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 250 South Executive Drive, Suite 300 Brookfield, WI 53005-4273 Attention: Billing Department

Evidence of Insurability

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

Check appropriate box(es): ☐ Life: \$			Reason for Applying: ☐ New Hire ☐ Late Enrollee					
☐ Life/AD&D ☐ Supp. Life:\$			☐ Increase in Coverage amount ☐ Reinstatement					
☐ Long Term Disability	□ AD&D:\$		_ □ Adding Depende	_				
☐ Short Term Disability	□ AD&D:\$		Other:	(°)(°)	, 5 101 00 , 014			
		PPLICANT INF						
Applicant's Name: Last, First,			Sex:	Age:	Date of B	irth:		
			\Box M \Box F	-				
Height:	Weight:		Applicant's Social Security No. Already Enrolled?					
8	8			DYes DNo				
Applicant's Home Address: (Applicant's Daytime Phone No.							
11-		,		()	100		
Applicant's Current Physicia	an's Name:		Date Last Visited:	Reason	for Visit:			
rippireum s'eurreme ringsien	an situme.		/ / /	. Reason for visit.				
Physician's Address: (Street,	City State Zin)		Physician's Phone No.					
ingolding ridiness. (Silect,	City, Suite, Zip)			i ilysician s	1 HOHE 110.			
Employee Member Name: (if	different than Applies	ant)	Employee's Job Title:					
Employee Member Maine: (II	uniciciii ulan Applica	uit <i>)</i>	Employee 8 Job Title:					
Employee's Date of Hire:	No of	Houre Employee	Works Per Week:	Employe	e's Annual Sa	lorv.		
Employee's Date of file:	110. 01	mours Employee	WOUND I CI WEEK.	\$	e s Aimiuai Sa	ıaı y.		
Employer Nomes		Employan's Addu	naga (Ctuant City, State 7					
Employer Name: Employer's Address: (Street, City, State, Zip)								
		HEALTH QU						
			orders or procedures ar	nd give detail	s below.			
I. Are you currently pregnan								
II. In the past 5 years have ye	ou been diagnosed or	treated by a medi	ical professional for any	of the followi	ng conditions	?		
A. HEART			D. PAIN & DISCOM	FORT				
1. Heart ailment?		□ Yes □ No	1. Arthritis, bursitis or	gout?		□ Yes □ No		
2. Chest pain, angina or shortne	ess of breath?	□ Yes □ No	2. Recurrent back pain	or slipped disl	k?	□ Yes □ No		
3. Irregular heart beat or heart i	□ Yes □ No	3. Disorder of the back	, neck or spine	e?	□ Yes □ No			
4. Rheumatic fever?	□ Yes □ No	4. Disorder of the muse	cles, bones or j	joints?	□ Yes □ No			
5. Disease or abnormality of heart muscle, nerves or			5. Temporomandibular joint (TMJ) Disorder?			□ Yes □ No		
vessels?		□ Yes □ No	• • • • • • • • • • • • • • • • • • • •					
6. Stress test; electrocardiogran	□ Yes □ No	6. Recurrent abdominal pain? □ Ye						
B. TUMORS/CYSTS			E. OTHER					
1. Cancer of any type?		□ Yes □ No	1. Stroke, seizure disore	der 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?					
1. High or low blood pressure	or hypertension?	□ Yes □ No	4. Dizziness or paralys	is?		□ Yes □ No		
2. Venereal disease, syphilis, go	onorrhea, genital warts		5. Asthma, emphysema	, breathing or l	lung			
genital herpes?		□ Yes □ No	disorder?			\square Yes \square No		
3. Disorder of kidneys or bladder or kidney stones?		□ Yes □ No	6. Indigestion, ulcers o	r irritable bow	vel?	□ 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 D	cquired Immune Deficiency Syndrome				
			(AIDS)?			\square Yes \square No		
6. Night sweats, persistent swo	llen glands or diarrhea	? ☐ Yes ☐ No	9. Aids Related Compl	lex (ARC)?		\square Yes \square No		
			10. Human Immunode	ficiency Virus	(HIV)?	☐ Yes ☐ No		

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HEALTH QUESTIONS <i>continued</i> Check all applicable disorders and give details below.								
III. In the nast 5	vears have you be			's and give details below. cal professional for a disease or disorder of	f the:			
A. Brain or nervous system?			☐ Yes ☐ No	D. Prostate, ovaries or uterus?				
B. Eyes, ears, no			☐ Yes ☐ No	E. Stomach, intestine, gallbladder or liver?				
C. Skin or lymph			□ Yes □ No	F. Thyroid, spleen or any gland?	□ Yes □ No			
	years, have you:		,	_	,			
	eived advice for the	use of alcohol or		C. Been treated or evaluated in a hospital of				
other chemica	ds or drugs? undergone any surge	News 7	☐ Yes ☐ No	medical or psychiatric facility? D. Sustained illness requiring medical care	☐ Yes ☐ No			
b. Scheduled of	undergone any surge	ery :		hospitalization?	□ Yes □ No			
V. In the last 12	months, have you	used tobacco of any	v kind? □ Yes □					
		on-prescribed med						
, 10 1 10 mg 11g 0 mg		preseries	2100010110 y 0 tr 0					
If you anaward	l "Voc" to ony Uool	th Ougstians in this	s form nloose s	explain below. (Please use another sheet of pa	oper if necessary			
Dates	Condit			ctor Names and Addresses	Results			
Dates	Condit	ions	Do	Ctor Names and Addresses	Results			
	ACT			ORIZATIONS & SIGNATURE				
coverage may be Insurance Compa by Madison Nati the Group Policy I acknowledge the amendment or risother than office guarantee approx I hereby authorize facility, state or length National Life Insurance. I agree the right to revokunderstand that a WARNING: All	e used as a basis for rany, Inc. of any char onal Life Insurance or, including any Actions Evidence of Insurance der hereto, are parters of Madison National of this form. The energy licensed physicocal government age surance Company, In the that this authorization is copy is available to ony person who know	rescission of my insurage in my medical concerns, Inc., the evely at Work required arability form (when of the insurance concerns, insurance or react, its legal representation, in connection wat any time. I agree the me upon request.	rance and/or de prodition while neffective date of ement. approved), the verage(s) applie Company, Inc., tioner, hospital, einsurance compatative or its rein with this form, slithat a photocop se or fraudulent	or failure to report information which is material of payment of a claim. I agree to notify Many enrollment is pending. I agree that if my enrollment is my enrollment in prison and/or subject to fines confinement in prison and/or and in the pending is material.	Madison National Life prollment is approved and with the terms of any endorsement, or broker, or persons bind coverage or ther medically related r, to give to Madison r underwriting e date and that I have original and I wingly presents false			
information in an benefits.	application for insu	rance may be guilty	of a crime and	subject to fines, confinement in prison, and/o	r denial of insurance			
Applicant's Signature				Date				
Downt/Cyondia	n Signatura (for Da	mondont appelloss v	ndan a sa 19)	Data				
raren/Guardia	m Signature (101 De	ependent enrollees u	nuel age 18)	Date				
	FOR INSURER USE ONLY: Decision: Decision: Approved Postponed Declined Effective Date: Date:							

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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.

								Please be sure to	
MADICON MATIONAL LIFE INCUDAN	ICE COMPANY INC)	(·	HEALTH OUR	OTHONO : /	give the actual no	ame
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Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601 Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 III. In the past 5 years have you been diagnosed or treated by a medical professional for a disea						of the medication	1		
Total Citation (2.7 comma 2.7 comma citation), we contribute to the citation (2.7 comma citation) and citati				A. Brain or nervous system?			you are taking, n	ot	
Evidence of Insurability					B. Eyes, ears, nose or throat?	eril ,			
(A separate form must be completed for each person seeking coverage.)					C. Skin or lymph nodes?	□ Yes □	No F. Thyroid, spleen or any gland?	just what the drug	g is
(A separate form must be	completed for each person seek	ding coverage.)			IV. In the past 5 years, have you: A. Sought or received advice the use	of alcohol or other	C. Been treated or evaluated in	used for.	
ck appropriate box(es): 🗆 Life: \$	Bassas for Appl		Late Enrollee		chemicals or drugs?	□ Yes □	No medical or psychiatric facilit		
e/AD&D □ Supp. Li Write	e your height in 🥻		Reinstatement		B. Scheduled or undergone any surg	ery?	No D. Sustained illness requiring the hospitalization?	·	
		dent(s) Applying for co	overage over GI		V. In the last 12 months, have you	used tobacco of any kind?		Take care to spell	l l
feet	and inches				VI. Please list all prescribed and			the medication	
pplicant's Name: Last, First, MI		Age: Date	of Birth:		,				
ight: Weight:	Applicant's Social S	Security No. Already En	rolled?					correctly.	
,g			Yes □ No						
pplicant's Home Address: (Street, City, State, Zip)		Applicant's Daytime I	Phone No.				ease explain below. (Please use another		_
pplicant's Current Physician's Name:	Date Last Visited:	Reason for Visit:			Dates Condit	ions	Doctor Names and Addresses	Results	
approant a Current r nysician a rvaine.	/ / / / /	Reason for VISIL:						- 	
Physician's Address: (Street, City, State, Zip)	<u> </u>	Physician's Phone No.	.						
Employee Member Name: (if different than Applicant)	Employee's Job Titl	le:					HORIZATIONS & SIGNATU	DE	
mployee's Date of Hire: No. of Ho	ours Employee Works Per Week:	Employee's Annua	al Salary:	/ If you	answered YES to an	y of the Health	on and form the basis of any covera		
		\$			ions, complete this e		s or failure to report information wh	nich is material to the issuance of	
ployer Name: En	nployer's Address: (Street, City, State,	, Zip)					lenial of payment of a claim. I agree my enrollment is pending. I agree to		
				section	n. The date should b	e the date ot	of any coverage will be determined		
ŀ	HEALTH QUESTIONS			the or	iginal diagnosis.		1		
Check Yes or No, circle all applica	able "Yes" disorders or procedures	and give details below.		THE OF	iginai alagnosis.		he Group Policy, Certificate of Insu	rance, and any endorsement,	
Are you currently pregnant? ☐ Yes ☐ No If "Ye							applied for. I understand that no insura	nce agent or broker, or persons	
. In the past 5 years have you been diagnosed or tre			ions?		other than officers of Madison National guarantee approval of this form.	onai Life Insurance Company,	, Inc., can modify, waive or change this	s form, nor bind coverage or	
. HEART Heart ailment?	D. PAIN & DISCOM		□ Yes □ No						
Chest pain, angina or shortness of breath?	☐ Yes ☐ No 2. Recurrent back pa	in or slipped disk?	□ Yes □ No				spital, clinic, Veterans Administration Fa company, Medical Information Bureau		
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No 3. Disorder of the ba		□ Yes □ No				ompany, Inc., its legal representative or		
4. Rheumatic fever? 5. Disease or abnormality of heart muscle perves or		uscles, bones or joints? ar joint (TMJ) Disorder?	□ Yes □ No		information to use for underwriting i	nsurance. I agree that this auth	norization, in connection with this form,	shall be valid for 24 months from	
5. Disease or abnormality of heart muscle, nerves or vessels?	☐ Yes ☐ No	ai joint (1 MJ) Disorder?	□ Yes □ No				ion at any time. I agree that a photocopy upon request. I have read the separate r		
Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No 6. Recurrent abdomin	nal pain?	□ Yes □ No		pertaining to the Medical Informatio			louce enclosed with this form	
B. TUMORS/CYSTS	E. OTHER		Lav. av.		WARNING: Any person who know	vingly presents a false or fraud	lulent claim for payment of a loss or ben		
l. Cancer of any type? 2. Tumors, cysts, or polyps?	☐ Yes ☐ No ☐ 1. Stroke, seizure, dis☐ Yes ☐ No ☐ 2. Migraine or persist		☐ Yes ☐ No		information in an application for inst		e and subject to fines, confinement in pr		
C. BLOOD AND URINE		sorder, depression or anxie			benefits.				
. High or low blood pressure or hypertension?	☐ Yes ☐ No 4. Dizziness or paral	ysis?	□ Yes □ No						-
 Venereal disease, syphilis, gonorrhea, genital warts or 		na, breathing or lung	UVes UNe				Read all ackno	wledgements and	
genital herpes? 3. Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No disorder? ☐ Yes ☐ No 6. Indigestion, ulcers	or irritable bowel?	☐ Yes ☐ No		Applicant's Signature			•	Lalada
l. Diabetes, high or low blood sugar?	Series No 7. Chronic fatigue?	or arrable bower.	□ Yes □ No					statements. Sign and	
. Protein, blood or sugar in urine?	☐ Yes ☐ No 8. Acquired Immune	Deficiency Syndrome					the application	n. Please remember -	- each
Night arrests, possistant arrellan alanda c- 3:	(AIDS)? ☐ Yes ☐ No 9. Aids Related Com	mlov (ABC)2	☐ Yes ☐ No		Parent/Guardian Signature (for D	ependent enrollees under age 1			
. Night sweats, persistent swollen glands or diarrhea?		deficiency Virus (HIV)?	☐ Yes ☐ No			•	individual shou	uld sign his or her ap	plication,
	1 70. Human milliunoc	actioner vitus (III v):	103 LINO		FOR INSURER USE ONLY:	Decision: ☐ Approved ☐ Postpor	however the er	mployee needs to sig	ın on
Please answer each and	every health auestic	n		Pleas	se be sure to contact	+ National			jii 011
							behalt of a mir	nor dependent child.	
Avoid drawing a continuo	ous line through the	yes or no bo	xes.	Insur	ance Services with a	ny changes		,	
Also, please make sure ye	our shock mark slow	1 6 11			1 1.1 1.4	11			
	our check mark cled	arly talls withi	n a yes	in yo	ur health while your	enrollment is			
or no box.	our check mark cled	arly talls within	n a yes		ur health while your ling. Failure to do s		n		

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.

of payment of a claim.