Why Take a Chance When You Can Make a Choice?
Protect Your Future Today with NIS Options Voluntary Insurance Plans
Basic-Plus Life Insurance Plan
Dependent Life Insurance (Family Unit Plan). Covers your Spouse and Dependent(s) only.

When to Choose This Option:
You may choose to purchase this minimal plan as an add-on to the mandatory Basic Life and AD&D Insurance plan if you would like to add coverage for your spouse and child/ren. If you want more coverage, choose the Supplemental Life Insurance plan instead or choose both plans.

What It Is:
Simple, basic Life Insurance plan that pays a flat cash amount to you in the event of the death of your spouse or child.

Coverage Choices:
• Plan 1: $2,000 Spouse and $2,000 Child
• Plan 2: $5,000 Spouse and $2,500 Child

End of Coverage:
When employee’s coverage ends.

Medical Questionnaire:
• Plan 1: Not required during initial open enrollment or within 30 days of eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.
• Plan 2: Required. If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts.

¹Children ages 14 days to age 19 (or 25 if a full-time student)
Optimum Life Insurance Plan
Optional Life and AD&D Insurance for you and Optional Life Insurance for your Dependents

When to Choose This Option:
If you would like to add more coverage than is offered in the mandatory Basic Life and AD&D Insurance and Dependent Life Insurance (Family Unit) plans, choose this premium plan.

What It Is:
Supplemental Life Insurance allows you to choose additional Life Insurance coverage at group rates for yourself, your spouse and/or your child/ren.

Coverage Choices:
- **Employee Life and AD&D Insurance:** Choose coverage in $1,000 increments, not to exceed five times your annual salary. Minimum: $5,000. Maximum: $300,000.
- **Spousal Life Insurance (No AD&D):** Choose up to 50% of your elected coverage, not to exceed $150,000.
- **Child/ren Life Insurance (No AD&D)¹:** Choose up to 25% of your elected coverage, not to exceed $20,000.

End of Coverage:
Coverage reduces based on age and terminates at retirement.

Medical Questionnaire:
Required.² If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts.

¹Children ages 14 days to age 19 (or 25 if a full-time student)
²Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details. Subject to plan maximums.
Disability Insurance Options

Many people think the chances of a disabling illness or accident are slim, but statistics show that 1 in 3 employees entering the workforce today will need to use their disability benefits before they reach retirement.¹

And illnesses such as arthritis and heart conditions are the culprit more often than accidents. If you couldn’t work, how would you pay the mortgage, buy food or pay bills?

Protect your income today by enrolling in your Short and Long-Term Disability Insurance Options plan.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Benefit Duration</th>
<th>Minimum Coverage</th>
<th>Maximum Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short-Term Income Insurance Protection Plan A</td>
<td>52 weeks*</td>
<td>$20 per week</td>
<td>$1,200, or a percentage of your salary, per week</td>
</tr>
<tr>
<td>Short-Term Disability Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short-Term Income Insurance Protection Plan B</td>
<td>Coordinated to end when your employer-paid Long-Term Disability benefits begin</td>
<td>66.67% of salary</td>
<td>$1,200 per week</td>
</tr>
<tr>
<td>Coordinated Short-Term Disability Insurance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Plus an additional 52 weeks at half the elected benefit amount if employee is confined to a hospital and not covered under any Long-Term Disability plan.

¹Source: Social Security Administration Website, www.ssa.gov/pubs/10029.html
When to Choose This Option:
If your employer does not provide Short-Term Disability Insurance, this plan is for you. If you have enough savings or accumulated sick leave pay to stay afloat without your income for about a year, then you do not need this coverage.

Coverage Choices:
Choose your coverage amount in $10 increments, subject to a maximum based on your annual wages (see rate sheet to calculate maximum) or $1,200/week, whichever amount is lower.

Also choose the wait time before benefits begin (Elimination Period):
- **7-Day Wait**: Benefits start immediately if accident, after seven days if illness.
- **28-Day Wait**: Benefits start immediately if accident, after 28 days if illness.

Benefit Duration:
Benefits continue for 52 weeks (plus an additional 52 weeks at half the benefit amount if you are confined to a hospital and not covered under any Long-Term Disability plan).

Medical Questionnaire:
Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.¹

¹Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current coverage amounts. See your HR department for details.
Short-Term Income Insurance Protection Plan B
Coordinated Short-Term Disability Insurance

When to Choose This Option:
If your employer provides an employer-paid Long-Term Disability Insurance plan, this plan will cover you from the time that you are out of work due to a covered accident, or 15 days after the start of a covered illness, until the time your Long-Term Disability Insurance payments begin. If you have enough savings or accumulated sick leave pay to stay afloat without your income for 60-180 days, then you do not need this coverage.

Coverage Choices:
The coverage amount is set at 66.67% of your weekly salary, not to exceed $1,200/week.

Benefit Duration:
Benefits continue until your employer-paid Long-Term Disability Insurance benefits begin. 60, 90, 120 or 180-day plans are available.

Medical Questionnaire:
Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.¹

If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current coverage amounts.

¹Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details.
When to Choose This Option:
If you are not covered by Long-Term Disability Insurance, this plan is for you.

Coverage Choices:
Choose the coverage amount in $100 increments, not to exceed 60% of your salary. Also choose a benefit duration of five years\(^1\) or until age 70.

Benefit Duration:
Benefits begin after 52 weeks or at the end of your Short-Term Disability Insurance plan, whichever is later. Benefits continue for five years\(^1\) or until age 70 based on your choice of plan.

Medical Questionnaire:
Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.\(^2\)

If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts.

\(^1\)May be less than five years depending upon your age at the onset of a covered disability.

\(^2\)Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details.
**Life Insurance Limitations**

**Age Reductions and Plan Termination:**
Basic Life and AD&D Insurance and Dependent Life Insurance (Family Unit Plan) benefits do not reduce due to age. Early retirees may continue coverage until age 65 if elected by the employer. With the Optional Life/AD&D for Employees and Dependents plan, the amount of coverage reduces 50% at age 70 and terminates at retirement.

**AD&D Insurance Exclusions**
AD&D coverage is for the employee only. Spousal and dependent Life Insurance does not include AD&D.

No AD&D Benefit is payable if the loss is caused or contributed to by any of the following:

- war, declared or undeclared, or any act of war
- intentionally self-inflicted injuries or attempted suicide, while sane or insane
- committing or attempting to commit a felony, engaging in illegal activity or actively participating in a violent disorder or riot
- any injury sustained while under the voluntary use or consumption of any poison, illegal drugs or controlled substance
- physical disease existing at the time of the accident
- medical negligence and malpractice
- bacterial infections
- while you are in the armed forces of any country or international authority
- any loss incurred while operating, riding in or descending from any aircraft, except as a fare-paying passenger on a commercial aircraft

**Disability Insurance Exclusions**
The policy does not cover any disability that is caused or contributed to by any of the following:

- war, declared or undeclared, or any act of war
- as a result of committing or attempting to commit a felony, other criminal conduct, engaging in illegal activity or actively participating in a violent disorder or riot
- while you are in the armed forces of any country or international authority
- while you are imprisoned or under house arrest
- as a result of intentionally self-inflicted injuries or
attempted suicide, while sane or insane

- as a result of an occupational disability arising out of the course of any employment for wage or profit (This applies to Short-Term Disability Insurance plans, but does not apply to the Long-Term Disability Insurance plan).

- **Pre-Existing Conditions:** Disabilities that are caused by a pre-existing condition or exist due to medical or surgical treatment of a pre-existing condition are not covered for the first 12 months, unless you have been continuously covered under a prior plan (and satisfied that plan’s pre-existing condition limitation). Pre-existing limitations also apply to increases in Disability Benefits.

**Disability Insurance Limitations**

- Payment of Disability Benefits is limited to six months if you reside outside of the United States or Canada.

- Disability Insurance benefits may not exceed 100% of pre-disability earnings.

- As with most all Disability Insurance plans, benefits are reduced by other income you may receive during a disability, including Social Security or State Retirement Disability.

- **Mental Disorders and Substance Abuse:** Disabilities related to mental or emotional illness are limited to 24 months of coverage for each period of disability. After the 24-month period, benefit payments are made only if you are still totally disabled and confined as an inpatient in a facility qualified to treat that illness. This limitation does not apply to the Short-Term Disability Insurance plans.

- **Substance Abuse:** If your disability is caused by substance abuse, you must be participating in a rehabilitative program recommended by a physician. Benefits will cease upon any of the following events (whichever comes first):
  - the maximum benefit period is achieved as stated in your certificate
  - you no longer participate in the rehabilitative program
  - you refuse to participate in an available rehabilitative program
  - you complete the rehabilitative program

The substance abuse limitation does not apply to the Short-Term Disability Insurance plans.
As a specialist in public sector employee benefits since 1969, NIS (National Insurance Services of Wisconsin, Inc.) helps employers align their unique and complex benefit challenges with the hard-to-understand language and practices of insurance and investment products.

Our expertise results in innovative benefit solutions that help:

- Use taxpayer dollars efficiently
- Build bridges between bargaining units, boards and employers
- Avoid employer liability and grievances

Madison National Life Insurance Company, Inc. is a Wisconsin Insurance company and a Member of the IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for over 25 years. For information on Independence Holding Company and the IHC Group, see independenceholding.com.
Basic-Plus Life Plan
Dependent Life Insurance (Family Unit Plan)

You may choose to purchase this minimal plan as an add-on to the Basic Life and AD&D Insurance if you would like to add coverage for your spouse and child(ren). If you want more coverage, choose the Supplemental Life Insurance plan instead or choose both plans. It is a simple, basic Life Insurance plan that pays a flat cash amount to you in the event of the death of your spouse or child. AD&D is not included with this plan.

- Plan 1: $2,000 Spouse, $2,000 Child(ren) coverage, monthly cost $1.00 per family regardless of number of children.
- Plan 2: $5,000 Spouse, $2,500 Child(ren) coverage, monthly cost $2.00 per family regardless of number of children.

Optimum Life Plan
Optional Life and AD&D Insurance for Employee and Optional Life Insurance for Dependents

If you would like to add more coverage than is offered in the Basic Life and AD&D Insurance and Dependent Life Insurance (Family Unit) plans, choose this premium plan. Supplemental Life Insurance allows you to choose additional Life Insurance coverage at group rates for yourself, your spouse and/or your child(ren).

Employee (Life and AD&D Insurance) .................................................................

Choose your coverage in $1,000 increments, not to exceed five times your annual salary. Minimum: $5,000. Maximum: $300,000.

Monthly rate per $1,000 of Life and AD&D Insurance coverage

<table>
<thead>
<tr>
<th>Age</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>$0.06</td>
</tr>
<tr>
<td>40-49</td>
<td>$0.23</td>
</tr>
<tr>
<td>50-59</td>
<td>$0.56</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.03</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.83</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.98</td>
</tr>
<tr>
<td>75+</td>
<td>$4.03</td>
</tr>
</tbody>
</table>

Calculate your monthly cost for your coverage:

\[
\text{Amount of Coverage} \div 1,000 = \text{Rate} \times \text{Monthly Cost}
\]

Spouse (Life Insurance Coverage) ..............................................................

Choose up to 50% of your elected coverage, not to exceed $150,000.

Monthly rate per $1,000 of Life Insurance coverage

<table>
<thead>
<tr>
<th>Spouse's Age</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>$0.06</td>
</tr>
<tr>
<td>40-49</td>
<td>$0.20</td>
</tr>
<tr>
<td>50-59</td>
<td>$0.55</td>
</tr>
<tr>
<td>60-64</td>
<td>$1.00</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.60</td>
</tr>
<tr>
<td>70-74</td>
<td>$2.95</td>
</tr>
<tr>
<td>75+</td>
<td>$4.00</td>
</tr>
</tbody>
</table>

Calculate your monthly cost for Spousal coverage:

\[
\text{Amount of Coverage} \div 1,000 = \text{Rate} \times \text{Monthly Cost}
\]

Child(ren) (Life Insurance Coverage) ......................................................

Choose up to 25% of your elected coverage, not to exceed $20,000.

Monthly rate $0.15 per $1,000 of Life Insurance coverage, regardless of the number of children.

Calculate your monthly cost for Child(ren) coverage:

\[
\text{Amount of Coverage} \div 1,000 \times 0.15 = \text{Rate} \times \text{Monthly Cost}
\]
### Short-Term Income Protection Plan A

**Short-Term Disability Insurance**

You may select any amount of weekly benefit from the tables below as long as your contracted annual school salary is at least as great as the amount shown in the annual salary column.

<table>
<thead>
<tr>
<th>Annual Salary</th>
<th>Weekly Benefit</th>
<th>Monthly Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,300</td>
<td>$20</td>
<td>$2.00</td>
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<tr>
<td>$1,950</td>
<td>$30</td>
<td>$3.00</td>
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<tr>
<td>$2,600</td>
<td>$40</td>
<td>$4.00</td>
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<tr>
<td>$3,250</td>
<td>$50</td>
<td>$5.00</td>
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<tr>
<td>$3,900</td>
<td>$60</td>
<td>$6.00</td>
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<tr>
<td>$4,550</td>
<td>$70</td>
<td>$7.00</td>
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<tr>
<td>$5,200</td>
<td>$80</td>
<td>$8.00</td>
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<tr>
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<td>$12.00</td>
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<tr>
<td>$8,450</td>
<td>$130</td>
<td>$13.00</td>
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<tr>
<td>$9,100</td>
<td>$140</td>
<td>$14.00</td>
</tr>
<tr>
<td>$9,750</td>
<td>$150</td>
<td>$15.00</td>
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<tr>
<td>$10,400</td>
<td>$160</td>
<td>$16.00</td>
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<tr>
<td>$11,050</td>
<td>$170</td>
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<tr>
<td>$12,350</td>
<td>$190</td>
<td>$19.00</td>
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<tr>
<td>$13,000</td>
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<tr>
<td>$13,650</td>
<td>$210</td>
<td>$21.00</td>
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<tr>
<td>$14,950</td>
<td>$230</td>
<td>$23.00</td>
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<tr>
<td>$16,250</td>
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<tr>
<td>$16,900</td>
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<tr>
<td>$17,550</td>
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<tr>
<td>$18,200</td>
<td>$280</td>
<td>$28.00</td>
</tr>
<tr>
<td>$18,850</td>
<td>$290</td>
<td>$29.00</td>
</tr>
<tr>
<td>$19,500</td>
<td>$300</td>
<td>$30.00</td>
</tr>
<tr>
<td>$20,150</td>
<td>$310</td>
<td>$31.00</td>
</tr>
</tbody>
</table>

### Short-Term Income Protection Plan B

**Coordinated Short-Term Disability Insurance**

This plan is only available if your employer provides employer-paid Long-Term Disability Insurance. The weekly benefit is 66.67% of your salary to a maximum of $1,200. The benefit duration must match your Long-Term Disability Insurance Elimination Period (two weeks when you first become disabled and benefits start).

### Calculate Your Monthly Cost:

\[
\text{Monthly Cost} = \text{Weekly Salary} \times 0.667 \times 10 \times \text{Rate (see chart)}
\]
Employee Information

Name of Employer

Name of Employee (Last, First, Middle Initial)

Home Address of Employee (Street, City, State, Zip)

Job Title

Primary Beneficiary(ies)

Name (Last, First, Middle)

Social Security #

Date of Birth

Employment Date

Job Duties

Hours Worked Per Week

Annual Salary

Warning:

Any person who 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.

Select Your Life Insurance Coverage

Basic-Plus Life Plan

Dependent Life Insurance (Family Unit Plan)

Request (Please choose one of the following options)

- Plan 1: Spouse $2,000/Child $2,000
- Plan 2: Spouse $5,000/Child $2,500

Optimum Life Plan

Optional Life and AD&D Insurance for Employee and Optional Life Insurance for Dependents

Request Employee Life and AD&D Insurance Amount: $

- Choose coverage in $1,000 increments, not to exceed five times your salary.
  - Minimum: $5,000. Maximum: $300,000.

Request Spousal Life Insurance Amount: $

- Choose up to 50% of your elected coverage, not to exceed $150,000.
  - Spouse Name: ___________________ Spouse Date of birth: ___________________

Request Child/ren Life Insurance Amount: $

- Choose up to 25% of your elected coverage, not to exceed $20,000 per child*.
  - Note: In order to elect child/ren coverage, you must elect coverage for yourself.

*Each child will receive the same coverage amount, but the rate covers all children in your family, regardless of the number of children you have.
Select Your Disability Insurance Coverage

Short-Term Income Protection Plan A
Short-Term Disability Insurance

[Box for Decline] [Box for Request]

Weekly Benefit Amount: $  
Choose your coverage amount in $10 increments, subject to a maximum based on your annual wages (see rate sheet to calculate maximum) or $1,200/week, whichever amount is higher.

Choose one of the following Elimination Periods:  
(The time between when a covered disability begins and the time the policy pays a benefit.)

[ ] 7 Days  [ ] 28 Days

Short-Term Income Protection Plan B
Coordinated Short-term Disability Insurance

[Box for Decline] [Box for Request]

Choose your Benefit Durations (Must match your employer-paid Long-Term Disability Insurance Elimination Period.* If you are unsure about your Elimination Period, please ask your HR department or Benefit Administrator.)

[ ] 60 Days  [ ] 90 Days  [ ] 120 Days  [ ] 180 Days

* Elimination Period is the time between when a covered disability begins and the time the policy pays a benefit.

Sign Here If You Are Enrolling in Coverage

By signing this Enrollment form, I understand and agree that:

• I authorize my Employer to make any required deductions, if any, from my salary to pay the premium for my insurance in effect.
• All statements and answers I have given are complete and true to the best of my knowledge and belief.
• Coverage is not in effect until after final approval is given by 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 have read the Fraud Warning on this enrollment form.

Dated this __________________ day of __________________, 20 __________

Applicant’s Signature

For National Insurance Services Use Only

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Date Received</th>
<th>Life Insurance Amount</th>
<th>Disability Amount</th>
</tr>
</thead>
</table>

Page 2 of 2
Do I Need to Fill Out the Attached Medical Questionnaire (Evidence of Insurability) Form?

To identify whether or not you are required to submit the attached medical questionnaire (Evidence of Insurability), follow the instructions under the plan(s) you have chosen.

NIS Options - Life Insurance Plans

Basic-Plus Life Plan
Dependent Life Insurance (Family Unit Plan)

Plan 1: Not required during initial open enrollment or within 30 days of eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire (submit a separate form for each person applying for coverage).

Plan 2: Required. Please submit a separate form for each person applying for coverage. Note: If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current coverage amounts.

Optimum Life Plan
Optional Life and AD&D Insurance for Employee and Optional Life Insurance for Dependents

Required. If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts. Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details. Subject to plan maximums. Please submit a separate form for each person applying for coverage.

NIS Options - Disability Insurance Plans
(Short-Term Disability, Coordinated Short-Term Disability and/or Long-Term Income Protection)

Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire. Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details. Subject to plan maximums.
Evidence of Insurability
(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es):  □ Life: $   □ Life/AD&D   □ Long Term Disability   □ Short Term Disability
□ Supp. Life: $   □ AD&D: $   □ AD&D: $

Reason for Applying:  □ New Hire   □ Late Enrollee   □ Increase in Coverage amount   □ Reinstatement
□ Adding Dependent(s)   □ Applying for coverage over GI   □ Other:

**APPLICANT INFORMATION**

**Applicant’s Name:** Last, First, MI  **Sex:**  □ M  □ F  **Age:**  /  /
**Height:**  **Weight:**  **Applicant’s Social Security No.:**  **Already Enrolled?**  □ Yes   □ No  **Applicant’s Daytime Phone No.:**  
**Applicant’s Home Address:** (Street, City, State, Zip)  **Physician’s Address:** (Street, City, State, Zip)

**Applicant’s Current Physician’s Name:**  **Physician’s Phone No.:**  **Date Last Visited:**  /  /  **Reason for Visit:**

**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?

<table>
<thead>
<tr>
<th>A. HEART</th>
<th></th>
<th>B. TUMORS/CYSTS</th>
<th></th>
<th>C. BLOOD AND URINE</th>
<th></th>
<th>D. PAIN &amp; DISCOMFORT</th>
<th></th>
<th>E. OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Heart ailment?</td>
<td>□ Yes   □ No</td>
<td>1. Cancer of any type?</td>
<td>□ Yes   □ No</td>
<td>1. High or low blood pressure or hypertension?</td>
<td>□ Yes   □ No</td>
<td>1. Arthritis, bursitis or gout?</td>
<td>□ Yes   □ No</td>
<td>8. Acquired Immune Deficiency Syndrome (AIDS)?</td>
</tr>
<tr>
<td>2. Chest pain, angina or shortness of breath?</td>
<td>□ Yes   □ No</td>
<td>2. Tumors, cysts, or polyps?</td>
<td>□ Yes   □ No</td>
<td>2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?</td>
<td>□ Yes   □ No</td>
<td>2. Recurrent back pain or slipped disc?</td>
<td>□ Yes   □ No</td>
<td>9. AIDS Related Complex (ARC)?</td>
</tr>
<tr>
<td>3. Irregular heart beat or heart murmur?</td>
<td>□ Yes   □ No</td>
<td>3. Disorder of the back, neck or spine?</td>
<td>□ Yes   □ No</td>
<td>3. Disorder of the muscles, bones or joints?</td>
<td>□ Yes   □ No</td>
<td>3. Disorder of the back, neck or spine?</td>
<td>□ Yes   □ No</td>
<td>10. Human Immunodeficiency Virus (HIV)?</td>
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<td>4. Rheumatic fever?</td>
<td>□ Yes   □ No</td>
<td>4. Disorder of the muscles, bones or joints?</td>
<td>□ Yes   □ No</td>
<td>4. Disorder of the muscles, bones or joints?</td>
<td>□ Yes   □ No</td>
<td>4. Disorder of the muscles, bones or joints?</td>
<td>□ Yes   □ No</td>
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<td>5. Disease or abnormality of heart muscle, nerves or vessels?</td>
<td>□ Yes   □ No</td>
<td>5. Temporomandibular joint (TMJ) Disorder?</td>
<td>□ Yes   □ No</td>
<td>5. Temporomandibular joint (TMJ) Disorder?</td>
<td>□ Yes   □ No</td>
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HEALTH QUESTIONS continued....

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
B. Eyes, ears, nose or throat? □ Yes □ No
C. Skin or lymph nodes? □ Yes □ No
D. Prostate, ovaries or uterus? □ Yes □ No
E. Stomach, intestine, gallbladder or liver? □ 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
B. Scheduled or undergone any surgery? □ Yes □ No
C. Been treated or evaluated in a hospital or medical or psychiatric facility? □ 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.)

<table>
<thead>
<tr>
<th>Dates</th>
<th>Conditions</th>
<th>Doctor Names and Addresses</th>
<th>Results</th>
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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 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: Date: Underwriter’s Signature: