MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717 • 1-800-356-9601
Administered By: North American Benefits Company • 20 Valley Stream Parkway, Suite 310, Malvern, PA 19355

Evidence of Insurability Form
Group Insurance

Insurance being applied for:	**Reason for applying:**
☐ Long Term Disability $ _____	☐ Increase in Insurance Amount
☐ Short Term Disability $ _____	☐ Applying for Increase over Guarantee Issue Amount
	☐ Late Enrollee
	☐ Other (specify):

Name of Group Policyholder	**Group No.**

CAUTION: Any misstated or untrue answers may give Madison National Life Insurance Co., Inc. the right to deny benefits or rescind insurance.

Applicant Information

Applicant Name *(Last, First, Middle)*		**Social Security No.**	
Street Address *(Street, City, State)*			
County		**Phone No.**	**Date of Birth**
Height:	**Weight:**	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married

U.S. Citizen ☐ Yes ☐ No *(additional information may be requested)*

- If "No", name the Country of Citizenship:

Hours Worked per Week	**Weekly Salary**	**Class**

Health Questions

The terms "diagnosed" and "treated" mean any diagnosis or treatment received by a member of the medical profession. Please answer "Yes" or "No" to the following questions.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

In the last 5 years has the Applicant been diagnosed with, received treatment or prescribed medication by a medical professional for:

1	a heart attack or aortic or heart valve surgery, angioplasty or coronary artery bypass?	Yes	No
2	chest pain or heart disease including angina, irregular heart beat and heart murmur?	Yes	No
3	shortness of breath, Rheumatic fever or disease or abnormality of heart muscle or vessels?	Yes	No
4	stress test, electrocardiogram or echocardiogram?	Yes	No
5	Cancer (of any type)?	Yes	No
6	Tumor, cyst, polyp or nodule?	Yes	No
7	high or low blood pressure or hypertension?	Yes	No

Health Questions *continued…*

The terms "diagnosed" and "treated" mean any diagnosis or treatment received by a member of the medical profession. Please answer "Yes" or "No" to the following questions.

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

In the last 5 years has the Applicant been diagnosed with, received treatment or prescribed medication by a medical professional for:

8	diabetes or high or low sugar?	Yes	No
9	complications due to diabetes, including nephropathy, neuropathy, or retinopathy?	Yes	No
10	protein, blood or sugar in urine?	Yes	No
11	any disorder of the respiratory system?	Yes	No
12	any disorder or disease of the stomach, liver, intestines, gallbladder rectum, pancreas or abdominal organs?	Yes	No
13	recurrent abdominal pain?	Yes	No
14	any disorder or disease of the blood, skin, thyroid, lymph or other glands?	Yes	No
15	kidney or bladder disorder, kidney stones or kidney disease?	Yes	No
16	night sweats, persistent swollen glands or diarrhea?	Yes	No
17	arthritis, bursitis or gout?	Yes	No
18	disorder of the muscles, bones or joints?	Yes	No
19	disorder of the back, neck or spine, or recurrent back pain or slipped disk?	Yes	No
20	Temporomandibular joint (TMJ) Disorder?	Yes	No
21	stroke, seizure disorder or epilepsy?	Yes	No
22	migraine or persistent headaches?	Yes	No
23	mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome?	Yes	No
24	dizziness or paralysis?	Yes	No
25	asthma, emphysema, breathing or lung disorder?	Yes	No
26	indigestion, ulcers or irritable bowel?	Yes	No
27	chronic fatigue or fibromyalgia?	Yes	No
28	disorder of the brain or nervous system?	Yes	No
29	disorder of the eyes, ears, nose or throat?	Yes	No
30	disorder of the prostate, ovaries or uterus?	Yes	No
31	alcohol or drug abuse or used narcotics, barbiturates, amphetamines, hallucinogens, heroin, cocaine, or other habit forming drugs, except as prescribed by a physician?	Yes	No

In the last 5 years has the Applicant:

32	scheduled or undergone any surgery or told , by a medical professional, surgery was needed?	Yes	No
33	been treated or evaluated in a hospital or medical or psychiatric facility?	Yes	No
34	sustained an illness requiring medical care or hospitalization?	Yes	No
35	had an application or reinstatement application postponed or declined?	Yes	No
36	**In the last 12 months, has the Applicant** used tobacco of any kind?	Yes	No
37	**Has the Applicant ever been** diagnosed, treated, or prescribed medication, by a licensed member of the medical profession, for Acquire Immune Deficiency Syndrome (AIDS)?	Yes	No

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For any "Yes" answer in the "Health Questions" section, please list the information here (use additional paper if necessary)**:**

Condition	**Results, Detail**
Dates Consulted	**Physician or Medical Facility Name and Address**
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Condition	**Results, Detail**
Dates Consulted	**Physician or Medical Facility Name and Address**

Please list all prescribed and non-prescribed medications the Applicant currently takes:

Applicant Agreement

By signing this Form, I understand and agree that:

- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Insurance is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- I can obtain any Certificate(s) of Insurance and other forms from the Group Policyholder or 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 understand that if I choose to sign this Application electronically or telephonically, I also have the right to withdraw my authorization to use my electronic or voice signature.
- **I have completed and signed the authorization for release of medical information**.

WARNING: The falsity of any statement in the application for any Policy shall not bar the right to recovery under the Policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the Insurer.

Applicant Signature	**Date of Signature**