MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 Mailing: North American Benefits Company (NABCO) 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es):	□ Life: \$		Reason for Apply	ing: □Nev	w Hire 🛛 Late Enrollee	
□ Life/AD&D	□ Supp. Life:\$ _		_ □ Increase in Cove	erage amoun	t 🗆 Reinstatement	
Long Term Disability	□ AD&D:\$		□ Adding Depende	ent(s) \Box Ap	plying for coverage over GI	
□ Short Term Disability	□ AD&D:\$		□ Other:			
		APPLICANT INF	ORMATION			
Applicant's Name: Last, First, MI			Sex:	Age:	Date of Birth:	
			$\Box M \Box F$		/ /	
Height:	Weight: Applicant's Soci		Applicant's Social Sec	curity No.	Already Enrolled?	
					🗆 Yes 🗆 No	
Applicant's Home Address: (Street, City, State, Zip)				Applicant's Daytime Phone No.		
				()	
Applicant's Current Physician's Name: D			Date Last Visited:	Reason for Visit:		
			/ /			
Physician's Address: (Street, City, State, Zip)				Physician's Phone No.		
•	••••••					
Employee Member Name: (if different than Applicant) Employee's Job			Employee's Job Title:	:		
		• <i>`</i>				
Employee's Date of Hire: No. of		o. of Hours Employee	f Hours Employee Works Per Week:		Employee's Annual Salary:	
		I V		\$	· ·	
Employer Name:	•	Employer's Addro	ess: (Street, City, State, 2	Zip)		
1 0				1 /		

HEALTH QUESTIONS Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below. I. Are you currently pregnant?				
II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?				
A. HEART D. PAIN & DISCOMFORT				
1. Heart ailment?	\Box Yes \Box No	1. Arthritis, bursitis or gout?	\Box Yes \Box No	
2. Chest pain, angina or shortness of breath?	\Box Yes \Box No	2. Recurrent back pain or slipped disk?	🗆 Yes 🗆 No	
3. Irregular heart beat or heart murmur?	\Box Yes \Box No	3. Disorder of the back, neck or spine?	\Box Yes \Box No	
4. Rheumatic fever?	\Box Yes \Box No	4. Disorder of the muscles, bones or joints?	\Box Yes \Box No	
5. Disease or abnormality of heart muscle, nerves or		5. Temporomandibular joint (TMJ) Disorder?	\Box Yes \Box No	
vessels?	\Box Yes \Box No			
6. Stress test; electrocardiogram or echocardiogram?		6. Recurrent abdominal pain?	\Box Yes \Box No	
B. TUMORS/CYSTS		E. OTHER		
1. Cancer of any type?	\Box Yes \Box No	1. Stroke, seizure disorder or epilepsy?	\Box Yes \Box No	
2. Tumors, cysts, or polyps?	\Box Yes \Box No	2. Migraine or persistent headaches?	\Box Yes \Box No	
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	\Box Yes \Box No	
1. High or low blood pressure or hypertension?	\Box Yes \Box No	4. Dizziness or paralysis?	\Box Yes \Box No	
2. Venereal disease, syphilis, gonorrhea, genital warts or		5. Asthma, emphysema, breathing or lung		
genital herpes?	\Box Yes \Box No	disorder?	\Box Yes \Box No	
3. Disorder of kidneys or bladder or kidney stones?		6. Indigestion, ulcers or irritable bowel?	\Box Yes \Box No	
4. Diabetes, high or low blood sugar?		7. Chronic fatigue?	\Box Yes \Box No	
5. Protein, blood or sugar in urine?	\Box Yes \Box No	8. Acquired Immune Deficiency Syndrome		
		(AIDS)?	\Box Yes \Box No	
6. Night sweats, persistent swollen glands or diarrhea?	\Box Yes \Box No	9. Aids Related Complex (ARC)?	\Box Yes \Box No	
		10. Human Immunodeficiency Virus (HIV)?	\Box Yes \Box No	

HEALTH QUESTIONS continued Check all applicable disorders and give details below.				
III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:				
A. Brain or nervous system?	\Box Yes \Box No	D. Prostate, ovaries or uterus?	\Box Yes \Box No	
B. Eyes, ears, nose or throat?	\Box Yes \Box No	E. Stomach, intestine, gallbladder or liver?	\Box Yes \Box No	
C. Skin or lymph nodes?	\Box Yes \Box No	F. Thyroid, spleen or any gland?	\Box Yes \Box No	
IV. In the past 5 years, have you:				
A. Sought or received advice for the use of alcohol or		C. Been treated or evaluated in a hospital or		
other chemicals or drugs?	\Box Yes \Box No	medical or psychiatric facility?		
B. Scheduled or undergone any surgery?	\Box Yes \Box No	D. Sustained illness requiring medical care or		
		hospitalization?	\Box Yes \Box No	
V. In the last 12 months, have you used tobacco of any kind? Ves No				
VI. Please list all prescribed and non-prescribed medications you currently take:				
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If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

WARNING: Any person who knowingly makes a false or fraudulent statement or representation in or relative to an application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdemeanor.

Applicant's Signature	Date
Parent/Guardian Signature (for Dependent enrollees under age 18)	Date

FOR INSURER USE ONLY:	Decision: Approved	Postponed Declined	Effective Date:
Underwriter's Signature:			Date: