

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Return application to:
National Insurance Services
250 South Executive Drive
Brookfield, WI 53005-4273
Attention: Billing Dept.]

Check appropriate box(es): <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Short Term Disability <input type="checkbox"/> Supplemental/Voluntary STD/LTD	<input type="checkbox"/> Life: \$ _____ <input type="checkbox"/> Supp. Life: \$ _____ <input type="checkbox"/> Vol. Life: \$ _____ <input type="checkbox"/> Dependent Coverage: _____	Reason for Application: <input type="checkbox"/> New Hire <input type="checkbox"/> Increase in Coverage <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Other: _____	<input type="checkbox"/> Late Enrollee <input type="checkbox"/> Applying for coverage over GI amount <input type="checkbox"/> Reinstatement
---	--	---	---

EVIDENCE OF INSURABILITY

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

Applicant's Name: Last	First	Middle Initial	Date of Birth	Age	Height	Weight	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Already Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant's Home Address (Street, City, State, Zip)			Applicant's Daytime Telephone #		Applicant's Social Security #			
Applicant's Current Physician's Name & Address				Date Last Visited		Reason for Visit		
Name of Employee Member if different than Applicant				Name & Address of Member's Employer				
Member's Job Title			Member's Date of Hire		# of Hours Member works per week		Member's Annual Salary	

HEALTH QUESTIONS – Circle all applicable disorders. Give details below. Use second page if necessary.

- | | |
|---|--|
| <p>I. Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, expected due date: _____</p> <p>II. During the past 5 years have you been diagnosed, been treated by a doctor or had reason to suspect you've had any of the following conditions or procedures:</p> <p>A. HEART</p> <p>1. Heart ailment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Chest pain, angina or shortness of breath? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Irregular heart beat or heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Rheumatic fever? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Disease or abnormality of heart muscle, nerves or vessels? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Stress test; electrocardiogram or echocardiogram? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. TUMORS/CYSTS</p> <p>1. Cancer of any type, past or present? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Tumors, cysts, or polyps? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. BLOOD AND URINE</p> <p>1. High or low blood pressure or hypertension? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Diabetes, high or low blood sugar? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Disorder of kidneys or bladder or kidney stones? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Protein, blood or sugar in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Night sweats, persistent swollen glands or diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. PAIN OR DISCOMFORT</p> <p>1. Arthritis, bursitis or gout? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Recurrent back pain or slipped disk? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Disorder of the back, neck or spine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Disorder of the muscles, bones or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Temporomandibular joint (TMJ)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Recurrent abdominal pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>E. OTHER</p> <p>1. Stroke, seizure, disorder or epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Migraine or persistent headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Nervous/mental disorder, depression, anxiety? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Dizziness or paralysis? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Asthma, emphysema, breathing or lung disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Indigestion, ulcers or irritable bowel? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Symptoms of chronic fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>III. Have you in the past 5 years had a disease or disorder of the:</p> <p>A. Brain or nervous system? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Eyes, ears, nose or throat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Skin or lymph nodes? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>D. Prostate, ovaries or uterus? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>E. Stomach, intestine, gallbladder or liver? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>F. Thyroid, spleen or any gland? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>IV. Have you been diagnosed by a member of the medical profession as having:</p> <p>A. Acquired Immune Deficiency Syndrome (AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Aids Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>V. Have you sought or received advice in the past 5 years for the use of alcohol or other chemicals or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>VI. Please list all prescribed and unprescribed medications you currently take: _____</p> <p>VII. Have you in the past 5 years:</p> <p>A. Scheduled or undergone any surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>B. Been treated or evaluated in a hospital or medical or psychiatric facility? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Sustained illness requiring medical care or hospitalization? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>VIII. Have you used tobacco of any kind during the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|--|

If you answer "yes" to any of the above questions, please explain below. Use next page if necessary.

DATE	CONDITION	DOCTOR AND ADDRESS	RESULT
------	-----------	--------------------	--------

If necessary, please use this space to provide additional information.

ACKNOWLEDGEMENTS AND AUTHORIZATIONS

I understand that 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(ies). 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 of any change in my medical condition while my enrollment application is pending. I agree that if my application is approved by Madison National Life, the effective date of any coverage will be determined in accordance with the terms of the group policy(ies), including any actively at work requirement.

I agree on behalf of myself and my dependents named herein, if any, to cooperate in providing Madison National Life with information needed to process this Evidence of Insurability form. This may include signing forms for the release by hospitals, doctors and other health care providers of pertinent patient records to Madison National Life, the Medical Information Bureau, or their legal representatives.

I acknowledge this Evidence of Insurability form, when approved, and any endorsement, amendment or rider hereto will be made part of the contract(s) applied for.

I understand that an insurance agent or broker, or persons other than officers of Madison National Life, cannot modify, waive or change this application, any requirements imposed by Madison National Life, nor bind coverage or guarantee approval of this application. No person, except an officer of Madison National Life, is authorized to vary or modify a contract.

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, having information with respect to any physical or mental condition, treatment, non-medical information, or any medical records originating from such organization on me or my dependents, to give to Madison National Life Insurance Company, its legal representative, or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization shall be valid for 30 months from the application date. 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.

I understand and affirm by my signature below that, to the best of my knowledge and belief, the information in this entire application is true and complete.

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

Applicant's Signature _____ Date _____

FOR HOME OFFICE USE ONLY

- Insurance Approved Effective _____
- Insurance Postponed
- Insurance Declined

Underwriter's Signature _____ Date _____