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): □ L	ife: \$	Reason for Applying: ☐ New Hire ☐ Late Enrollee								
	☐ Increase in Coverage amount ☐ Reinstatement									
	_ ~ rr				_					
☐ Short Term Disability ☐ A	☐ Other:									
		ICANT INF	ORMATION							
Applicant's Name: Last, First, MI			Sex:	Age:	Date of Birth:					
		$\square M \square F$	8							
Height: We	ight:		Applicant's Social Sec	Security No. Already Enrolled?						
Treasure (28			☐ Yes ☐ No						
Applicant's Home Address: (Stree	Applicant's Daytime Phone No.									
Applicant's Home Address. (Succ	i, City, State, Zip)	Applicant's Daytine 1 none 100.								
Applicant's Current Physician's	Namas	Data Last Visited Deagan for Visite								
Applicant's Current I hysician's	Name.		Date Last Visited: Reason for Visit:							
Dhysician's Address (Street City	Chata 7:a)		Physician's Phone No.							
Physician's Address: (Street, City,	State, Zip)			Pnysician's Pno	ne No.					
Terrologo Mond N. C. 1900			Т 1 Т 1 /ГР/43							
Employee Member Name: (if diffe	erent than Applicant)		Employee's Job Title:							
	1 0									
Employee's Date of Hire:	No. of Hou	rs Employee	Works Per Week:	Employee's Annual Salary:						
				\$						
Employer Name:	Emp	oloyer's Addr	ess: (Street, City, State, Z	Zip)						
	111	EALTH QU	ESTIONS							
Check Yes or N	No, circle all applicat	ole "Yes" dise	orders or procedures ar	nd give details be	low.					
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 be				of the following o	conditions?					
A. HEART	g		D. PAIN & DISCOM	_						
1. Heart ailment?		□ Yes □ No	1. Arthritis, bursitis or		□ Yes □ No					
2. Chest pain, angina or shortness of	hreath?		2. Recurrent back pain							
3. Irregular heart beat or heart murm		☐ Yes ☐ No	3. Disorder of the back							
4. Rheumatic fever?	iui :		4. Disorder of the muse							
		5. Temporomandibular								
5. Disease or abnormality of heart muscle, nerves or vessels?		□ Yes □ No	5. Temporomandibular	John (1M3) Dison	uer:					
	6. Stress test; electrocardiogram or echocardiogram?		6. Recurrent abdomina	ıl nain?	□ Yes □ No					
B. TUMORS/CYSTS	enocardiogram:	□ Yes □ No	6. Recurrent abdominial pain?							
1. Cancer of any type?		□ Yes □ No	1. Stroke, seizure disord	der or enilensy?	□ Yes □ No					
2. Tumors, cysts, or polyps?		☐ Yes ☐ No								
C. BLOOD AND URINE										
1. High or low blood pressure or hy	nortongion?	□ Yes □ No	4. Dizziness or paralys		anxiety?					
	*									
2. Venereal disease, syphilis, gonorr genital herpes?	nca, gennal warts of	□ Yes □ No	5. Asthma, emphysema disorder?	, oreaumig or rung	□ Yes □ No					
3. Disorder of kidneys or bladder or	· kidney etonos?	☐ Yes ☐ No								
				<u>C</u>						
4. Diabetes, high or low blood sugar	. (☐ Yes ☐ No	7. Chronic fatigue?	Anfinianar-C	☐ Yes ☐ No					
5. Protein, blood or sugar in urine?		☐ Yes ☐ No	8. Acquired Immune D							
C Night assessed assessed as a silver of the	Jan da an di1 0	□ V □ N	(AIDS)?	lass (ADC)	□ Yes □ No					
6. Night sweats, persistent swollen g	giands or diarrhea?	☐ Yes ☐ No	9. Aids Related Complex (ARC)?							
			10. Human Immunode	nciency Virus (HI	\square Yes \square No					

HEALTH QUESTIONS continued									
					ve details below.		0.43		
_	•	een diagnosed or trea	•	_	ssional for a disease or	r disorder o	of the:	1	
A. Brain or nervous system?				D. Prostate, ovaries or uterus?				□ Yes □ No	
B. Eyes, ears, nose or throat? C. Skin or lymph nodes?		☐ Yes ☐ No	E. Stomach, intestine, gallbladder or liver? F. Thyroid, spleen or any gland?				☐ Yes ☐ No		
				r. Hiyi	old, spicell of any giand	11			
	years, have you:	a use of alcohol or		C Reen	treated or evaluated in	n a hoenital	or	1	
A. Sought or received advice for the use of alcohol or other chemicals or drugs?			□ Yes □ No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?				□ Yes □ No	
B. Scheduled or undergone any surgery?			☐ Yes ☐ No	D. Sustained illness requiring medical care or					
X7 T 4b - 14 12	1-1-19 = x/ =		italization?			□ Yes □ No			
		used tobacco of any			talras				
vi. Piease iist a	n prescribed and	non-prescribed med	ications you c	urrenuy •	таке:	ĺ			
						I			
If you answered	l "Yes" to any Hea	alth Questions in this	form, please	explain be	elow. (Please use anoth	er sheet of p	aper if ne	ecessary.)	
Dates	Condi	itions	Do	ctor Nam	es and Addresses]	Results	
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dependents under of coverage may National Life Instance and AD&D insurance I acknowledge that amendment or risother than office guarantee approx I hereby authorized facility, so Madison National underwriting instand that I have the request. I understand I have WARNING: A	er the Group Policy be used as a basis surance Company, proved by Madisor the terms of the G e, the AD&D cove his Evidence of Ins der hereto, are par ers of Madison Nat val of this form. The any licensed physiate or local gover al Life Insurance C urance. I agree the he right to revoke to the right to see m my person who kno	I understand that and for rescission of my in Inc. of any change in a National Life Insurational Policy, including the age may have a Warsurability form (when the office of the insurance covariant Life Insurance Covariant, medical practional Life Insurance Covariant, including at this authorization, in this authorization at a thin authorization at a son collected may, in conversional records are the wingly presents a false that the conversional records are the conversional re	y misstatemen insurance and/my medical conce Company, g any Actively exclusion for approved), the erage(s) applied company, Inc., itioner, hospitance or reinsural representative nonnection when the connection when the connecti	ts or failu for denial of ondition versions, Inc., the at Work is benefits. The Group Potential, can modial, clinic, ance compose or its re- with this for ee that a postances, be- conal infor- claim for-	orm the basis of any core to report information of payment of a claim. While my enrollment is effective date of any corequirement. I understand that no insurant of the company of the company consumer reportions any consumer reportions any and all suffers any and all suffers any of this author consumer that the company of this author consumer that the company of the company of this author consumer that the company of the co	n which is r I agree to n pending. I a overage will and that if r surance, and rance agent his form, nor on Facility, ng agency, of ch informat 24 months f rization is a ties with thi	naterial to totify Ma agree that agree that a be determy covers. I any end or broker bind cover or other representation to use from my six authoricowingly properties.	o the issuance dison t if my rmined in age includes dorsement, r, or persons verage or medically yer, to give to e for signature date to me upon ization. I also presents false	
Applicant's Signature				Date					
Parent/Guardia	n Signature (for D	Dependent enrollees un	der age 18)	Date					
FOR INSURER USE ONLY: Decision: Approved Postponed				□ Declined					

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 t	to)
MADISON NATIONAL LIFE INSURANCE COMPANY, INC.							give the actual	name		
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601						Check all applicable disorders and give details below.				
lome Office: 1241 John Q. Hammons Drive, Madison, WI 53717								cal professional for a disease or di	of the medication	
Evidence of Insurability					A. Brain or nerv			D. Prostate, ovaries or uterus?	you are taking,	not
					B. Eyes, ears, no C. Skin or lymph		☐ Yes ☐ No	E. Stomach, intestine, gallbladder F. Thyroid, spleen or any gland?	just what the dr	
(A separate form must be completed for each person seeking coverage.)						5 years, have you:	163 1110	1. Thyroid, spicen of any giand.		og is
` •					A. Sought or rec	ceived advice the use of alcohol of		C. Been treated or evaluated in a	used for.	
Check appropriate box(es): ☐ Life: \$ ☐ Life/AD&D ☐ Supp. Li		-	New Hire ☐ Late Enroll nount ☐ Reinstateme		chemicals or	drugs? r undergone any surgery?	☐ Yes ☐ No	medical or psychiatric facility D. Sustained illness requiring me		
Long Term Disability	ite your h	eight in dent(s)	Applying for coverage ove		D. Scheduled of	undergone any surgery:	la res a No	hospitalization?	Take care to spe	ا اام
	t and incl				V. In the last 12	2 months, have you used tobacc	co of any kind? ☐ Yes ☐	No		
Applicant's Name: Last, First, MI	i dila ilici	Age:	Date of Birth:		VI. Please list a	all prescribed and non-prescri	ibed medications you c	urrently taker	the medication	
Appreciate 5 / values Edisk, 7 ilos, 7/1		□ M □ F	/ / /					⊢ ′	correctly.	
Height: Weight:		Applicant's Social Security N	Already Enrolled?					1	Corrocny.)
Applicant's Home Address: (Street, City, State, Zip)	Appli	cant's Daytime Phone No.		If you answered	d "Yes" to any Health Question	ns in this form, please o	explain below. (Please use another sh	neet of paper if necessary.)	$\overline{}$
		())		Dates	Conditions		ctor Names and Addresses	Results	
Applicant's Current Physician's Name:		Date Last Visited:	Reason for Visit:			,				
Physician's Address: (Street, City, State, Zip)		/ / / Physi.	cian's Phone No.	— I		1				
- a social o Address (Succe, City, Suite, Zip)		1 Hysi	cana o a none ivo.							
Employee Member Name: (if different than Application	int)	Employee's Job Title:						ODIZATIONS & SIGNATURE		
Employee's Date of Hire: No. of	Hours Employee	Works Per Week: Er	nployee's Annual Salary:			YES to any of th	ie Health 🗜	ORIZATIONS & SIGNATURE n and form the basis of any coverage	issued to me and/or my	
Employer Name:	Employer's Addr	ress: (Street, City, State, Zip)		- $ $ $ $ $ $ $ $ $ $ $ $	uestions, com	plete this explan	ation [or failure to report information which enial of payment of a claim. I agree to		
Employer Name.	Zimpioyer 37tuur	essi (succi, city, suic, zip)				te should be the	data of	ny enrollment is pending. I agree that	if my enrollment is approved	
							udie oi	f any coverage will be determined in a	accordance with the terms of	
Check Yes or No, circle all app	HEALTH QU		dataila kalani	\ th	e original diag	gnosis.)			
I. Are you currently pregnant? \(\text{Yes} \subseteq \text{No}, \text{ circle all ap}			details below.		amendment or ri	rider hereto, are part of the insur-		e Group Policy, Certificate of Insurar ed for. I understand that no insurance		
II. In the past 5 years have you been diagnosed or			following conditions?	-	other than office	ers of Madison National Life Ins		can modify, waive or change this fo		
A. HEART		D. PAIN & DISCOMFORT			guarantee appro	oval of this form.				
1. Heart ailment?	☐ Yes ☐ No	 Arthritis, bursitis or gout? 	□Yes		I hereby authoriz	ize any licensed physician, medic	cal practitioner, hospital.	clinic, Veterans Administration Facil	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 of 		No No	facility, state or l	local government agency, insurar	ince or reinsurance comp	oany, Medical Information Bureau, In	c., consumer reporting	
Rheumatic fever?	☐ Yes ☐ No	Disorder of the back, neck to Disorder of the muscles, bo						my, Inc., its legal representative or its		
5. Disease or abnormality of heart muscle, nerves or		Temporomandibular joint (T						ation, in connection with this form, she any time. I agree that a photocopy o		
vessels? 6. Stress test; electrocardiogram or echocardiogram?	☐ Yes ☐ No	Recurrent abdominal pain?		No.	valid as the origi	ginal and I understand that a copy	is available to me upon	request. I have read the separate noti		
B. TUMORS/CYSTS	□ res □ No	E. OTHER	□ Yes	□ No		e Medical Information Bureau as				
1. Cancer of any type?	☐ Yes ☐ No	Stroke, seizure, disorder or e	epilepsy?	No				claim for payment of a loss or benefit subject to fines, confinement in priso		
2. Tumors, cysts, or polyps?	□ Yes □ No	Migraine or persistent heada		□No	benefits.	in approauon for insurance may t	oc gainy or a crime and	sucject to fines, commentent in priso	n, and or utilial of insurance	
C. BLOOD AND URINE		Nervous/mental disorder, de								
High or low blood pressure or hypertension? Venezged disease, symbilis, generating genital years.	☐ Yes ☐ No	Dizziness or paralysis? Asthmo. amphysama breath		No				D 1 11 1		
2. Venereal disease, syphilis, gonorrhea, genital wart genital herpes?	or □ Yes □ No	Asthma, emphysema, breath disorder?	ing or lung	No				Kead all acknow	vledgements and	
Disorder of kidneys or bladder or kidney stones?	□ Yes □ No	Indigestion, ulcers or irritab		No	Applicant's Sig	gnature			•	nd data
4. Diabetes, high or low blood sugar?	☐ Yes ☐ No	7. Chronic fatigue?	□ Yes	□ No					tatements. Sign a	
5. Protein, blood or sugar in urine?	□ Yes □ No	8. Acquired Immune Deficien						the application.	Please remember	r – each
Night sweats, persistent swollen glands or diarrhea	?	(AIDS)? 9. Aids Related Complex (AR		No No	Parent/Guardia	ian Signature (for Dependent enr	rollees under age 18)			
o. regardoreato, peroistent awonen giands of diaffiles	. I Les LINO	Alus Related Complex (AR Human Immunodeficiency		No	FOR INSURE	TO LICE ONLY	Assessed 50 Deates 1		d sign his or her d	
			, , , , , , , , , , , , , , , , , , , ,		FOR INSURER	ER USE UNLT: Decision: A	Approved Destponed Destponed Destponed Description	however the em	ployee needs to s	sian on
Please answer each and						to contact Natio			or dependent chil	
Avoid drawing a contin						rices with any cho	~			,
Also, please make sure	your chec	ck mark clearly f	alls within a ye			while your enroll				
or no box.					•	ure to do so coul				
				- I t	he rescission of	of insurance and	Vor 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.