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): ☐ Life: \$		Reason for Applying: ☐ New Hire ☐ Late Enrollee						
☐ Life/AD&D ☐ Supp. Life:\$			☐ Increase in Coverage amount ☐ Reinstatement					
☐ Long Term Disability ☐ AD&D:\$			_					
☐ Short Term Disability ☐ AD&D:\$	Other:							
APPLICANT INFORMATION								
Applicant's Name: Last, First, MI			Sex:	Age: Date of	Birth:			
			$\square M \square F$	/	/			
Height: Weight:			Applicant's Social Security No. Already Enrolled?					
			O See See See See See See See See See S					
Applicant's Home Address: (Street, City, S	State, Zip)		Applicant's Daytime Phone No.					
			()					
Applicant's Current Physician's Name:			Date Last Visited: Reason for Visit:					
inplicant s current i nysician s i tamet			/ / Keason for visit.					
Physician's Address: (Street, City, State, Z	(in)		Physician's Phone No.					
1 Hysician's Address. (Succe, City, State, 2	лр <i>)</i>			i nysician s i none ivo.				
Employee Member Name: (if different than	n Annligant)		Employee's Job Title:					
Employee Member Name: (If different than	ii Applicant)		Employee 8 Job Title:					
Employee's Date of Hire:	No of Hou	ua Employas	XV 1 D XV 1 D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
Employee's Date of Fife:	No. of Hou	irs Employee	Works Per Week:	Employee's Annual S	Salary:			
E 1 N	 E		(Ct., C't., Ct., 7	'				
Employer Name:	Em]	pioyer´s Adar	ess: (Street, City, State, Z	up)				
		EALTH QU						
Check Yes or No, circle				nd give details below.				
I. Are you currently pregnant? ☐ Yes ☐	No If "Yes	s", what is you	ur expected due date:					
II. In the past 5 years have you been diag	nosed or trea	ted by a medi	cal professional for any	of the following condition	ıs?			
A. HEART			D. PAIN & DISCOM	FORT				
1. Heart ailment?		☐ Yes ☐ No		thritis, bursitis or gout?				
2. Chest pain, angina or shortness of breath?				ent back pain or slipped disk?				
3. Irregular heart beat or heart murmur?	☐ Yes ☐ No		1 11					
4. Rheumatic fever?	☐ Yes ☐ No	4. Disorder of the muse		☐ Yes ☐ No				
5. Disease or abnormality of heart muscle, no	2 100 2110	5. Temporomandibular						
vessels?	□ Yes □ No	2. Temporomanarousar						
6. Stress test; electrocardiogram or echocard	☐ Yes ☐ No	6. Recurrent abdominal pain? ☐ Ye						
B. TUMORS/CYSTS			E. OTHER					
1. Cancer of any type?	☐ Yes ☐ No	1. Stroke, seizure disord	☐ Yes ☐ No					
2. Tumors, cysts, or polyps?			·	2. Migraine or persistent headaches?				
C. BLOOD AND URINE			3. Nervous/mental disorder, depression or anxiety?					
High or low blood pressure or hypertensic	on?	☐ Yes ☐ No	4. Dizziness or paralys		☐ Yes ☐ No			
2. Venereal disease, syphilis, gonorrhea, gen		2 100 2110	5. Asthma, emphysema		2 100 2110			
genital herpes?		□ Yes □ No	disorder?	,	□ Yes □ No			
3. Disorder of kidneys or bladder or kidney	stones?	☐ Yes ☐ No	6. Indigestion, ulcers o	r irritable bowel?	☐ Yes ☐ No			
4. Diabetes, high or low blood sugar?		☐ Yes ☐ No	7. Chronic fatigue?					
5. Protein, blood or sugar in urine?				Acquired Immune Deficiency Syndrome				
			(AIDS)?		□ Yes □ No			
6. Night sweats, persistent swollen glands or	diarrhea?	☐ Yes ☐ No	9. Aids Related Compl	ex (ARC)?	☐ Yes ☐ No			
71			10. Human Immunode:		☐ Yes ☐ No			

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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?			D. Prostate, ovaries or uterus?			
B. Eyes, ears, no			☐ Yes ☐ No ☐ Yes ☐ No	E. Stomach, intestine, gallbladder or liver?			
	C. Skin or lymph nodes?		□ 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			
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 Sign	nature			Date			
Downt/Cyondia	n Signatura (for Da	mondont appelloss v	ndan a sa 19)	Data			
Parent/Guardian Signature (for Dependent enrollees under age 18) Date							
FOR INSURER USE ONLY: Decision: Approved Decision: Declined Effective Date: Underwriter's Signature: 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	o)
MADISON NATIONAL LIFE INSLID	NCE COMP.	ANY INC)		HEALTH OUEST	TONS continued	give the actual r	name
MADISON NATIONAL LIFE INSURANCE COMPANY, INC. Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601 Check all applicable disorders and give details below.							of the medicatio		
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 III. In the past 5 years have you been						edical professional for a disease or di			
Evidence of Insurability					A. Brain or nervous system?	you are taking, r	not		
					B. Eyes, ears, nose or throat? C. Skin or lymph nodes?	☐ Yes ☐ N		just what the dru	
		or each person seeking cove	erage.)		IV. In the past 5 years, have you:		1. Thyroid, spicen of any giand.		by is
· •				, l	A. Sought or received advice the us	se of alcohol or other	C. Been treated or evaluated in a	used for.	
Check appropriate box(es): ☐ Life: \$ ☐ Life/AD&D ☐ Supp. Li		-	New Hire ☐ Late Enrollee		chemicals or drugs? B. Scheduled or undergone any sur	gery?			
Long Term Disability	ite your he	eight in dent(s)	Applying for coverage over GI		B. Scheduled of undergone any sur	gery:	hospitalization?	Take care to spe	7
	t and inch			_	V. In the last 12 months, have you	u used tobacco of any kind? □ Ye	s 🗆 No		,11
Applicant's Name: Last, First, MI	i dila ilici	Age:	Date of Birth:	•	VI. Please list all prescribed and	non-prescribed medications yo	u currently taker	the medication	
Appreciate 5 / values Edus, 7 ilos, 7/1		□M □F	/ / /				+ ´	correctly.	
Height: Weight:		Applicant's Social Security N		1			1	L Corrocny.)
Applicant's Home Address: (Street, City, State, Zip)	Applic	☐ Yes ☐ No cant's Daytime Phone No.	-	If you answered "Ves" to any He	alth Questions in this form, plea	se explain below. (Please use another sh	neet of paper if necessary)	
		())		Dates Cond		Doctor Names and Addresses	Results	
Applicant's Current Physician's Name:		Date Last Visited: R	eason for Visit:					******	1
Physician's Address: (Street, City, State, Zip)		/ / / Physic	cian's Phone No.						
Luysician s Address. (Succe, City, State, Zip)		Filysic	an s i none ivo.						
Employee Member Name: (if different than Applica	nt)	Employee's Job Title:					CHODIZATIONS & SIGNATURE		
Employee's Date of Hire: No. of	Hours Employee	Works Per Week: En	nployee's Annual Salary:		ou answered YES to ar		on and form the basis of any coverage	issued to me and/or my	
Employer Name:	Employer's Addr	ess: (Street, City, State, Zip)		- Que	estions, complete this	explanation	s or failure to report information which enial of payment of a claim. I agree to		
Employer Name.	Employer system	essi (ouces, eny, oute, z.ip)			ion. The date should l		my enrollment is pending. I agree that	if my enrollment is approved	
						be life dule of	of any coverage will be determined in	accordance with the terms of	
Check Yes or No, circle all app	HEALTH QUI		dataile balow	the \	original diagnosis.				
I. Are you currently pregnant? Yes No If			details below.		amendment or rider hereto, are nar	rt of the insurance coverage(s) and	he Group Policy, Certificate of Insuran blied for. I understand that no insurance		
II. In the past 5 years have you been diagnosed or			ollowing conditions?	1 1	other than officers of Madison Nat		nc., can modify, waive or change this fo		
A. HEART		D. PAIN & DISCOMFORT] [guarantee approval of this form.				
1. Heart ailment?	□ Yes □ No	Arthritis, bursitis or gout?	□ Yes □ N		I hereby authorize any licensed phy	ysician, medical practitioner, hospi	tal, clinic, Veterans Administration Faci	lity, or other medically related	
Chest pain, angina or shortness of breath? Irregular heart beat or heart murmur?	☐ Yes ☐ No	 Recurrent back pain or slipp Disorder of the back, neck or 			facility, state or local government a	igency, insurance or reinsurance co	mpany, Medical Information Bureau, In	nc., consumer reporting	
Rheumatic fever?	□ Yes □ No	Disorder of the muscles, bor					npany, Inc., its legal representative or its rization, in connection with this form, sh		
5. Disease or abnormality of heart muscle, nerves or		5. Temporomandibular joint (T		1 1			rization, in connection with this form, sn at any time. I agree that a photocopy o		
vessels? 6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	Recurrent abdominal pain?	□ Yes □ N	- 1	valid as the original and I understar	nd that a copy is available to me up	on request. I have read the separate not		
B. TUMORS/CYSTS	LIES LINO	E. OTHER	□ Yes □ N		pertaining to the Medical Informati			4 lil	
Cancer of any type?	□ Yes □ No	1. Stroke, seizure, disorder or e] [ent claim for payment of a loss or benefi nd subject to fines, confinement in priso		
2. Tumors, cysts, or polyps?	☐ Yes ☐ No	Migraine or persistent heada			benefits.	nay ov gamy or a crime a	in priso	,	
C. BLOOD AND URINE	DV DN	Nervous/mental disorder, dep Discripage or possibility		- 1					
 High or low blood pressure or hypertension? Venereal disease, syphilis, gonorrhea, genital warts 	☐ Yes ☐ No	 Dizziness or paralysis? Asthma, emphysema, breathi 	ng or lung				D		
genital herpes?	□ Yes □ No	disorder?	Yes N		Applicant's C'		Kead all acknow	vledgements and	
Disorder of kidneys or bladder or kidney stones?	☐ Yes ☐ No	Indigestion, ulcers or irritab] [Applicant's Signature		+ authorizations of	tatements. Sign an	d data
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	□ Yes □ N						
5. Protein, blood or sugar in urine?	□ Yes □ No	8. Acquired Immune Deficience					the application.	Please remember	– each
6. Night sweats, persistent swollen glands or diarrhea	?	(AIDS)? 9. Aids Related Complex (ARC	☐ Yes ☐ N C)? ☐ Yes ☐ N		Parent/Guardian Signature (for I	Dependent enrollees under age 18)			
or regard or varie, persistent errollen glands of diaffiled	. 103 5140	10. Human Immunodeficiency			FOR INSURER USE ONLY:	Decision: ☐ Approved ☐ Postponed		d sign his or her a	
					Hadamatada Ciasatura		however the em	ployee needs to si	gn on
Please answer each and					ease be sure to contac			or dependent child	
Avoid drawing a contin				_	urance Services with a	,			
Also, please make sure	your chec	ck mark clearly fo	alls within a yes		your health while you				
or no box.					nding. Failure to do s				
				l the	e rescission of insuran	ce and/or denial			

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.