MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • 1-800-356-9601
Administrator: North American Benefits Company (NABCO)
Mailing Address: NABCO, 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

Evidence of Insurability For Group Insurance

Insurance being applied for:	**Reason for applying:**
☐ Basic Life $ ______________ ☐ Supplement Life $ ______________	☐ Increase in Insurance Amount ☐ Applying for Increase over Guarantee Issue Amount ☐ Reinstatement ☐ Late Enrollee ☐ Adding Dependent(s) ☐ Other (specify):
Name of Group Policyholder	**Group No.**

Member Information

Member Name *(Last, First, Middle)*		**Social Security No.**
Dependent Name *(Last, First, Middle)* (if the applicant is a Dependent)		**Social Security No.**
Street Address *(Street, City, State)*		
County	**Phone No.**	**Date of Birth**
Height: / **Weight:**	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married
U.S. Citizen ☐ Yes ☐ No *(additional information may be requested)* - If "No", name the Country of Citizenship:		
Name of Organization you currently work for *(if applicable)*		
Date of Hire	**Position/Job Title**	
Hours Worked per Week	**Annual Salary**	**Class**

Health Questions

The terms "diagnosed", "advised" and "treated" mean any diagnosis, advice or treatment received by a member of the medical profession. Please answer "Yes" or "No" to the following questions.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

In the last 5 years has the Applicant been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:

1	a heart attack or aortic or heart valve surgery, angioplasty or coronary artery bypass?	☐ Yes ☐ No
2	chest pain or heart disease including angina, irregular heart beat and heart murmur?	☐ Yes ☐ No
3	shortness of breath, Rheumatic fever or disease or abnormality of heart muscle or vessels?	☐ Yes ☐ No
4	stress test, electrocardiogram or echocardiogram?	☐ Yes ☐ No
5	Cancer (of any type)?	☐ Yes ☐ No
6	Tumor, cyst, polyp or nodule?	☐ Yes ☐ No
7	high or low blood pressure or hypertension?	☐ Yes ☐ No
8	diabetes or high or low sugar?	☐ Yes ☐ No
9	complications due to diabetes, including nephropathy, neuropathy, or retinopathy?	☐ Yes ☐ No
10	protein, blood or sugar in urine?	☐ Yes ☐ No
11	any disorder of the respiratory system?	☐ Yes ☐ No
12	any disorder or disease of the stomach, liver, intestines, gallbladder rectum, pancreas or abdominal organs?	☐ Yes ☐ No
13	recurrent abdominal pain?	☐ Yes ☐ No
14	any disorder or disease of the blood, skin, thyroid, lymph or other glands?	☐ Yes ☐ No
15	kidney or bladder disorder, kidney stones or kidney disease?	☐ Yes ☐ No
16	night sweats, persistent swollen glands or diarrhea?	☐ Yes ☐ No
17	arthritis, bursitis or gout?	☐ Yes ☐ No
18	disorder of the muscles, bones or joints?	☐ Yes ☐ No
19	disorder of the back, neck or spine, or recurrent back pain or slipped disk?	☐ Yes ☐ No
20	Temporomandibular joint (TMJ) Disorder?	☐ Yes ☐ No
21	stroke, seizure disorder or epilepsy?	☐ Yes ☐ No
22	migraine or persistent headaches?	☐ Yes ☐ No
23	mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome)?	☐ Yes ☐ No
24	dizziness or paralysis?	☐ Yes ☐ No
25	asthma, emphysema, breathing or lung disorder?	☐ Yes ☐ No
26	indigestion, ulcers or irritable bowel?	☐ Yes ☐ No
27	chronic fatigue or fibromyalgia?	☐ Yes ☐ No
28	alcohol or drug abuse or used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician?	☐ Yes ☐ No
29	human immunodeficiency virus (AIDS Virus)?	☐ Yes ☐ No
30	Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☐ No
31	disorder of the brain or nervous system?	☐ Yes ☐ No
32	disorder of the eyes, ears, nose or throat?	☐ Yes ☐ No
33	disorder of the prostate, ovaries or uterus?	☐ Yes ☐ No

Health Questions continued…

The terms "diagnosed", "advised" and "treated" mean any diagnosis, advice or treatment received by a member of the medical profession. Please answer "Yes" or "No" to the following questions.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

In the last 5 years has the Applicant:

34	scheduled or undergone any surgery or told surgery was needed?	☐ Yes ☐ No
35	been treated or evaluated in a hospital or medical or psychiatric facility?	☐ Yes ☐ No
36	sustained an illness requiring medical care or hospitalization?	☐ Yes ☐ No
37	**In the last 12 months, has the Applicant** used tobacco of any kind?	☐ Yes ☐ No

For any "Yes" answer in the "Health Questions" section, please list the information here (use additional paper if necessary)**:**

Condition	**Results, Detail**
Dates Consulted	**Physician or Medical Facility Name and Address**
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Dates Consulted	**Physician or Medical Facility Name and Address**
Condition	**Results, Detail**
Dates Consulted	**Physician or Medical Facility Name and Address**

Please list all prescribed and non-prescribed medications the Applicant currently takes:

Member Agreement

By signing this Membership Form, I understand and agree that:

- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- I can obtain any Certificate(s) of Insurance and other forms from the Group Policyholder or Madison National Life. Insurance Company, Inc.
- No person, except an officer of Madison National Life Insurance Company, Inc., is authorized to vary or modify a contract.
- I understand that if I choose to sign this Application electronically or telephonically, I also have the right to withdraw my authorization to use my electronic or voice signature.
- **I have completed and signed the Authorization for Release of Medical Information** *(HIPAA Compliant)* **form**.

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.

Member Signature	**Date of Signature**
Parent/Guardian Signature (for Dependent applicants under age 18)	**Date of Signature**