MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
National Insurance Services
300 North Corporate Drive, Suite 300
Brookfield, WI 53045
Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es):		**Reason for Applying:** ☐New Hire ☐Late Enrollee
☐Life/AD&D	☐Supp. Life:$ _____	☐Increase in Coverage amount ☐Reinstatement
☐Long Term Disability	☐AD&D:$ _____	☐Adding Dependent(s) ☐Applying for coverage over GI
☐Short Term Disability	☐AD&D:$	☐Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** ☐M ☐F	**Age:**	**Date of Birth:** / /

Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐Yes ☐No

Applicant's Home Address: (Street, City, State, Zip)	**Applicant's Daytime Phone No.** ( )

Applicant's Current Physician's Name:	**Date Last Visited:** / /	**Reason for Visit:**

Physician's Address: (Street, City, State, Zip)	**Physician's Phone No.**

Employee Member Name: (if different than Applicant)	**Employee's Job Title:**

Employee's Date of Hire:	**No. of Hours Employee Works Per Week:**	**Employee's Annual Salary:** $

Employer Name:	**Employer's Address:** (Street, City, State, Zip)

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐Yes ☐No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐Yes ☐No	1. Arthritis, bursitis or gout?	☐Yes ☐No
2. Chest pain, angina or shortness of breath?	☐Yes ☐No	2. Recurrent back pain or slipped disk?	☐Yes ☐No
3. Irregular heart beat or heart murmur?	☐Yes ☐No	3. Disorder of the back, neck or spine?	☐Yes ☐No
4. Rheumatic fever?	☐Yes ☐No	4. Disorder of the muscles, bones or joints?	☐Yes ☐No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐Yes ☐No	5. Temporomandibular joint (TMJ) Disorder?	☐Yes ☐No
6. Stress test; electrocardiogram or echocardiogram?	☐Yes ☐No	6. Recurrent abdominal pain?	☐Yes ☐No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐Yes ☐No	1. Stroke, seizure disorder or epilepsy?	☐Yes ☐No
2. Tumors, cysts, or polyps?	☐Yes ☐No	2. Migraine or persistent headaches?	☐Yes ☐No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐Yes ☐No
1. High or low blood pressure or hypertension?	☐Yes ☐No	4. Dizziness or paralysis?	☐Yes ☐No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐Yes ☐No	5. Asthma, emphysema, breathing or lung disorder?	☐Yes ☐No
3. Disorder of kidneys or bladder or kidney stones?	☐Yes ☐No	6. Indigestion, ulcers or irritable bowel?	☐Yes ☐No
4. Diabetes, high or low blood sugar?	☐Yes ☐No	7. Chronic fatigue?	☐Yes ☐No
5. Protein, blood or sugar in urine?	☐Yes ☐No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐Yes ☐No
6. Night sweats, persistent swollen glands or diarrhea?	☐Yes ☐No	9. Aids Related Complex (ARC)?	☐Yes ☐No
		10. Human Immunodeficiency Virus (HIV)?	☐Yes ☐No

HEALTH QUESTIONS *continued….*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	☐Yes ☐No	D. Prostate, ovaries or uterus?	☐Yes ☐No
B. Eyes, ears, nose or throat?	☐Yes ☐No	E. Stomach, intestine, gallbladder or liver?	☐Yes ☐No
C. Skin or lymph nodes?	☐Yes ☐No	F. Thyroid, spleen or any gland?	☐Yes ☐No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	☐Yes ☐No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	☐Yes ☐No
B. Scheduled or undergone any surgery?	☐Yes ☐No	D. Sustained illness requiring medical care or hospitalization?	☐Yes ☐No

V. In the last 12 months, have you used tobacco of any kind? ☐Yes ☐No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

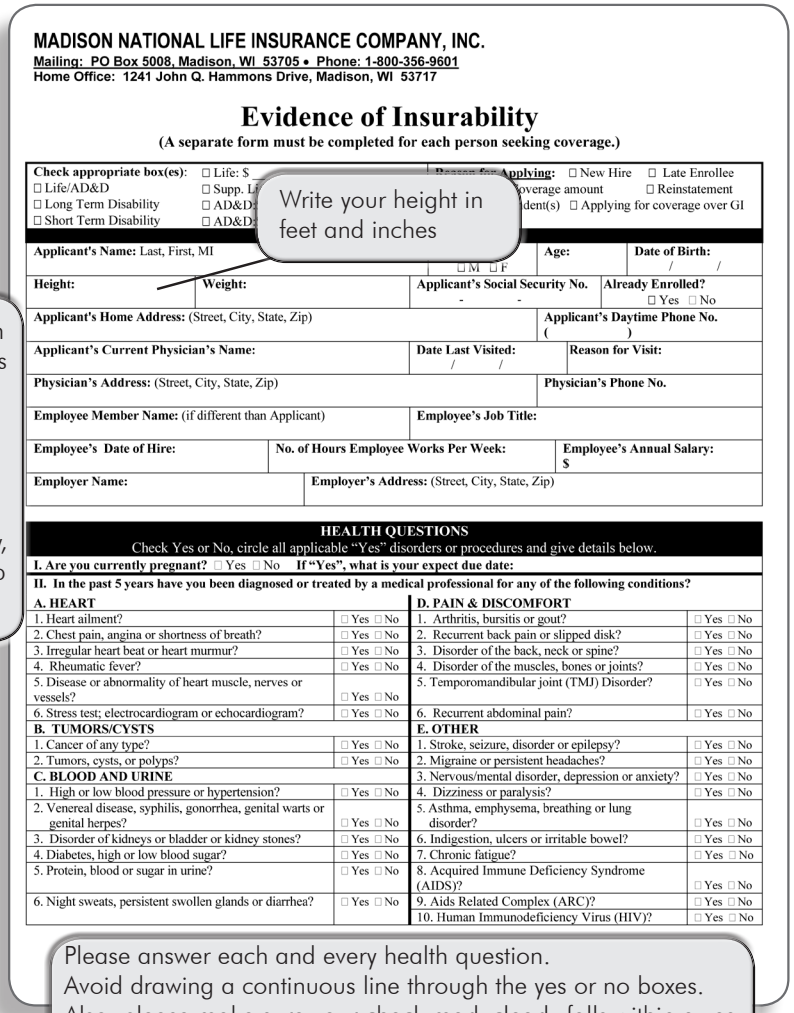
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature	**Date**
Parent/Guardian Signature (for Dependent enrollees under age 18)	**Date**

FOR INSURER USE ONLY:	Decision: ☐ Approved ☐ Postponed ☐ Declined	Effective Date:
Underwriter's Signature:		Date:

Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. Please use **blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. **If you are requesting coverage for family members, complete an additional form for each person.**



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Evidence of Insurability
(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): ☐ Life: $ ☐ Life/AD&D ☐ Supp. Li ☐ Long Term Disability ☐ AD&D ☐ Short Term Disability ☐ AD&D **Applying:** ☐ New Hire ☐ Late Enrollee ☐ Increase coverage amount ☐ Reinstatement ☐ Dependent(s) ☐ Applying for coverage over GI

Applicant's Name: Last, First, MI | **Age:** | **Date of Birth:** / /
☐ M ☐ F

Height: | **Weight:** | **Applicant's Social Security No.** - - | **Already Enrolled?** ☐ Yes ☐ No

Applicant's Home Address: (Street, City, State, Zip) | **Applicant's Daytime Phone No.** ( )

Applicant's Current Physician's Name: | **Date Last Visited:** / / | **Reason for Visit:**

Physician's Address: (Street, City, State, Zip) | **Physician's Phone No.**

Employee Member Name: (if different than Applicant) | **Employee's Job Title:**

Employee's Date of Hire: | **No. of Hours Employee Works Per Week:** | **Employee's Annual Salary:** $

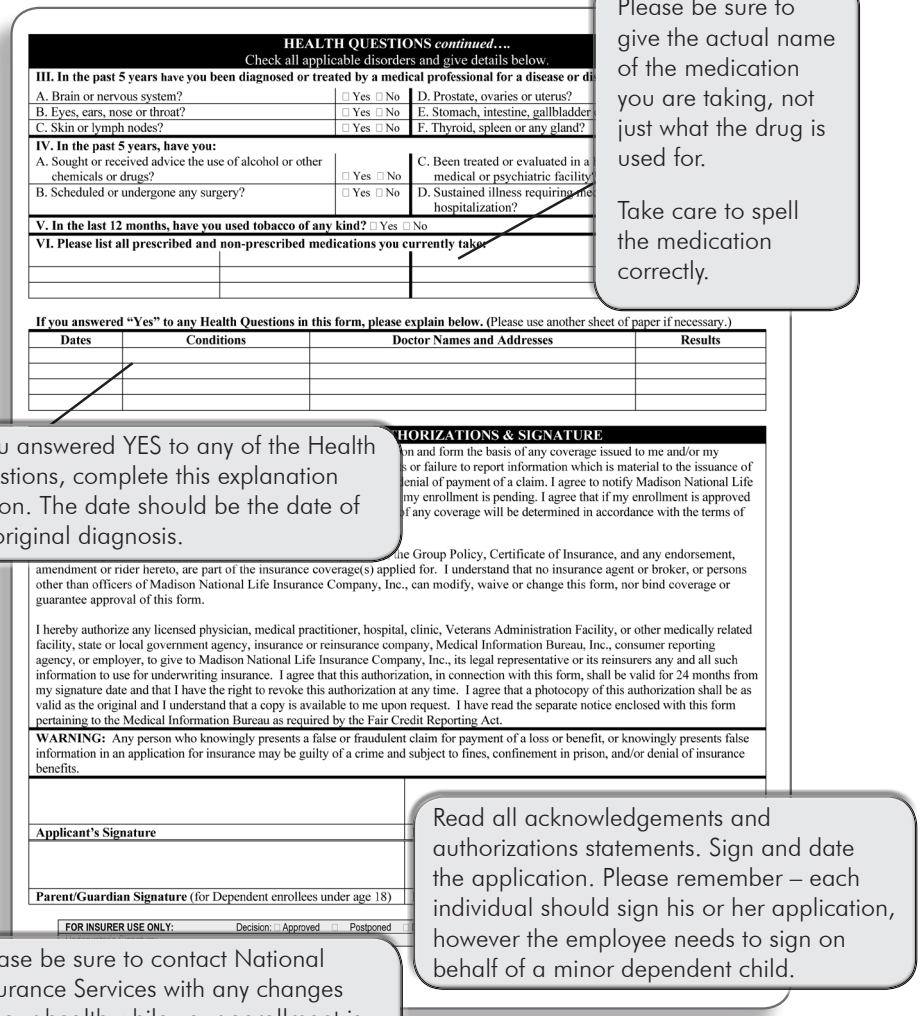
Employer Name: | **Employer's Address:** (Street, City, State, Zip)

HEALTH QUESTIONS
Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? ☐ Yes ☐ No **If "Yes", what is your expect due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		**D. PAIN & DISCOMFORT**	
1. Heart ailment?	☐ Yes ☐ No	1. Arthritis, bursitis or gout?	☐ Yes ☐ No
2. Chest pain, angina or shortness of breath?	☐ Yes ☐ No	2. Recurrent back pain or slipped disk?	☐ Yes ☐ No
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No	3. Disorder of the back, neck or spine?	☐ Yes ☐ No
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muscles, bones or joints?	☐ Yes ☐ No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	5. Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	6. Recurrent abdominal pain?	☐ Yes ☐ No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure, disorder or epilepsy?	☐ Yes ☐ No
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	2. Migraine or persistent headaches?	☐ Yes ☐ No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐ Yes ☐ No
1. High or low blood pressure or hypertension?	☐ Yes ☐ No	4. Dizziness or paralysis?	☐ Yes ☐ No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐ Yes ☐ No	5. Asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	6. Indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	☐ Yes ☐ No
5. Protein, blood or sugar in urine?	☐ Yes ☐ No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
6. Night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?	☐ Yes ☐ No
		10. Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No



HEALTH QUESTIONS *continued….*
Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or di

A. Brain or nervous system?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder	
C. Skin or lymph nodes?	☐ Yes ☐ No	F. Thyroid, spleen or any gland?	

IV. In the past 5 years, have you:

A. Sought or received advice the use of alcohol or other chemicals or drugs?	☐ Yes ☐ No	C. Been treated or evaluated in a medical or psychiatric facility?	
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring me hospitalization?	

V. In the last 12 months, have you used tobacco of any kind? ☐ Yes ☐ No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

HORIZATIONS & SIGNATURE

on and form the basis of any coverage issued to me and/or my s or failure to report information which is material to the issuance of denial of payment of a claim. I agree to notify Madison National Life my enrollment is pending. I agree that if my enrollment is approved f any coverage will be determined in accordance with the terms of

he Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, Medical Information Bureau, Inc., consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request. I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Applicant's Signature

Parent/Guardian Signature (for Dependent enrollees under age 18)

FOR INSURER USE ONLY: Decision: ☐ Approved ☐ Postponed

Write your height in feet and inches

Provide both your address and your physician's address completely, including address, city, state and zip code.

Please answer each and every health question. Avoid drawing a continuous line through the yes or no boxes. Also, please make sure your check mark clearly falls within a yes or no box.

If you answered YES to any of the Health Questions, complete this explanation section. The date should be the date of the original diagnosis.

Please be sure to give the actual name of the medication you are taking, not just what the drug is used for.

Take care to spell the medication correctly.

Please be sure to contact National Insurance Services with any changes in your health while your enrollment is pending. Failure to do so could result in the rescission of insurance and/or denial of payment of a claim.

Read all acknowledgements and authorizations statements. Sign and date the application. Please remember – each individual should sign his or her application, however the employee needs to sign on behalf of a minor dependent child.

If you have any questions when you complete this form please feel free to contact Medical Underwriting at National Insurance Services at 800-627-3660 between the hours of 8 am and 5 pm central time, Monday through Friday.