Supplemental Life and AD&D Insurance

Make Your Loved Ones Top Priority Today

What is Supplemental Life Insurance?

Supplemental Life Insurance allows you to choose additional Life Insurance coverage at group rates. The premium payment for this coverage is paid through convenient deductions from your paycheck.

What is Supplemental AD&D Insurance?

Accidents happen. With AD&D Insurance - Accidental Death and Dismemberment Insurance - you are covered. If you were to suffer a covered loss of life, limb, hands, feet or eyes as a result of an accident, this policy will pay a benefit to you or your beneficiary.

What is Dependent Life Insurance?

Your Supplemental Life Insurance plan may include an option to choose Dependent Life Insurance for your spouse and/or children, and is usually very affordable. If something unexpected happens, this plan can help cover funeral, or end of life expenses; the last thing you want to worry about during a difficult time.

Can You Afford Extra Coverage?

With this offer, you can take advantage of affordable group rates, rather than relying upon individual insurance which may be more expensive. Your employer is looking out for you and your family. They have made the decision to offer this Supplemental Insurance coverage so that you can protect your loved ones at a reasonable cost.

How Much Life Insurance Coverage Do You Need?

According to U.S. News & World Report's website, common wisdom holds that you should plan on having seven to ten times your annual income as a starting point for Life Insurance.[1] To estimate your personal needs, you can use an online calculator at www.lifehappens.org.

What Age Should You Think About Buying Additional Life Insurance?

Most people know that those with a family and/or a mortgage need Life Insurance. However, many believe that unmarried young people who have no dependents or mortgage do not need Life Insurance. The reality is that when people die young, the surviving family may be unprepared for the shock. A Life Insurance policy may ease tension during that time by helping with unexpected expenses such as funeral fees, debts or medical bills not covered by insurance.

Are There Any Medical Questions or Tests Needed to Qualify for Supplemental Life Insurance?

Individual Life Insurance carriers often require medical questions, blood tests or a visit with a nurse or physician. With group insurance, the insurance company's risk is lower because it is based on the claims history of the entire group, rather than your personal health history. Therefore, the insurance

(over)

[1]U.S. News & World Report Feb.2012, www.money/usnews.com

This brochure is not the insurance contract. It is a brief description of Life and AD&D Insurance.

company is often able to offer a period of time where you can purchase Supplemental Life and AD&D Insurance without medical questions or tests. Certain conditions may apply.

When Will Coverage End?

Coverage usually ends at retirement, a specified age or if you enter the armed forces on a full time basis. Also, the amount of the benefit usually decreases as you age. Both of these will be identified in your certificate of coverage. If your employment ends for a reason other than retirement, some policies contain a portability arrangement that allows you to choose to take the Life Insurance coverage with you. Restrictions apply, premiums and fees may be higher and you must apply for coverage and pay the first premium payment within a specified period of time following termination. Note: AD&D Insurance is usually not portable.

How is the Life Insurance Paid to My Loved Ones?

Your beneficiary fills out a Life Insurance claim form and submits it along with other documentation, including an original or certified copy of the death certificate. After approval, they will receive the funds usually in one lump sum from the insurance carrier. Note that the employee is the beneficiary for any Dependent Life coverage.

A Few Reasons Why You May Need Additional Life Insurance:

Single person with no dependents:
- Funeral expenses
- Medical bills
- Elderly parents you may support
- Debts (credit cards, student loans)

Single person with dependents:
- Funeral expenses
- Medical bills
- Debts (car, mortgage)
- Childcare/Caretaker fees
- Health Insurance payment
- Elderly parents you may support
- Education costs

Couple with no dependents:
- Funeral expenses
- Medical bills
- Elderly parents you may support
- Debts (mortgage, car)

Couple with dependents:
- Funeral expenses
- Medical bills
- Debts (mortgage, car)
- Child-rearing expenses
- Health Insurance payment
- Elderly parents you may support
- Education costs

Older couple:
- Funeral expenses
- Medical bills
- Estate taxes
- Income for surviving spouse
- Debts (home, vacation home, recreational vehicle)
- Health Insurance payment
- Assets for children or grandchildren

NATIONAL INSURANCE SERVICES
Corporate office: 250 South Executive Drive, Suite 300
Brookfield, WI 53005
800.627.3660 | www.NISBenefits.com

Insurance Benefit Enrollment Form

Return to: National Insurance Services, Attn: Billing Department
250 S. Executive Drive, Suite 300 Brookfield, WI 53005-4273
Phone 1.800.627.3660 Fax 262.785.9269

NATIONAL INSURANCE SERVICES

Enter your information:

Employer Name: **City of Willmar**			NIS Group Number: **027027**	
Full Name (Last name, First name, Middle Initial):			Date of Hire:	
Home Address:		City:	State:	Zip:
Social Security Number:	☐ Single ☐ Married	U.S. Citizen? ☐ Yes ☐ No*	Date of Birth:	☐ Male ☐ Female
Occupation/Title:			Hours worked per week:	Annual Salary:

*If you are not a U.S. Citizen, please provide a copy of your Visa.

Insurance benefits:

Employer-Provided Insurance Benefits:

☒ Basic Life and AD&D ☒ Long-Term Disability (must be disabled 90 consecutive calendar days before disability benefits begin)

Optional Insurance Benefits:

☐ Elect	☐ Decline	Supplemental Life and AD&D **Employees not Currently Enrolled:** Supplemental Life and AD&D Amount $_____ You may elect coverage in $10,000 increments to a maximum of $300,000, not to exceed 5 times annual salary. Election Amounts in excess of $150,000 for employees under age 70; $20,000 for employees ages 70 to 74; $0 for employees age 70 and over will require the completion of the attached Evidence of Insurability form.
☐ Elect	☐ Decline	Supplemental Life and AD&D **Employees Currently Enrolled:** Supplemental Life and AD&D Amount $_____You may elect coverage in $10,000 increments to an additional $20,000 without completing evidence of insurability (EOI); however the combined supplemental amount in force plus additional election is subject to a coverage amount of $150,000, any combined amounts in excess of $150,000 will require completion of the attached Evidence of Insurability form. If you are currently enrolled and elect to add more than $20,000 we will also require completion of the attached Evidence of Insurability form.
☐ Elect	☐ Decline	Spouse Supplemental Life and AD&D Amount $_____ You may elect coverage in $5,000 increments to a maximum of $50,000, not to exceed 50% of the employee's amount. Spouse election Amounts of Supplemental Life Coverage in excess of $25,000 for Spouses under age 60; $0 for Spouses age 60 and over will require completion of the attached Evidence of Insurability form.

Supplemental Life Rates (Employee & Spouse)

Age	Rate per $1,000	Age	Rate per $1,000
0-29	$0.05	55-59	$0.51
30-34	$0.08	60-64	$0.68
35-39	$0.09	65-69	$1.28
40-44	$0.12	70-74	$2.06
45-49	$0.20	75-79	$3.56
50-54	$0.30	80-99	$5.37

Supplemental Coverage Amount $_____ x _____ / 1,000 = $_____
(Coverage Amount) (Rate) (Monthly Premium)

☐ Elect	☐ Decline	Dependent Life Infant Supplemental Life (14 days to 6 months) $250 Child Supplemental Life (6 months to 19 years, or 25 years if a full-time student) $10,000 The cost is a $1.30 flat rate, regardless of the number of children in the family

More on other side ----------→

Full Name:	Employer Name: **City of Willmar**	Date:

Optional Insurance Benefits:

☐ Elect ☐ Decline

Short-Term Disability Amount $_____ You may elect coverage in $100 increments to a maximum of $1,500, with a minimum election of $100

Election Amount cannot exceed 60% of annual salary divided by 52:

_____ / 52 = _____ x 60% = _____

(Annual Salary) (Weekly Salary) (Maximum Weekly Benefit – must round down to nearest $100)

TO CALCULATE YOUR PREMIUM:

_____ x _____ / 10 = _____

(My weekly Benefit Election) (Rate) (My Monthly Premium)

Short-Term Disability Rates

Age	Rate per $10 of Weekly Benefit	Age	Rate per $10 of Weekly Benefit
0-24	$0.45	45-49	$0.82
25-29	$0.99	50-54	$0.93
30-34	$0.55	55-59	$1.32
35-39	$0.59	60-64	$1.62
40-44	$0.63	65+	$1.78

Sign here (required whether electing or declining any coverage):

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective.

Warning: Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

I**nstructions for the employee:** Complete and return this form to your Benefits Administrator.

Instructions for the Benefits Administrator: Retain a copy of this form for your records and provide employee with a copy. Mail original to National Insurance Services at the address above.

More on next page ----------→

Full Name:	Employer Name: **City of Willmar**	Date:

Enter your Life Insurance beneficiary information:

Primary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Secondary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit

Spouse's Signature (May be required if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation.)		
Spouse's Name:	Signature:	Date:

Add spouse/dependent information:

Please provide the following information if electing Dependent Coverage**.** Attach additional pages if necessary.

Full Name	**Date of Birth**	**Social Security #**	**Full-Time Student?**
Spouse:			n/a
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No
Child:			☐ Yes ☐ No

Sign here:

Signature:	Date:

Please note: Please fill out the attached "Evidence of Insurability" medical questionnaire form ONLY if any of the following applies to you:

Employees Not Currently Enrolled in Supplemental Life:

- **Election Amounts in excess of $150,000 for employees under age 70**
- **Election Amounts in excess of $20,000 for employees ages 70-74**
- **Election Amounts in excess of $0 for employees age 70 and over**

Employees that are Currently Enrolled in Supplemental Life:

- **Any Combined (new & existing) election amounts in excess of $150,000**
- **Election Amounts in excess of $20,000**

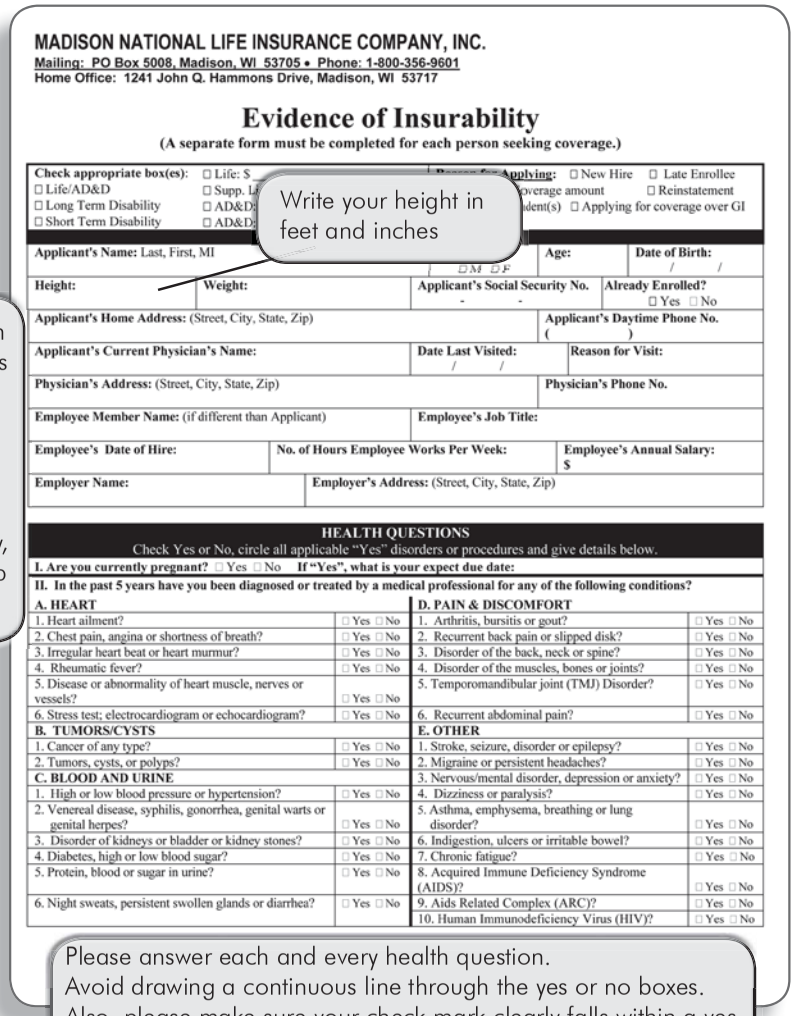
Spouse Supplemental Life:

- **Election Amounts in excess of $25,000 for Spouses under age 60**
- **Election Amounts in excess of $0 for Spouses age 60 and over**

All prior declines are subject to Evidence of Insurability

Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. Please use **blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. **If you are requesting coverage for family members, complete an additional form for each person.**



MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

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

Check appropriate box(es): ☐ Life: $ ☐ Life/AD&D ☐ Supp. La ☐ Long Term Disability ☐ AD&D ☐ Short Term Disability ☐ AD&D — Applying: ☐ New Hire ☐ Late Enrollee ☐ Reinstatement — overage amount — dent(s) ☐ Applying for coverage over GI

Applicant's Name: Last, First, MI | 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 expect due date:

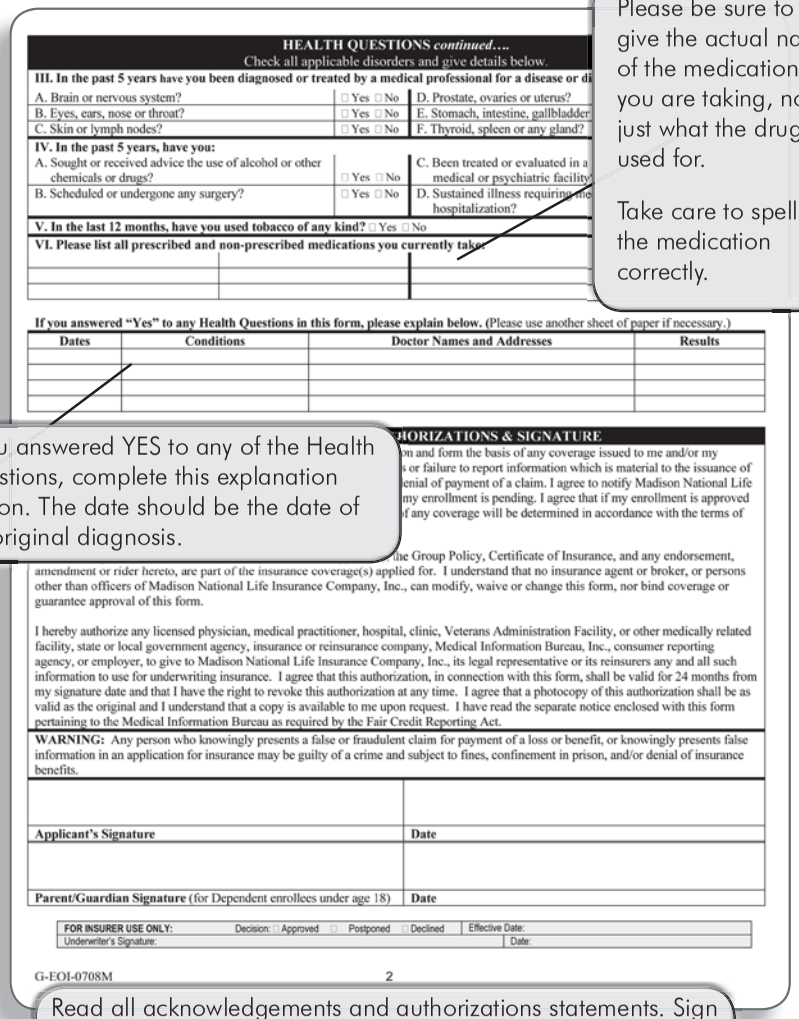
II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

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

Write your height in feet and inches

Provide both your address and your physician's address completely, including address, city, state and zip code.

Please answer each and every health question.
Avoid drawing a continuous line through the yes or no boxes.
Also, please make sure your check mark clearly falls within a yes or no box.



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 di

A. Brain or nervous system?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder	
C. Skin or lymph nodes?	☐ Yes ☐ No	F. Thyroid, spleen or any gland?	

IV. In the past 5 years, have you:

A. Sought or received advice the use of alcohol or other chemicals or drugs?	☐ Yes ☐ No	C. Been treated or evaluated in a medical or psychiatric facility?	
B. Scheduled or undergone any surgery?	☐ Yes ☐ No	D. Sustained illness requiring hospitalization?	

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

If you answered YES to any of the Health Questions, complete this explanation section. The date should be the date of the original diagnosis.

Please be sure to give the actual name of the medication you are taking, not just what the drug is used for.

Take care to spell the medication correctly.

HORIZATIONS & SIGNATURE

…on and form the basis of any coverage issued to me and/or my …s or failure to report information which is material to the issuance of …enial of payment of a claim. I agree to notify Madison National Life …my enrollment is pending. I agree that if my enrollment is approved …f any coverage will be determined in accordance with the terms of …

…he 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, 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 presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

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:

G-EOI-0708M 2

Read all acknowledgements and authorizations statements. Sign and date the application. Please remember – each individual should sign his or her application, however the employee needs to sign on behalf of a minor dependent child.

If you have any questions when you complete this form please feel free to contact Pauline Gayle at National Insurance Services at 800-627-3660 ext 1263 between the hours of 8 am and 5 pm central time, Monday through Friday.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.
Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
National Insurance Services
250 South Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attention: Billing Department

Evidence of Insurability

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

Check appropriate box(es):		**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 understand that if my coverage includes AD&D insurance, the AD&D coverage may have a War exclusion for benefits.

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 is available to me upon request. I understand this information collected may, in certain circumstances, be disclosed to third parties with this authorization. I also understand I have the right to see my personal records and correct personal information collected.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

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: