

# 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.)

|                                                                                                                                                                                                                                                                                                                                                  |                                              |                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------|------------------------------|
| <b>Check appropriate box(es):</b> <input type="checkbox"/> Life: \$ _____<br><input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp. Life: \$ _____<br><input type="checkbox"/> Long Term Disability <input type="checkbox"/> AD&D: \$ _____<br><input type="checkbox"/> Short Term Disability <input type="checkbox"/> AD&D: \$ _____ |                                              | <b>Reason for Applying:</b> <input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee<br><input type="checkbox"/> Increase in Coverage amount <input type="checkbox"/> Reinstatement<br><input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Applying for coverage over GI<br><input type="checkbox"/> Other: _____ |                                                                                      |                              |
| <b>APPLICANT INFORMATION</b>                                                                                                                                                                                                                                                                                                                     |                                              |                                                                                                                                                                                                                                                                                                                                                     |                                                                                      |                              |
| <b>Applicant's Name:</b> Last, First, MI                                                                                                                                                                                                                                                                                                         |                                              | <b>Sex:</b><br><input type="checkbox"/> M <input type="checkbox"/> F                                                                                                                                                                                                                                                                                | <b>Age:</b>                                                                          | <b>Date of Birth:</b><br>/ / |
| <b>Height:</b>                                                                                                                                                                                                                                                                                                                                   | <b>Weight:</b>                               | <b>Applicant's Social Security No.</b><br>- -                                                                                                                                                                                                                                                                                                       | <b>Already Enrolled?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No |                              |
| <b>Applicant's Home Address:</b> (Street, City, State, Zip)                                                                                                                                                                                                                                                                                      |                                              |                                                                                                                                                                                                                                                                                                                                                     | <b>Applicant's Daytime Phone No.</b><br>( )                                          |                              |
| <b>Applicant's Current Physician's Name:</b>                                                                                                                                                                                                                                                                                                     |                                              | <b>Date Last Visited:</b><br>/ /                                                                                                                                                                                                                                                                                                                    | <b>Reason for Visit:</b>                                                             |                              |
| <b>Physician's Address:</b> (Street, City, State, Zip)                                                                                                                                                                                                                                                                                           |                                              |                                                                                                                                                                                                                                                                                                                                                     | <b>Physician's Phone No.</b>                                                         |                              |
| <b>Employee Member Name:</b> (if different than Applicant)                                                                                                                                                                                                                                                                                       |                                              | <b>Employee's Job Title:</b>                                                                                                                                                                                                                                                                                                                        |                                                                                      |                              |
| <b>Employee's Date of Hire:</b>                                                                                                                                                                                                                                                                                                                  | <b>No. of Hours Employee Works Per Week:</b> |                                                                                                                                                                                                                                                                                                                                                     | <b>Employee's Annual Salary:</b><br>\$                                               |                              |
| <b>Employer Name:</b>                                                                                                                                                                                                                                                                                                                            |                                              | <b>Employer's Address:</b> (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

|                                                               |                                                          |
|---------------------------------------------------------------|----------------------------------------------------------|
| 1. Heart ailment?                                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Chest pain, angina or shortness of breath?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Irregular heart beat or heart murmur?                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Rheumatic fever?                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Disease or abnormality of heart muscle, nerves or vessels? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Stress test; electrocardiogram or echocardiogram?          | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### B. TUMORS/CYSTS

|                              |                                                          |
|------------------------------|----------------------------------------------------------|
| 1. Cancer of any type?       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Tumors, cysts, or polyps? | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### C. BLOOD AND URINE

|                                                                            |                                                          |
|----------------------------------------------------------------------------|----------------------------------------------------------|
| 1. High or low blood pressure or hypertension?                             | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Disorder of kidneys or bladder or kidney stones?                        | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Diabetes, high or low blood sugar?                                      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Protein, blood or sugar in urine?                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Night sweats, persistent swollen glands or diarrhea?                    | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### D. PAIN & DISCOMFORT

|                                              |                                                          |
|----------------------------------------------|----------------------------------------------------------|
| 1. Arthritis, bursitis or gout?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Recurrent back pain or slipped disk?      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Disorder of the back, neck or spine?      | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Disorder of the muscles, bones or joints? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Temporomandibular joint (TMJ) Disorder?   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Recurrent abdominal pain?                 | <input type="checkbox"/> Yes <input type="checkbox"/> No |

### E. OTHER

|                                                    |                                                          |
|----------------------------------------------------|----------------------------------------------------------|
| 1. Stroke, seizure disorder or epilepsy?           | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Migraine or persistent headaches?               | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Nervous/mental disorder, depression or anxiety? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Dizziness or paralysis?                         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 5. Asthma, emphysema, breathing or lung disorder?  | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 6. Indigestion, ulcers or irritable bowel?         | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Chronic fatigue?                                | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Acquired Immune Deficiency Syndrome (AIDS)?     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Aids Related Complex (ARC)?                     | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 10. Human Immunodeficiency Virus (HIV)?            | <input type="checkbox"/> Yes <input type="checkbox"/> 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?    | <input type="checkbox"/> Yes <input type="checkbox"/> No | D. Prostate, ovaries or uterus?              | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Eyes, ears, nose or throat? | <input type="checkbox"/> Yes <input type="checkbox"/> No | E. Stomach, intestine, gallbladder or liver? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| C. Skin or lymph nodes?        | <input type="checkbox"/> Yes <input type="checkbox"/> No | F. Thyroid, spleen or any gland?             | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**IV. In the past 5 years, have you:**

|                                                                                  |                                                          |                                                                                |                                                          |
|----------------------------------------------------------------------------------|----------------------------------------------------------|--------------------------------------------------------------------------------|----------------------------------------------------------|
| A. Sought or received advice for the use of alcohol or other chemicals or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No | C. Been treated or evaluated in a hospital or medical or psychiatric facility? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| B. Scheduled or undergone any surgery?                                           | <input type="checkbox"/> Yes <input type="checkbox"/> No | D. Sustained illness requiring medical care or hospitalization?                | <input type="checkbox"/> Yes <input type="checkbox"/> 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.

|                                                                         |             |
|-------------------------------------------------------------------------|-------------|
|                                                                         |             |
| <b>Applicant's Signature</b>                                            | <b>Date</b> |
|                                                                         |             |
| <b>Parent/Guardian Signature (for Dependent enrollees under age 18)</b> | <b>Date</b> |

|                              |                                                                                                                  |                 |
|------------------------------|------------------------------------------------------------------------------------------------------------------|-----------------|
| <b>FOR INSURER USE ONLY:</b> | Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Postponed <input type="checkbox"/> Declined | Effective Date: |
| Underwriter's Signature:     |                                                                                                                  | Date:           |