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 Applying:** New Hire Late Enrollee
Life/AD&D	Supp. Life:$ _____	Increase in Coverage amount Reinstatement
Long Term Disability	AD&D:$ _____	Adding Dependent(s) Applying for coverage over GI
Short Term Disability	AD&D:$	Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** M F	**Age:**	**Date of Birth:** / /

Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** Yes No

Applicant's Home Address: (Street, City, State, Zip)	**Applicant's Daytime Phone No.** ( )

Applicant's Current Physician's Name:	**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 Title:**

Employee's Date of Hire:	**No. of Hours Employee Works Per Week:**	**Employee's Annual Salary:** $

Employer Name:	**Employer's Address:** (Street, City, State, Zip)

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? Yes No **If "Yes", what is your expected due date:**

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?	Yes	No	1. Arthritis, bursitis or gout?	Yes	No
2. Chest pain, angina or shortness of breath?	Yes	No	2. Recurrent back pain or slipped disk?	Yes	No
3. Irregular heart beat or heart murmur?	Yes	No	3. Disorder of the back, neck or spine?	Yes	No
4. Rheumatic fever?	Yes	No	4. Disorder of the muscles, bones or joints?	Yes	No
5. Disease or abnormality of heart muscle, nerves or vessels?	Yes	No	5. Temporomandibular joint (TMJ) Disorder?	Yes	No
6. Stress test; electrocardiogram or echocardiogram?	Yes	No	6. Recurrent abdominal pain?	Yes	No
B. TUMORS/CYSTS			**E. OTHER**		
1. Cancer of any type?	Yes	No	1. Stroke, seizure disorder or epilepsy?	Yes	No
2. Tumors, cysts, or polyps?	Yes	No	2. Migraine or persistent headaches?	Yes	No
C. BLOOD AND URINE			3. Nervous/mental disorder, depression or anxiety?	Yes	No
1. High or low blood pressure or hypertension?	Yes	No	4. Dizziness or paralysis?	Yes	No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	Yes	No	5. Asthma, emphysema, breathing or lung disorder?	Yes	No
3. Disorder of kidneys or bladder or kidney stones?	Yes	No	6. Indigestion, ulcers or irritable bowel?	Yes	No
4. Diabetes, high or low blood sugar?	Yes	No	7. Chronic fatigue?	Yes	No
5. Protein, blood or sugar in urine?	Yes	No	8. Acquired Immune Deficiency Syndrome (AIDS)?	Yes	No
6. Night sweats, persistent swollen glands or diarrhea?	Yes	No	9. Aids Related Complex (ARC)?	Yes	No
			10. Human Immunodeficiency Virus (HIV)?	Yes	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?	Yes	No	D. Prostate, ovaries or uterus?	Yes	No
B. Eyes, ears, nose or throat?	Yes	No	E. Stomach, intestine, gallbladder or liver?	Yes	No
C. Skin or lymph nodes?	Yes	No	F. Thyroid, spleen or any gland?	Yes	No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	Yes	No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	Yes	No
B. Scheduled or undergone any surgery?	Yes	No	D. Sustained illness requiring medical care or hospitalization?	Yes	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 agree to 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, [Medical Information Bureau, Inc.,] 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. [I have read the separate notice enclosed with this form pertaining to the Medical Information Bureau as required by the Fair Credit Reporting Act.]

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.

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: