MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

PO Box 5008, Madison, WI 53705 • 1-800-356-9601 (Phone)
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

GROUP APPLICATION

EMPLOYER GROUP INFORMATION				
Legal Name of Employer: (Please print)			**Requested Effective Date:** / /	**IRS Tax ID No.:**
Street Address:			**PO Box No.:**	**SIC No.:**
City:	**State:**	**Zip Code:**	**Nature of Business:**	
Group Contact Name:	**Title:**		**Phone No.:** ( )	
Employer Email Address:				
Business Type: ☐ Corporation ☐ Partnership ☐ Non-Profit ☐ Other:				**Years in Business:**
Subsidiaries Included:				
Bill Type: ☐ List Bill ☐ Self Bill	**Bill Frequency:** ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Other:			

Will this coverage replace existing coverage? ☐ Yes ☐ No
If "Yes", please complete the following:

Coverage:	**Insurer:**	**Termination Date:** / /
Coverage:	**Insurer:**	**Termination Date:** / /

(A copy of the current Insurer's policy/booklet and the most recent billing statement must accompany this Application.)

EMPLOYEE ELIGIBILITY INFORMATION

Please note that temporary, seasonal, part-time Employees, retirees, and Employees residing outside of the United States are generally excluded unless specifically identified by the Employer and approved by Madison National Life Insurance Company, Inc.

Employees must work the following minimum number of hours per week: ☐ 30 ☐ 40 ☐ Other: _____

On the Requested Effective Date, current Employees ☐ are eligible immediately ☐ must satisfy the Employee Waiting Period as specified below

Employee Waiting Period:
☐ Date of hire (eligible immediately)
☐ First day of the month coinciding with or following ☐ _____ days ☐ _____ months of employment
☐ Other: _____

On the Requested Effective Date, are there any Employees not actively at work? ☐ Yes ☐ No
If "Yes", please complete the "Actively-at-Work Statement" section of this Application.

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Underwriting Decision:	Notes:	
Effective Date of Coverage:	Plan No.	
Underwriter's Signature:		Date:

ACTIVELY-AT-WORK STATEMENT

This statement certifies that as of the Requested Effective Date, all Employees who are eligible for insurance as described in this Application are actively at work with the following exceptions:

Name of Employee who is not Actively at Work	Date of Birth	Last Day Worked	Expected Return to Work Date	Reason for Absence

I understand that insurance coverage for the Employees listed above is not guaranteed without written acceptance by an authorized representative of Madison National Life Insurance Company, Inc.

Printed Name of Authorized Employer Representative

Title

Signature of Authorized Employer Representative

Date

BASIC LIFE AND AD&D INSURANCE

☐ **PROPOSAL ATTACHED FOR BASIC LIFE AND AD&D INFORMATION (OR COMPLETE FIELDS BELOW)**

Class	Class Description	Basic Life Benefit	Basic AD&D Benefit	Basic Dependent Life		
				Spouse	Child 6 months and older	Child 14 days to 6 months
1		$	$	$	$	$
2		$	$	$	$	$
3		$	$	$	$	$

	Employee Insurance		Dependent Insurance	
Class	Guarantee Issue	Maximum Issue	Guarantee Issue	Maximum Issue
1				
2				
3				

Insurance Reduction Schedule

☐ Benefits reduce 35% at age 65, 50% at age 70 and terminate at retirement

☐ Other: _____

asfdsafdsa

Group Basic Life and AD&D Optional Benefits

Life Insurance Options

☐ Waiver of Premium Benefit ☐ Accelerated Death Benefit/Living Benefit ☐ Other _____

AD&D Insurance Options

☐ Seat Belt Benefit ☐ Air Bag Benefit

☐ Other AD&D Optional Benefits: _____

_____

Critical Illness Rider

☐ Employee only Amount: $_____

☐ Employee + family Amount: $_____

SUPPLEMENTAL LIFE AND AD&D INSURANCE

PLEASE ATTACH PROPOSAL FOR SUPPLEMENTAL LIFE AND AD&D INSURANCE INFORMATION *AND* COMPLETE FIELDS BELOW

Please "✓" the Supplemental Life insurance coverage being applied for:

☐ Employee Supplemental Life ☐ Spouse Supplemental Life ☐ Child Supplemental Life

☐ Employee Supplemental AD&D ☐ Spouse Supplemental AD&D ☐ Child Supplemental AD&D

PREMIUM CONTRIBUTIONS

	Employee Basic Life and AD&D Insurance		Basic Dependent Life Insurance	
Class	**Employer Contribution**	**Employee Contribution**	**Employer Contribution**	**Employee Contribution**
1				
2				
3				

Please complete the information below, based on the coverage(s) elected:

Coverages:	**Total Number of Eligible Employees**	**Total Number of Enrolled Employees**
Basic Life/AD&D:		
Basic Dependent Life:		
Supplemental Life/AD&D:		
Dependent Supplemental Life/AD&D:		

If Benefits are based on Earnings, Earnings are defined as:

☐ Base Salary Only ☐ Base Salary plus Commissions (using a 12-month rolling average)

☐ Base Salary plus Bonuses (using a 36-month rolling average) ☐ Other:_____

GROUP TERM LIFE AND AD&D PREMIUM RATES

Basic Life - per $1,000 of coverage $	Basic AD&D - per $1,000 of coverage $	Basic Dependent Life - per family unit $
Supplemental Life - per $1,000 of coverage or attached rate schedule $	Supplemental AD&D - per $1,000 of coverage $	Dependent Supplemental Life/AD&D - per $1,000 of coverage or attached rate schedule $

Rate Guarantee Period: ☐_____ months ☐_____ years

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Notes:

SHORT TERM DISABILITY INSURANCE

☐ **PROPOSAL ATTACHED FOR SHORT TERM DISABILITY INFORMATION**

(OR COMPLETE FIELDS BELOW)

Class	Class Description	Benefit Percentage	Flat Benefit/ Max Benefit	Elimination Period Accident / Sickness	Maximum Duration
1		%	$	days / days	wks
2		%	$	days / days	wks
3		%	$	days / days	wks

Class	Employer Contribution	Employee Contribution
1	%	% made ☐ Pre-tax ☐ Post-tax
2	%	% made ☐ Pre-tax ☐ Post-tax
3	%	% made ☐ Pre-tax ☐ Post-tax

Does the Employer gross up the Employee's salary in order to contribute toward premium? ☐ Yes ☐ No

Total Number of Eligible Employees:_____ Total Number of Enrolled Employees:_____

If Benefits are based on Earnings, Earnings are defined as:

☐ Base Salary Only ☐ Base Salary plus Commissions (using a 12-month rolling average)

☐ Base Salary plus Bonuses (using a 36-month rolling average) ☐ Other:_____

Short Term Disability Coverage Design

Definition of Disability ☐ Total ☐ Partial ☐ Zero Day Residual

Minimum Benefit Specify: _____ **Pre-existing Condition Exclusion** ☐ 3/12 ☐ 6/12 ☐ 12/12 ☐ Other _____ ☐ None

Short Term Disability Coverage Optional Benefits

☐ **First Day Hospital** ☐ In-patient only ☐ Out-patient included

☐ **Reasonable Accommodation Benefit $**_____

☐ **Survivor Benefit**

☐ **Waiver of Premium Benefit**

If there are other Employer requirements for this coverage, please describe: _____

_____

Short Term Disability Coverage Rate

Rate $_____ per $10 Weekly Benefit **Rate Guarantee Period** ☐ _____ months ☐ _____ years

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Notes:

LONG TERM DISABILITY INSURANCE

☐ **PROPOSAL ATTACHED FOR LONG TERM DISABILITY COVERAGE (OR COMPLETE FIELDS BELOW)**

Class	Class Description	Benefit Percentage	Maximum Benefit	Guarantee Issue
1		%	$	$
2		%	$	$
3		%	$	$

Class	Elimination Period	Own-Occupation Period	Benefit Duration
1	☐ 90 days ☐ 180 days ☐ Other:	☐ 2 years ☐ Other:	☐ SSNRA ☐ To age 65 ☐ Other:
2	☐ 90 days ☐ 180 days ☐ Other:	☐ 2 years ☐ Other:	☐ SSNRA ☐ To age 65 ☐ Other:
3	☐ 90 days ☐ 180 days ☐ Other:	☐ 2 years ☐ Other:	☐ SSNRA ☐ To age 65 ☐ Other:

Class	Employer Contribution	Employee Contribution
1	%	% made ☐ Pre-tax ☐ Post-tax
2	%	% made ☐ Pre-tax ☐ Post-tax
3	%	% made ☐ Pre-tax ☐ Post-tax

Does the Employer gross up the Employee's salary in order to contribute toward premium? ☐ Yes ☐ No

Total Number of Eligible Employees: _____ Total Number of Enrolled Employees: _____

If Benefits are based on Earnings, Earnings are defined as:

☐ Base Salary Only ☐ Base Salary plus Commissions (using a 12-month rolling average)

☐ Base Salary plus Bonuses (using a 36-month rolling average) ☐ Other:_____

Long Term Disability Coverage Design

Definition of Disability ☐ Total ☐ Partial ☐ Zero Day Residual

Minimum Benefit ☐ Greater of 10% or $100 ☐ Flat $100 ☐ Other _____

Integration with income from other sources ☐ Full Family ☐ Primary Only ☐ Other _____ % All Sources

Integration with Work Earnings ☐ Proportionate Formula ☐ 50%

Pre-existing Condition Exclusion ☐ 3/12 ☐ 6/12 ☐ 12/12 ☐ 12/24 ☐ Other _____

Long Term Disability Coverage Optional Benefits

☐ **Conversion of Insurance**

☐ **Reasonable Accommodation Benefit** $ _____

☐ **Survivor Benefit** ☐ 3 month ☐ GMB ☐ 6 month ☐ LMB ☐ 12 month

☐ **Work Incentive Benefit** ☐ 12 months ☐ 24 months

☐ **Cost of Living Adjustment** ☐ _____ % for _____ years ☐ Other _____

☐ **Buy Up** (please describe) _____

☐ **Other optional benefits** (please attach proposal which describes other benefits)_____

Long Term Disability Coverage Rate

Rate $ _____ per $100 Monthly Covered Payroll **Rate Guarantee Period** ☐ _____ months ☐ _____ years

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Notes:

Terms and Conditions

- The Employer agrees that any insurance applied for shall not become effective unless this Application and any attached page(s) are received, accepted and approved by Madison National Life Insurance Company, Inc. (hereinafter referred to as "Insurer"). The Employer further agrees that insurance applied for shall not become effective or remain effective unless the Employer: a) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and b) meets the participation and contribution requirements.
- The Employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If Certificates of Insurance are issued from this Application, and are accepted by the Employer, we will apply the premium deposit to the first premium due for such coverage. If no coverage is put into force, the premium deposit will be refunded.
- Your agent or broker cannot change or waive any provision of this Application or the Policy or policies without the written approval of an officer of the Insurer.
- The Employer acknowledges and understands that if this Application is approved, the Group Policy and Certificates will determine the rights and benefits, and that this Application is subject to the terms and conditions of such contract documents.
- The Employer agrees to offer and allow all eligible Employees to apply for coverage in accordance with, and within, the Employer's rules regarding classes eligible for coverage at the time of hire and during his/her probationary (waiting) period. The Employer will require that any Employee, who declines to apply at this time, sign a statement to that effect, which will be maintained by the Employer. Should the Insurer's guidelines require an Employee to submit evidence of insurability, such Employee must complete and submit to the Insurer an Evidence of Insurability form. No coverage shall be in effect for said Employees until Insurer approves and accepts the enrollment form and Evidence of Insurability form.
- The Employer agrees to timely notify the Insurer of any Employee termination, status change, or other material changes that may affect the eligibility of Employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The Employer agrees to notify Employees and other Insured Persons who cease to be eligible for coverage under its policies(s) of their right, if any, to continue group coverage and their right, if any, to apply to Insurer for an individual conversion policy. The Employer shall provide such Employees and other insured persons with the forms and applications necessary to continue group coverage or to apply for such conversion coverage as may then be available.
- The Employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The Employer understands that coverage may also be terminated for other reasons as provided in the Group Policy.
- The person signing this form below certifies that he or she is fully authorized by the Employer to execute this Agreement on the Employer's behalf.
- The person signing this form has personally reviewed all answers to the questions on this application and represent that all of the information provided is true and complete. It is the Employer's responsibility to provide truthful, complete and accurate information. The person signing this form understands that any material misstatements or failure to report information may be used as the basis of rescission or termination of coverage.
- If the Employer is unable maintain any minimum Employee participation requirement under this plan, then coverage may cease.

IMPORTANT: Please review the Fraud Warning page before signing this Application.

The undersigned Employer hereby makes application for insurance coverages described within this Application. This Application is subject to the Terms and Conditions stated above.

Printed Name of Authorized Employer Representative	**Title**
Signature of Authorized Employer Representative	**Date**

AGENT'S STATEMENT

Is the insurance being applied for replacing any insurance now in force? ☐ **Yes** ☐ **No**

I have fully explained to the Employer the coverage and provisions of the selected group insurance product benefits. I have also fully explained to the Employer that completing this Application does not guarantee insurance and does not bind Madison National Life Insurance Company, Inc. (hereinafter referred to as "Insurer") to issue a contract or otherwise extend any insurance. I understand I have no authority to alter this Application to bind the Insurer by making any promise and/or representation, or to waive or change the terms, conditions and/or provisions of any insurance contract or other requirement imposed by the Insurer.

I hereby certify that either the Employer fully completed this Application on its own, or that I have truly and accurately recorded in this Application the information supplied to me by the Employer.

Agent's Name as printed on the license	**State of license and Agent license number**
Signature of Licensed Agent	**Date**

FRAUD WARNING: The following Fraud Warning applies to residents of all states except those states listed separately below.

FRAUD 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.

STATE-SPECIFIC FRAUD WARNINGS

ARIZONA WARNING: Any person who knowingly presents false or fraudulent information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, and/or denial of insurance benefits.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

GEORGIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

KANSAS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA 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 is guilty of a crime and may be subject to fines and confinement in prison.

MARYLAND WARNING: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEBRASKA 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 may be subject to fines, confinement in prison and/or denial of insurance benefits.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files an application or a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO 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 is guilty of a crime and may be subject to civil fines, and criminal penalties.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

TENNESSEE WARNING: It is a crime to knowingly supply false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.