MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Return To: 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • Phone: 1-800-356-9601

APPLICATION FOR PORTABLE GROUP TERM LIFE INSURANCE

INSURED INFORMATION

Name: (Last, First, MI)	**Date of Birth:** / /	☐ **Female** ☐ **Male**	☐ **Single** ☐ **Married**
Social Security No.	**U.S. Citizen?** ☐ **Yes** ☐ **No** If you are not a United States citizen, please attach a copy of your Visa.		
Street Address, City, State, Zip Code:			

Beneficiaries: * (If you are married, a primary beneficiary designation of someone other than your spouse may not be effective under your state law. Please consult with your legal advisor before making such a designation.)

☐ **Primary** ☐ **Secondary**	**Name** (Last, First, Middle)	**Relationship:**	**Percent of Benefit:** %
☐ **Primary** ☐ **Secondary**	**Name** (Last, First, Middle)	**Relationship:**	**Percent of Benefit:** %
☐ **Primary** ☐ **Secondary**	**Name** (Last, First, Middle)	**Relationship:**	**Percent of Benefit:** %

*** Spouse's Signature**	**Signature Date**

COVERAGE ELECTIONS

Dependent Coverage: (if applicable)
Any dependents covered under your prior group term life insurance with Us, immediately preceding the requested effective date of this coverage, may elect this coverage. Please complete the following information:

Dependent Names	***Full-Time Student?***		**Birth Date**	**Social Security No.**	**U.S. Citizen?**
		Spouse			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*

**If a Dependent is not a United States citizen, please attach a copy of his/her Visa.*

Please list the benefit amount(s) you wish to port, as applicable:

Insured:	**Spouse**	**Child**	**Family**
$	**$**	**$**	**$**

The amount must be less than or equal or the benefit amount each Insured Person had under the prior group term life insurance with Us, immediately preceding the requested effective date of this coverage.

Please check below the applicable insurance coverage(s) you are electing. You can only port some or all of the insurance coverages each Insured Person actually had under the prior group term life insurance with Us, immediately preceding the requested effective date of this coverage.

☐ **Basic Life,** ☐ **Basic Life and AD&D,** ☐ **Supplemental Life,** ☐ **Supplemental Life and AD&D**

FOR INSURER USE ONLY:		
Notes:		
Date Received:	**Effective Date of Coverage:**	**Plan No.**

THIRD-PARTY NOTICE REQUEST

As an Applicant for this portable coverage, you have the right to designate another person to receive correspondence in the event any past due premiums could cause a possible termination of this coverage. This person is known as a "third party" and this person would not receive regular premium billings or other insurance correspondence.

Would you like to designate a third-party to receive notice if this coverage is going to terminate due to nonpayment of premium? ☐ Yes ☐ No If "Yes, please complete the following:

Name of Designee *(First, Middle, Last)*:

Address of Designee:

INSURED COVERAGE AUTHORIZATION

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim 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.

By signing this Application I understand and agree that:

- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Madison National Life Insurance Company, Inc. will bill me directly for any premiums owed.
- 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, is authorized to vary or modify a contract.

Applicant Signature	**Date**

EMPLOYER AUTHORIZATION OF EMPLOYEE ELIGIBILITY

EMPLOYER: Please complete the following information about your employee and his/her coverage.

Employer's Name:	**Group Plan No.**

EMPLOYEE'S EMPLOYMENT AND COVERAGE INFORMATION

Date of Hire:	**Effective Date of Coverage:**	**Date of Termination:**

Date Insurance Coverage Will End *(including extension, if applicable)***:**	**Reason for Termination:**

AMOUNT OF (PORTABLE LFIE) ELIGIBLE COVERAGE CURRENTLY IN-FORCE:

Insured: **$**	**Spouse** **$**	**Child** **$**	**Family** **$**

Date Portability Coverage Information Was Given to Employee:

Name of Employer Representative completing this section:	**Title of Employer Representative:**

Telephone No.	**Fax No.**	**Email Address:**

Employer Representative Signature	**Date**