

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.**

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

Evidence of Insurability

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

Check appropriate box(es): Life: S Disease-Free Applying: New Hire Late Enrollee
 Life/AD&D Supp. L Coverage amount Reinstatement
 Long Term Disability AD&D Dependent(s) Applying for coverage over 60
 Short Term Disability AD&D

Applicant's Name: Last, First, MI _____ 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) _____

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.

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?
 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 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 the use of alcohol or other chemicals or drugs? Yes No C. Been treated or evaluated in a medical or psychiatric facility Yes No
 B. Scheduled or undergone any surgery? Yes No D. Sustained illness requiring medical 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:

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.

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

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

AUTHORIZATIONS & SIGNATURE
 I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related agency, 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

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.

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.

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.