

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Prostate, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Stomach, intestine, gallbladder or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Skin or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	F. Thyroid, spleen or any gland?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Scheduled or undergone any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Sustained illness requiring medical care or hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No

V. In the last 12 months, have you used tobacco of any kind? Yes No

VI. Please list all prescribed and non-prescribed medications you currently take:

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: <input type="checkbox"/> Approved <input type="checkbox"/> Postponed <input type="checkbox"/> Declined	Effective Date:	
Underwriter's Signature:		Date:	