

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office Phone: 1-800-356-9601
1241 John Q. Hammons Drive, Madison, WI 53717

Return to: North American Benefits Company (NABCO)
20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

EMPLOYER NAME _____ **PLAN NUMBER** _____

EMPLOYEE INFORMATION

Name of Employee: (Last, First, MI)		Social Security Number:	Date of Birth: / /
Employee Street Address:			Hours per Week:
City:	State:	Zip:	
Class:	Date of Hire: / /	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Single <input type="checkbox"/> **Spouse/ Partner
Job Title:	Annual Salary: \$	US Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No – If no, attach a copy of the Employee's Visa.	

Late Enrollees – Reason for late enrollment: Change in Marital Status/Date _____ Add dependent(s)/Date _____
 Other _____/Date _____

*** Spouse” means a person to whom You are legally married or have entered in to a civil union partnership and from whom You are not legally separated. Civil union is a relationship that meets the requirements of a civil union pursuant to the New Jersey Civil Union Act and same sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage. Civil union couples shall have all of the same benefits, protections and responsibilities under law, whether they derive from statute, administrative court rule, public policy, common law or any other source of civil law, as are granted to spouses in a marriage.*

Beneficiaries: Indicate your beneficiary designation in the space below. If you need more space, please use another sheet.

- ****If you have a Spouse, a primary beneficiary designation of a person or organization other than your spouse may not be valid under your state law. Please consult your legal advisor before making such a designation.**
- You may designate more than one primary or secondary beneficiary. Please be sure to indicate the percentage share that each beneficiary should receive. The total within each class – primary and secondary – must equal 100%.

Primary Beneficiary (ies)

Name (Last, First, MI)	Relationship	Percent of Benefit

Secondary Beneficiary (ies)

Name (Last, First, MI)	Relationship	Percent of Benefit

****Spouse Signature (if required)** _____ **Date** _____

Insurance Coverage Election

The following coverages are only available if your Employer offers them. Please “” the applicable insurance coverage(s) you are electing. NOTE: If you decline coverages, please complete the Employee Waiver of Insurance section of this form.

LIFE /AD&D COVERAGE

<input type="checkbox"/> Employee Basic Life/AD&D	<input type="checkbox"/> Employee Supplemental Life/AD&D \$ _____	<input type="checkbox"/> Employee Voluntary Life/AD&D \$ _____
<input type="checkbox"/> Dependent Basic Life/AD&D – Family	<input type="checkbox"/> Dependent Supplemental Life/AD&D – Family	<input type="checkbox"/> Dependent Voluntary Life/AD&D – Family
<input type="checkbox"/> Dependent Basic Life/AD&D – Spouse	<input type="checkbox"/> Dependent Supplemental Life/AD&D – Spouse \$ _____	<input type="checkbox"/> Dependent Voluntary Life/AD&D – Spouse \$ _____
<input type="checkbox"/> Dependent Basic Life/AD&D – Child(ren)	<input type="checkbox"/> Dependent Supplemental Life/AD&D – Child(ren) \$ _____	<input type="checkbox"/> Dependent Voluntary Life/AD&D – Child(ren) \$ _____

<input type="checkbox"/> Retiree Basic Life/AD&D	<input type="checkbox"/> Retiree Supplemental Life/AD&D \$ _____	<input type="checkbox"/> Retiree Voluntary Life/AD&D \$ _____
<input type="checkbox"/> Critical Illness Rider <input type="checkbox"/> Employee only <input type="checkbox"/> Employee + family		

EMPLOYEE COVERAGE AUTHORIZATION

By signing this Enrollment form, I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium for my insurance in effect.
- 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.
- No person, except an officer of Madison National Life Insurance Company, Inc., is authorized to vary or modify a contract.
- I have received and read the Fraud Warning page of this enrollment form.

Employee/Applicant Signature

Date

EMPLOYEE WAIVER OF INSURANCE

I have been given the opportunity to apply for the group insurance plan coverage as presented to me, but do NOT wish to enroll in the insurance plans offered. Coverage not elected in the Insurance Coverage Election portion of this form is assumed to be coverage that I have refused.

I understand that if my dependents or I decide to apply for this group insurance plan at a later date, Evidence of Insurability will be required at my own expense. The Evidence of Insurability must be approved by Madison National Life Insurance company, Inc.

Employee Signature

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.