIII of the Social Security Act or would be so reimbursable but for the application of a deductible or coinsurance. But it will pay benefits for covered expenses you incur that exceed the amount paid or payable by such governmental plans or laws.

**PART D LIFETIME MAXIMUM BENEFITS**

The maximum dollar amount for all covered care that we will pay during the lifetime of the policy is shown in the Schedule. That lifetime dollar maximum is determined by multiplying the Daily Benefit amount by the benefit day option, both of which are shown in the Schedule. The lifetime dollar maximum may be greater than the amount shown in the Schedule if the optional inflation shield rider is in force. Coverage under this policy automatically ends after we have paid out the lifetime dollar maximum.

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

## PART E

## DEFINITIONS

When we use the following words in this policy or in any optional rider, this is what we mean:

**Activities of Daily Living:** (a) eating; (b) dressing; (c) toileting; (d) transferring; (e) continence and (f) bathing. You are considered to need assistance for each of these activities when:

- Eating:** You cannot, without the aid of another person, maintain an adequate food and fluid intake consistent with your dietary needs.
- Dressing:** You cannot, without the aid of another person, put on and take off all necessary items of clothing, including medically necessary braces and artificial limbs.
- Toileting:** You cannot, without the aid of another person, get to and from the toilet, get on and off the toilet and maintain a reasonable level of associated personal hygiene.
- Transferring:** You cannot, without the aid of another person, walk or get in or out of a chair, wheelchair, bed, or other stationary position.
- Continence:** You cannot, without the aid of another person, voluntarily control bowel and bladder functions or use an external catheter or other equipment.
- Bathing:** You cannot, without the aid of another person, wash yourself by sponge bath in either a tub or shower, including getting into or out of the tub or shower.

**Adult Day Health Care:** A program of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

**Adult Day Health Care Center:** (a) a facility licensed or certified by the state in which it is located to provide Adult Day Health Care; or (b) if licensing/certification is not required, a part of a facility (or center operated by a facility) that is licensed or certified as a hospital or any type of nursing home by the state in which it is located; or (c) a facility that is approved for Medicaid.

**Anniversary Date:** The same day and month as the Policy Date in each later year.

**Assisted Living Care Facility:** A facility that is licensed or certified as an Assisted Living Care Facility in accordance with any applicable state or local laws, with the primary purpose of providing care and services to support needs resulting from Cognitive Impairment or loss of functional capacity. The facility must have a trained employee available at all times to provide that care, and the facility must have established procedures for overseeing the administration of medications. The specific section or unit of the facility where you receive assisted living care must meet all of the above stated requirements.

**Benefit Period:** A period of covered care for the same or related Conditions, that is not separated by at least 180 days during which you are free of such care.

**Case Coordinator:** A licensed health care professional, from an agency we will choose, whose training includes managing and arranging for the type of care and services covered under this policy. This person can be a Doctor, Nurse, social worker or other similarly trained and licensed professional. Your Case Coordinator will provide a comprehensive evaluation of your status and will be responsible for developing, implementing and coordinating your Plan of Care. This person will further be responsible for assisting in the selection of providers, making arrangements to initiate services, providing ongoing care monitoring, and revising the Plan of Care as circumstances dictate. The Case Coordinator will work in consultation with your Physician.

**Chronically Ill Individual:** Any individual who has been certified within the preceding twelve (12) month period by a Licensed Health Care Practitioner as: being unable to perform (without Substantial Assistance from another individual) at least two (2) Activities of Daily Living for a period of at least ninety (90) days due to a loss of functional capacity; having a similar level of disability; or requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

**Cognitive Impairment:** Deterioration of or loss in your intellectual capacity due to organic brain disease or disorder, which requires supervision to protect yourself or others, as measured by clinical evidence and standardized tests that measure your impairment in the following areas:

- (a) Your short or long-term memory;
- (b) Your orientation as to person (such as who you are), place (such as where you are) and time (such as day, date and year);
- (c) Your deductive or abstract reasoning.

Such loss in intellectual capacity can result from Alzheimer's Disease or related degenerative and dementing illnesses.

**Condition:** Sickness, disease or injury. These include Mental or Nervous Disorders that cause Cognitive Impairment.

**Elimination Period:** The number of days for which no benefit is payable. The Elimination Period, if any, starts on the date that benefits would otherwise begin and is in effect for the number of days shown in the Schedule. Only one Elimination Period will be applied to any one Benefit Period.

**Home Health Agency:** An entity that provides home care services and is: (a) certified for participation in the Medicare program; or (b) licensed or certified as a Home Health Agency where required by the state; or (c) is otherwise acceptable to us if licensing or certification is not required. The Home Health Agency must keep records of nursing reports and the Plan of Care. These records must be available to us upon authorized request.

**Home Health Aide Services:** Assistance with simple health care tasks, personal hygiene, Activities of Daily Living, managing medications, and other related services provided by a Home Health Agency.

**Home Health Professional Services:** One or more of the following services for your care and treatment that are provided by a Home Health Agency in a noninstitutional setting, under the direction of a Nurse and according to a written diagnosis and Plan of Care:

- (a) nursing services;
- (b) physical therapy;
- (c) speech therapy;
- (d) respiratory therapy;
- (e) occupational therapy; and
- (f) nutritional services provided by a licensed dietician.

**Homemaker Services:** Assistance provided by a Home Health Agency with managing and maintaining a household, when you can no longer manage those activities and an informal caregiver is not available. This may include preparing meals, doing laundry and incidental household tasks.

**Hospice Care:** Services (not drugs or other supplies) provided by a Hospice Facility or a Home Health Agency that are designed to provide you with palliative care or to alleviate discomfort during the last phases of life. To be eligible for Hospice Care you must be diagnosed by your Doctor as having no more than 6 months to live.

**Hospice Facility:** A facility that is primarily engaged in providing care for terminally ill patients whose life expectancy is six months or less. It must be licensed, certified or registered as may be required by the state.

**Injury:** Accidental bodily Injury that results in loss independent of Sickness and other causes.

**Licensed Health Care Practitioner:** Any Physician and any registered professional Nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary.

**Maintenance or Personal Care Services:** Any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which the individual is a Chronically Ill Individual (including the protection from threats to health and safety due to severe Cognitive Impairment).

**Mental or Nervous Disorder:** A neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease or disorder.

**Nurse:** A person duly licensed as a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.).

**Nursing Home:** A health care facility that is licensed as a Nursing Home by the state in which it is located and that provides, as its main function, Skilled Nursing Care, Intermediate Nursing Care or Custodial Care. The facility must: (a) provide this care on a continuing inpatient basis as prescribed by a Plan of Care; (b) supervise the care through a nursing staff; (c) maintain clinical records for all patients; (d) maintain control and records of medications given; and (e) have arrangements for the services of a Doctor to furnish medical care in case of an emergency. The specific section or unit of the facility where you receive Nursing Home Care must meet the above described licensing requirements and also must provide, as the main function of that section or unit, care that meets all of the other requirements above. (Items (c) and (d) need not apply when you receive only Custodial Care.)

A Nursing Home is NOT a facility for the treatment of alcoholism, drug addiction or chemical dependency.

**Nursing Home Care:** Skilled Nursing Care, Intermediate Nursing Care or Custodial Care provided in a Nursing Home.

- (a) **Skilled Nursing Care or Intermediate Nursing Care** must be prescribed in your Plan of Care. This care uses professional nursing methods and procedures that are administered by licensed or certified health care personnel. It includes posthospital care, rehabilitation nursing care, maintenance therapy, administration of medication, injections and catheterization.
- (b) **Custodial Care** means care that is given to residents of a Nursing Home who, not needing daily nursing care, cannot properly care for themselves due to age or a covered Condition. This care must be prescribed in your Plan of Care.

**Physician or Doctor:** A licensed practitioner of the healing arts acting within the scope of his/her license.

**Plan of Care:** A written document prescribing individualized treatment or services that your Condition requires. The plan must be prepared by your Case Coordinator and approved by your Doctor. If case coordination is not used, the plan must be prepared by a Doctor or other licensed medical professional, and must be approved by your Doctor. The Plan of Care must be updated or recertified at least once every 90 days, and the updated or recertified plan must be approved by your Doctor.

**Policy Date:** The date on which this policy first became effective. That date is shown on the Schedule.

**Qualified Long-Term Care Services:** Any necessary diagnostic, preventative, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill Individual or are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

**Reasonable and Customary Charge:** An amount measured by comparing it with charges normally made for similar services and supplies to individuals of similar medical Condition in the locality where the charge is made. All covered charges for which this policy provides benefits are based on the Reasonable and Customary Charges for covered services.

**Schedule:** Is attached to and is a part of this policy.

**Sickness:** An illness or disease that you have or acquire.

**Substantial Assistance:** Physical assistance (minimal, moderate, or maximal) without which the individual would not be able to perform the Activities of Daily Living.

**We, Us or Our:** Mutual Protective Insurance Company.

**You or Your:** The Insured named in the Schedule.

## **PART F GENERAL BENEFIT INFORMATION**

### **(1) The Schedule Shows:**

- (a) The Daily Benefit which is the basis for our payment of the services we cover. (That amount may be greater if the optional inflation shield rider is in force.)
- (b) The Elimination Period that applies to the Benefit Period; and
- (c) The dollar maximum for all covered care that we will pay during the lifetime of the policy. (That amount may be greater if the optional inflation shield rider is in force.)

If the Schedule shows your lifetime dollar maximum as Unlimited/Lifetime, there is no lifetime dollar maximum for this policy.

- (2) **Receipt of Multiple Covered Services on the Same Day:** If you receive more than one type of covered service on the same day, we will pay the Reasonable and Customary Charge for each service, but in no event shall the total amount paid exceed the Daily Benefit. This is subject to the weekly benefit option under Part K, Care Coordination Benefit.

## **PART G ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

To be eligible for any type of benefit under this policy, your Doctor must show that you are chronically ill. A chronically ill person has been certified by a Licensed Health Care Practitioner as:

- (1) Being unable to perform (without Substantial Assistance from another individual) at least two Activities of Daily Living for a period of at least 90 days due to loss of functional capacity;
- (2) Having a level of disability similar (as determined under regulations prescribed by the Secretary in consultation with the Secretary of Health and Human Services) to the level of disability described in clause (1); or
- (3) Requiring substantial supervision to protect such individual from threats to health and safety due to severe Cognitive Impairment.

**Independent Evaluation:** We may, at our expense, have you examined or evaluated by independent medical experts. The studies they perform will be for the purpose of assessing and confirming that you are eligible for care as shown above, and the treatment or services prescribed in the Plan of Care meet all of the requirements of this policy.

## **PART H**

### **NURSING HOME CARE BENEFITS**

**Limitations or Conditions on Eligibility for Benefits:** All of the following conditions apply to receipt of Nursing Home Care benefits.

- (1) You must qualify under one of the eligibility requirements set out in Part G.
- (2) You must receive Nursing Home Care in a Nursing Home, as defined.
- (3) The care received must be prescribed in your Plan of Care.
- (4) Your Plan of Care must be updated or recertified at least once every 90 days.
- (5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

**Benefit:** When you are eligible for and receive Nursing Home Care covered by this policy, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made by the Nursing Home, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. It will be paid for each day you receive care in a Nursing Home. This benefit is subject to your lifetime dollar maximum.

## **PART I**

### **HOME CARE BENEFITS**

**Limitations or Conditions on Eligibility for Benefits:** All of the following conditions apply to receipt of home care benefits: (Home care benefits consist of Home Health Professional Services, Home Health Aide Services and Homemaker Services.)

- (1) You must qualify under one of the eligibility requirements set out in Part G.
- (2) You must receive Home Health Professional Services, Home Health Aide Services or Homemaker Services, as defined.
- (3) The care received must be prescribed in your Plan of Care.
- (4) Your Plan of Care must be updated or recertified at least once every 90 days.
- (5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

**Benefit:** When you are eligible for and receive Home Health Professional Services, Home Health Aide Services or Homemaker Services in your home, we will pay a benefit. That benefit will be the Reasonable and Customary Charges for each day of Home Health Professional Services, and 80% of the Reasonable and Customary Charges for each day of Home Health Aide Services or Homemaker Services, not to exceed the amount of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

**Additional Home Care Benefits:** We will also pay a benefit for the following items, which can serve as cost-effective alternatives that allow you to remain in your own home. These benefits are not subject to the Elimination Period, and will not satisfy it. These benefits (except respite care) are not subject to the Daily Benefit, but will count toward your lifetime dollar maximum. These benefits are subject to all other conditions that apply to home care benefits.

- (1) **Caregiver Training Benefit:** We will pay a lifetime benefit of up to 5 times the amount of your original Daily Benefit for the reasonable and customary cost of training a friend or family member to help you at home. We will not pay this benefit for anyone who will be paid to care for you.
- (2) **Equipment Benefit:** We will pay a lifetime benefit of up to 50 times the amount of your original Daily Benefit for the purchase or rental of supportive equipment or in-home safety devices that allow you to stay in your home for at least 90 days. Such equipment or devices may include ramps, grab bars, a special bed, or an emergency medical alert system.
- (3) **Respite Care Benefit:** We will pay the Reasonable and Customary Charge of temporary care in your home, an institution, or community-based program in order to give your primary in-home caregiver a rest. This benefit is subject to the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care, and is further subject to a 21-day maximum per calendar year.

## **PART J**

### **COMMUNITY CARE BENEFITS**

**Limitations or Conditions on Eligibility for Benefits:** All of the following conditions apply to the receipt of community care benefits: (Community care benefits consist of Adult Day Health Care and Hospice Care.)

- (1) You must qualify under one of the eligibility requirements set out in Part G.
- (2) You must receive Adult Day Health Care or Hospice Care, as defined. Adult Day Health Care must be received in an Adult Day Health Care Center. Hospice Care must be provided by a Hospice Facility or a Home Health Agency.
- (3) The care received must be prescribed in your Plan of Care.
- (4) Your Plan of Care must be updated or recertified at least once every 90 days.
- (5) You must receive covered care in excess of the number of days shown in the Schedule as the Elimination Period that applies to each Benefit Period.

**Benefit:** When you are eligible for and receive Adult Day Health Care or Hospice Care, we will pay a benefit. That benefit will be the Reasonable and Customary Charges made for each day of Adult Day Health Care or Hospice Care, not to exceed 50% of the Daily Benefit shown in the Schedule or in effect at the time you receive care. Benefits are subject to your lifetime dollar maximum.

## **PART K**

### **CARE COORDINATION BENEFIT**

Additional benefits are available under this policy when you agree to and receive coordination of care through a Case Coordinator. When you agree to coordination of care, we will pay for all expenses associated with the services of your Case Coordinator, as well as the following benefits:

- (1) **Elimination Period Waiver:** You will receive benefits for the first day of care for any type of care covered under this policy. The policy Elimination Period will not apply.
- (2) **Weekly Benefit:** Instead of a Daily Benefit, you will receive a Weekly Benefit. The Weekly Benefit will consist of a weekly (Monday through Sunday) maximum of up to 7 times your Daily Benefit for the Reasonable and Customary Charges for care received during the week. This benefit is subject to your lifetime dollar maximum. The added flexibility of this benefit is valuable because the amount and kind of care you need could exceed your Daily Benefit on any given day.

- (3) **Enhanced Home Care Benefit:** Instead of 80%, we will pay 100% of Reasonable and Customary Charges, subject to the Weekly Benefit, for Home Health Aide Services and Homemaker Services provided under the direction of your Case Coordinator. Additionally, we will waive the requirement that Homemaker Services be provided through a Home Health Agency when your Case Coordinator determines that these services may be supplied in a more cost-effective manner by alternate providers. This benefit is subject to your lifetime dollar maximum.
- (4) **Assisted Living Care Facility Benefit:** We will pay 80% of the Reasonable and Customary Charge for care in an Assisted Living Care Facility, subject to the Weekly Benefit, when your Case Coordinator recommends this alternative in your Plan of Care. We will not pay home care or community care benefits while you are receiving the Assisted Living Care Facility benefit. This benefit is subject to your lifetime dollar maximum.

#### **PART L**

#### **BED RESERVATION BENEFIT**

**Limitations or Conditions on Eligibility for Benefits:** To be eligible to receive benefits under this provision, you must meet all of the conditions listed below.

- (1) You must be hospitalized temporarily during the course of your covered stay in a Nursing Home or Assisted Living Care Facility.
- (2) The Nursing Home or Assisted Living Care Facility must charge you to keep your room available during your hospital stay.
- (3) Your hospitalization must be the result of a covered Condition.
- (4) You must have satisfied any Elimination Period that applies to the Benefit Period. If you have not, your days in the hospital will apply to the Elimination Period.

**Benefit:** When you meet the eligibility requirements of this provision we will pay a benefit. It will be equal to the Reasonable and Customary Charge the Nursing Home or Assisted Living Care Facility makes to hold your room during the hospital stay, not to exceed the amount of the Daily Benefit for all covered care shown in the Schedule or in effect at the time you receive care. We will pay this benefit for up to 14 days per calendar year, subject to the Elimination Period and your lifetime maximum dollar amount for all covered care shown in the Schedule or in effect at the time you receive care. Unused benefit days cannot be carried over from one calendar year to the next.

#### **PART M**

#### **RESTORATION OF BENEFITS IN THE EVENT OF POLICY LAPSE DUE TO COGNITIVE IMPAIRMENT OR LOSS OF FUNCTIONAL CAPACITY**

If coverage under this policy ends due to nonpayment of premium, you or any person acting on your behalf will have 5 months to request reinstatement of the policy on the grounds that you suffered from Cognitive Impairment or loss of functional capacity at the time of lapse. We will require the same evidence of Cognitive Impairment or loss of functional capacity that is required for eligibility for benefits under this policy. We also must receive the back premium from the date of default. If these conditions are met, we will reinstate the policy without evidence of insurability. The coverage will be at the same level that existed prior to the date of the lapse. This provision does not apply to a policy that terminated because you requested cancellation or because we paid the maximum dollar amount.

## **PART N**

### **DEFERRED INFLATION PROTECTION OPTION**

When you applied for this policy, you were given the opportunity to defer adding an optional Inflation Shield Rider. If you elected that option we will give you the opportunity to add an inflation rider without evidence of insurability within 90 days prior to the third Anniversary Date of the policy, if you have not incurred a claim under the policy. The additional premium required for the inflation rider will be based on your age at the time this benefit is added. Increases will begin to take effect on the first Anniversary Date after the inflation rider is in force.

## **PART O**

### **WAIVER OF PREMIUM**

After we have paid benefits for Nursing Home Care for 90 days in a row, we will waive the payment of premiums that come due thereafter during the continuance of consecutive days for which such benefits are paid. This waiver, which includes premiums for any attached rider, will continue until the first day of the month following the date we stop paying benefits for Nursing Home Care.

## **PART P**

### **RIGHT TO REDUCE COVERAGE**

You have the right to reduce the benefits of this policy without providing evidence of insurability. Changes may include:

- a) a longer Elimination Period;
- b) a lower Daily Benefit; or
- c) a shorter benefit day option, resulting in a reduced lifetime dollar maximum.

Benefits will not be reduced to a level below the minimum level approved by the Commissioner of Insurance on the date you request reduction.

## **PART Q**

### **HOW TO FILE A CLAIM**

- (1) **Notice of Claim:** You must give us written notice of a claim within 20 days after loss starts or as soon as you can. You may give the notice or you may have someone do it for you. The notice should give your name and policy number. Notice should be mailed to our Home Office in Omaha, Nebraska, or to one of our agents.
- (2) **Claim Forms:** When we receive your notice, we will send you forms for filing proof of loss. If these forms are not sent to you in 15 days, you will have met the proof of loss rule below if, in 90 days after the loss began (or, in the event of a continuing loss, within 90 days after the first month of the loss for which we are liable), you gave us a written statement of what happened.
- (3) **Proof of Loss:** You must give us written proof of your loss in 90 days or as soon as you can. In the event of a continuing loss that is eligible for periodic payments, you must give us written proof within 90 days after the end of the period of loss for which we are liable. But proof must be furnished within 15 months after loss began, except in the absence of legal capacity.

## **PART R**

### **PAYMENT OF CLAIMS**

- (1) **Time of Payment of Claims:** Benefits for continuing care are paid monthly when loss lasts longer than one month. When we receive your proof of loss, benefits that accrued up to the date of the proofs will be paid at the end of each month. All other benefits are paid as soon as we receive your proof of loss. Benefits unpaid when our liability ends are paid when we receive your proof of loss.

- (2) **Payment of Claims:** Benefits will be paid directly to you. Benefits unpaid at your death will be paid to your beneficiary or your estate.

If any benefit is payable to your estate, to a minor, or to any person not able to give a valid release, we may pay up to \$1,000.00 to any relative by blood or connection by marriage of the Insured or beneficiary that we find entitled to the payment. Any payment we make in good faith will fully discharge us to the extent of the payment.

- (3) **Claim Review and Appeal Procedure:** In the event of any claim denial with which you do not agree, you have the right to submit a written request to the Company at its Home Office asking for a review of the denial of benefits. That request may include documents from your Physician or care provider that support your basis for the requested review. Within 30 days after we receive that written request, we will notify you or your representative of the results of the review.

## **PART 5**

## **POLICY PROVISIONS**

- (1) **Entire Contract; Changes:** This policy, with any attachments (and the copy of your application), is the entire contract of insurance. No agent may make contracts, determine insurability or change the application or policy in any way. Only an executive officer of ours can approve a change. That change must be shown in the policy.

- (2) **Time Limit on Certain Defenses:** After two years from the Policy Date, no misstatements, except knowing and intentional misstatements relating to the Insured's health, can be used to void the policy. If this policy is reinstated on the basis of a health application, the contestable period will be two years from the reinstatement date.

**Pre-Existing Conditions:** We will not reduce or deny a claim under this policy because a Sickness or Injury existed before the Policy Date.

- (3) **Grace Period:** Your premium must be paid on or before the date it is due or during the 31-day grace period that follows. Your policy stays in force during your grace period.
- (4) **Reinstatement:** Your policy will lapse if you do not pay your premium before the end of the grace period. If we later accept a premium and do not require an application for reinstatement, that payment will put this policy back in force. If we require an application for reinstatement and, as may be needed, issue a conditional receipt, this policy will be put back in force when we approve it. If we fail to notify you of disapproval within 45 days of the date of application (or the date of the conditional receipt, where that is required), your policy will be put back in force on that 45th day.

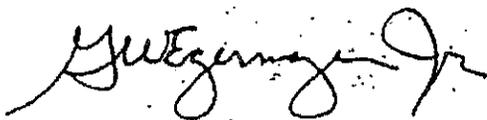
Your reinstated policy will cover only loss due to Injury that begins after the date your policy was put in force. Also, it will cover only loss due to Sickness that begins after the date the policy was put back in force.

In all other respects, you and we will have the same rights under this policy that we had before it lapsed. The premium we accept to reinstate this policy may be used for a period for which premiums had not been paid. But it will not be used for any period more than 60 days before the reinstatement date.

- (5) **Physical Examination:** We, at our expense, can have you examined as often as reasonably needed while a claim is pending.

- (6) **Legal Action:** You can't bring a legal action to recover under your policy for at least 60 days after you have given us written proof of loss. You can't start such an action more than three years after the date written proof of loss is required.
- (7) **Change of Beneficiary; Assignment:** Only you have the right to change the beneficiary. This right is yours unless you make a beneficiary designation that may not be changed. Consent of the beneficiary is not required to make a change in this policy. Also, such consent is not required to surrender this policy or to assign the benefits.
- (8) **Misstatement of Age:** If your age has been misstated, the amount payable will be that which the premium would have bought at the correct age.
- (9) **Illegal Occupation:** We will not be liable for any loss to which a contributing cause was your commission of or attempt to commit a felony. Nor will we be liable for any loss to which a contributing cause was your being engaged in an illegal occupation.
- (10) **Other Insurance With Us:** You may have only one policy like this one at any one time. If you have more than one such policy, the one you, your beneficiary or your estate selects will remain in force. We will return all premiums paid for all other such policies.
- (11) **Extension of Benefits:** Termination of this policy will be without prejudice to any benefits payable for institutionalization if such institutionalization began while the policy was in force and continues without interruption after termination. "Institutionalization" means Nursing Home Care, as defined in the policy. This extension of benefits beyond the period the policy was in force will be limited to the duration of the Benefit Period, if any, or to the payment of the maximum dollar amount. It will be subject to the policy Elimination Period and all other applicable provisions of the policy.
- (12) **Term of Coverage:** Your coverage starts on the Policy Date at 12:01 a.m. standard time where you live. It ends at 12:01 a.m. on the same standard time on the first renewal date. Each time you renew your policy, the new term begins when the old term ends.
- (13) **Conformity With State Statutes:** The provisions of the policy must conform with the laws of the state in which you reside on the Policy Date. If any do not, this clause amends them so that they do conform.
- (14) **Annual Meeting:** Our annual meeting is held at 10:00 a.m. on the second Friday of May at our Home Office.

This policy is signed in our behalf by our Chief Executive Officer and Secretary.



Chairman of the Board  
Chief Executive Officer



Secretary

**DUPLICATE**

Countersigned By \_\_\_\_\_

Licensed Resident Agent

MUTUAL PROTECTIVE INSURANCE COMPANY  
1515 SOUTH 75TH STREET  
OMAHA, NE 68124

DUPLICATE

SCHEDULE

POLICY NO. - OS34226

POLICY TYPE - 696

INSURED - GLADYS E WHITE  
9223 60 AVE CT E  
PUYALLUP WA 98371-6155

		POLICY PREMIUMS	
POLICY DATE.....	08/08/1999	SEMI-ANNUAL.....	\$3,013.92
		ANNUAL.....	\$5,796.00

DAILY BENEFIT, REASONABLE AND CUSTOMARY	
CHARGES UP TO.....	\$120.00
ELIMINATION PERIOD FOR ANY ONE BENEFIT PERIOD.....	90 DAYS
BENEFIT DAY OPTION.....	1095
LIFETIME DOLLAR MAXIMUM.....	\$131,400.00

POLICY 696/3 YR., PLAN 9 OPTION F

-ENDORSEMENT-

**MEDICO® INSURANCE COMPANY**  
1515 SOUTH 75TH STREET  
OMAHA, NE 68124

POLICY NUMBER - 0S34226

RIDER PAGE 1 OF 1

Insured: GLADYS E WHITE

**THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.**

**NAME CHANGE ENDORSEMENT**

**Name Change:** Whenever in the policy the name MUTUAL PROTECTIVE INSURANCE COMPANY is set forth, the name Medico™ Insurance Company is hereby substituted.

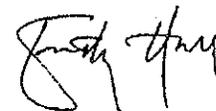
The notice of the **Annual Meeting** in the policy is deleted and the following provision substituted in lieu thereof:

**Medico™ Mutual Insurance Holding Company Provision:** Pursuant to the laws of the State of Nebraska, as a policyholder of the Company, you are a member of the Medico™ Mutual Insurance Holding Company and are entitled to vote either in person or by proxy at any and all meetings of the Medico™ Mutual Insurance Holding Company. An annual meeting of Medico™ Mutual Insurance Holding Company shall be held at the Home Office of the Company in the city of Omaha, Nebraska, on the second Friday of May each year at 10:00 a.m., Central Time.

All other provisions and conditions of the policy remain unchanged. The effective date of this endorsement is January 1, 2006.

**ANY ENDORSEMENT IS A PART OF YOUR POLICY. THE NUMBER IS SHOWN ABOVE.**

  
Secretary

  
President

MIR-2006-CHG

10142005

## PRIVACY NOTICE TO MEDICO™ INSURANCE COMPANY AND MEDICO™ LIFE INSURANCE COMPANY POLICYHOLDERS

**Your privacy is our concern.** Certain laws regulate the collection, use and disclosure of a consumer or customer's nonpublic information. Medico™ Insurance Company and Medico™ Life Insurance Company do not sell or otherwise disclose any nonpublic personal information about our customers or former customers to anyone outside the Medico™ Group Family, except as permitted by law. **You don't need to take any action to prevent disclosure;** this notice is solely for your information.

**General Privacy Information:** It is the policy of Medico™ Insurance Company and Medico™ Life Insurance Company, their independent agents and those companies whose policies we administer together with ours to:

- Collect only information necessary or relevant to our business.
- Make a reasonable effort to ensure that information we act upon is accurate, relevant, timely and complete.
- Use only legitimate means to collect information.
- Make personal information available externally only to respond to legitimate business needs, to regulatory or other government authorities or as otherwise permitted by law.
- Limit employees' access to those who need to and are trained in the proper handling of personal information.
- Require anyone outside our corporate family (nonaffiliates) who perform services for us to conform to our privacy standards. We also require them not to use your nonpublic personal information for any other purpose.
- Not to disclose your nonpublic personal information to others for their own marketing purposes.
- Not to reveal your health, character, personal habits or reputation to anyone for marketing purposes.

The following summary explains the kinds of information that Medico™ Insurance Company and Medico™ Life Insurance Company or their agents may collect, what is done with the information and how you can find out about information, if any, we have about you in our records.

**What kind of information do we collect about you and from whom?** Most of our information comes directly from you. The application you complete, as well as any additional information you provide, generally gives us most of the information we need to know. Sometimes we may contact you by phone or mail to obtain additional information. Depending on the nature of your insurance transaction, we may need additional information about you or other individuals proposed for coverage from outside sources, such as medical records, credit reports, court records or other public records. We also might obtain information from third parties, such as other insurance companies or financial institutions that you have notified us of.

**What do we do with the information collected about you?** The information is kept with your application/policy records. We review it in evaluating your request for insurance coverage and in determining your rates. We will also refer to and use information in our policy records for purposes related to issuing and servicing insurance policies and settling claims. Your agent may use information about you in his/her files for insurance marketing purposes or to help you with your overall insurance program.

***To whom do we disclose information about you?*** We will not disclose information about you to others without your written consent unless the disclosure is necessary to conduct our business. By law, we are also permitted to share some or all of your nonpublic personal information with affiliates or nonaffiliates without prior permission under certain circumstances to certain persons and organizations such as:

- Our affiliated insurance companies.
- Your agent or broker.
- Parties who perform a business, professional or insurance function for our company, including our reinsurance companies.
- Businesses that conduct actuarial or underwriting studies.
- Affiliates or nonaffiliates that market our products. The parties we may share nonpublic personal information with include life and health insurers, insurance agents and marketing firms.
- Other insurance companies, agents or consumer reporting agencies as reasonably necessary in connection with any application, policy or claim involving you.
- Insurance support organizations which are established to collect information for the purpose of detecting and preventing insurance crimes or fraudulent claims.
- Insurance regulatory or law-enforcement agencies in connection with the regulation of our business.

Should you cease to be one of our policyholders or after your claim is settled, it is our policy to archive our information for a period of 5 years.

***How do we protect the confidentiality of information about you?*** We restrict access to nonpublic information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal regulations to guard your nonpublic personal information. Confidentiality agreements are obtained from third-party vendors where services they perform for us in connection with our normal business operation may give them access to nonpublic information. Finally, Medico™ Insurance Company and Medico™ Life Insurance Company educate their employees regarding privacy so that they know about its importance.

***How can you find out about information we have about you?*** You have the right to know what kind of information we keep in our files about you, to have reasonable access to it and receive a copy. Write to us if you have questions about information that you would like to receive. When you write us, please provide your complete name, address, type of policy and policy number that was issued or applied for with us and identify the information you seek.

Medico™ Group  
Attn: Policyholder Services  
1515 South 75<sup>th</sup> Street  
Omaha, NE 68124

**EXHIBIT B**



**MEDICO GROUP**

Medico Insurance Company • Medico Life Insurance Company

August 27, 2007

REC'D P.S.

SEP 10 2007

GLADYS E WHITE  
9223 60 AVE CT E  
PUYALLUP WA 98371

Policy No.: 0S34226

Dear Gladys E White,

You may name an Advisor(s) to provide extra security against the unintentional lapse of your insurance policy. This will enable us to send a notification to the person you name in case of an unpaid premium. If you do not wish to take advantage of this opportunity, please sign the waiver below and return the form to us.

Please designate a person in the space provided and sign below,

- or -

sign the Waiver that follows.

1. Advisor's Name: Charles Silvermail  
 Home Address: 34402 Thomas Rd. E  
 City: Eastonville State: Wash Zip: 98328  
 Phone Number: (253) 960 879 5543
2. Name of Second Advisor (Optional): \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_

You have the right to change this written designation at least once every two years.

X DATE: Sept 16-07 SIGNATURE: Gladys E White

**WAIVER OF PROTECTION AGAINST UNINTENDED LAPSE**

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice.

X DATE: Sept 16-07 SIGNATURE: Charles Silvermail

Please return this completed form in the enclosed postage-paid envelope.

U2460

02052004

Protecting Your Future Today®

1515 South 75th Street • Omaha, NE 68124 • (402) 391-6900 • fax (402) 391-6489 • www.gomedico.com

**EXHIBIT C**

Medico® Insurance Company

1515 South 75th Street  
Omaha, NE 68124  
1-800-228-6080  
gomedico.com



**PREMIUM NOTICE**

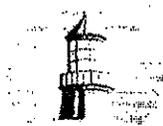
To change billing address or phone no., check here and see reverse side.

Your telephone number as listed in our records: (253) 845-1228

**THIS NOTICE IS FOR ONE POLICY ONLY, OTHER POLICIES YOU MAY HAVE WILL BE BILLED SEPARATELY.**

Make check or money order payable to: **MEDICO® INSURANCE COMPANY**

GLADYS E WHITE  
9223 60 AVE CT E  
PUYALLUP WA 98371-6155



Policy No. **0S34226**  
**PREMIUM DUE 02/08/2009**

<b>PAY THIS AMOUNT</b>	
6 MOS	\$3,018.92
<b>OR YOU MAY PAY:</b>	
12 MOS	\$5,796.00
3 MOS	\$1,564.92
2 MOS	\$1,053.80

Please return upper portion with payment. Keep lower portion for your records.

**IMPORTANT**

Dear Gladys E White,

As you know, insurance policies become more valuable as they grow older. Health policies have "waiting periods" that disappear after a period of time. Life policies often have cash values that increase with age. You risk losing these advantages — as well as potential benefits — if you allow your policy to lapse.

It's also important to realize that replacing a policy may be costly. As health costs rise, so do insurance premiums. And as you grow older, the premium for coverage may rise based on your age.

If you need information or answers, please call our **TOLL-FREE** number, **1-800-228-6080**. Our Customer Service staff is here to help from 7:30 a.m. to 4:45 p.m., Monday through Thursday; and 7:30 a.m. to 11:30 a.m. on Friday, Central Time.

At Medico Insurance Company, prompt and courteous service is more than just a concept — *it's a practice that comes first!*

Sincerely,

Timothy J. Hall  
President

Date Paid \_\_\_\_\_ Check or M.O. No. \_\_\_\_\_ Amount \_\_\_\_\_ Policy # 0S34226  
Long-Term Care  
Medico® Insurance Company • 1515 So. 75th Street • Omaha, Nebraska 68124 • Website: gomedico.com

At Medico® Insurance Company  
we are proud of our commitment to protect your future today.



**FINAL PREMIUM NOTICE**

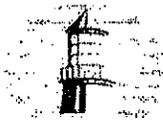
To change billing address or phone no., check here and see reverse side.

Your telephone number as listed in our records: (253) 845-1228

**THIS NOTICE IS FOR ONE POLICY ONLY. OTHER POLICIES YOU MAY HAVE WILL BE BILLED SEPARATELY.**

Make check or money order payable to: **MEDICO® INSURANCE COMPANY**

GLADYS E WHITE  
9223 60 AVE CT E  
PUYALLUP WA 98371-6155



Policy No. 0S34226  
**PREMIUM DUE 02/08/2009**

<b>PAY THIS AMOUNT</b>	
6 MOS	\$3,013.92
<b>OR YOU MAY PAY:</b>	
12 MOS	\$5,796.00
3 MOS	\$1,564.92
2 MOS	\$1,053.80

**Please return upper portion with payment. Keep lower portion for your records.**

176

Dear Gladys E White,

At this time we have not received your renewal premium and your policy is in its GRACE PERIOD. Your coverage will lapse if you don't act soon.

You recognized the need for this type of insurance when you applied for your policy.

We want to make it as convenient as possible to continue your coverage. You made a wise decision when you applied and it would be a shame to let it lapse when there are alternative ways of paying. Your premium notice shows the various modes and amounts you may pay — please take a moment to review it. I should mention that we also offer "Automatic Bank Withdrawal," a bank plan for paying premiums. You simply authorize your bank to honor our check each month (or every three months, if you prefer) for the premium. The Automatic Bank Withdrawal method saves time and postage. Of course you can discontinue the bank plan at any time.

If you have any questions or need any help, or if you want to change to our Automatic Bank Withdrawal Plan — please call our **TOLL-FREE** number 1-800-228-6080 between 7:30 a.m. and 4:45 p.m., Monday through Thursday; and 7:30 a.m. and 11:30 a.m. on Friday, Central Time. Our Customer Service Representatives are ready to help you.

Sincerely,

Timothy J. Hall  
President

Date Paid \_\_\_\_\_ Check or M.O. No. \_\_\_\_\_ Amount \_\_\_\_\_ Policy # 0S34226  
Long-Term Care  
Medico® Insurance Company • 1515 So. 75th Street • Omaha, Nebraska 68124 • Website: gomedico.com

At Medico® Insurance Company  
we are proud of our commitment to protect your future today.



**MEDICO® GROUP**  
*Medico® Insurance Company*

March 20, 2009

CHERYL SILVERNAIL  
34402 THOMAS RD E  
EATONVILLE WA 98328

RE: Gladys E White  
Policy No.: 0S34226  
Due: 02/08/2009

Dear Cheryl Silvernail,

You have been named as the Advisor to receive notification of this past due premium for Gladys E. White.

All of our long-term care/home health care policyholders are given the opportunity to name an Advisor. The Advisor receives a notice from us any time the policyholder's premium is 30 days past due. Our policyholder trusts you to contact him/her to discuss the importance of paying the policy premium.

If the premium is not received within 35 days from the date of this letter, the policy will lapse for nonpayment of premium.

Thank you,

Timothy J. Hall  
President

Medico® Insurance Company

1515 South 75th Street  
Omaha, NE 68124  
1-800-228-6080  
gomedico.com



**PAST DUE PREMIUM NOTICE**

To change billing address or phone no., check here and see reverse side.

Your telephone number as listed in our records: (253) 845-1228

**THIS NOTICE IS FOR ONE POLICY ONLY. OTHER POLICIES YOU MAY HAVE WILL BE BILLED SEPARATELY.**

Make check or money order payable to: **MEDICO® INSURANCE COMPANY**

GLADYS E WHITE  
9223 60 AVE CT E  
PUYALLUP WA 98371-6155



Policy No. 0S34226  
PREMIUM DUE 02/08/2009

<b>PAY THIS AMOUNT</b>	
6 MOS	\$3,013.92
<b>OR YOU MAY PAY:</b>	
12 MOS	\$5,796.00
3 MOS	\$1,564.92
2 MOS	\$1,053.80

Please return upper portion with payment. Keep lower portion for your records.

480

**YOUR POLICY PREMIUM IS PAST DUE!**

Dear Gladys E White,

Health care costs are rising along with everyday living costs. I'm sure you agree that should the unexpected happen, you'd want the added financial protection your policy may provide.

We are sending this letter to remind you that your insurance premium is past due. Experience shows that most policies expire inadvertently or the policyholder later decides to regain the policy at a higher cost.

We must receive your premium within the next 30 days or your policy will lapse.

Please mail your premium payment today in the enclosed postage-paid envelope.

**You may be able to change your plan benefits and reduce your premium cost but continue your long-term care coverage. Please contact your agent or our Customer Service Department for details.**

If you have any questions please call **TOLL-FREE 1-800-228-6080** between 7:30 a.m. and 4:45 p.m., Monday through Thursday; and 7:30 a.m. and 11:30 a.m. on Friday, Central Time.

Policyholder Service Department  
Medico Insurance Company

Date Paid \_\_\_\_\_ Check or M.O. No. \_\_\_\_\_ Amount \_\_\_\_\_ Policy # 0S34226  
Long-Term Care  
Medico® Insurance Company • 1515 So. 75th Street • Omaha, Nebraska 68124 • Website: gomedico.com

At Medico® Insurance Company  
we are proud of our commitment to protect your future today.