

SERFF Tracking Number: MADS-126356116 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 43883
Company Tracking Number: INDIV LIFE QUESTIONNAIRES
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Indiv Life Questionnaires
Project Name/Number: /

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: Indiv Life Questionnaires

SERFF Tr Num: MADS-126356116 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 43883

Sub-TOI: L08.000 Life - Other

Co Tr Num: INDIV LIFE State Status: Approved-Closed
QUESTIONNAIRES

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Sue Long, Cheryl

Disposition Date: 10/29/2009

Richards, Andrea Greiber

Date Submitted: 10/23/2009

Disposition Status: Approved-
Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 10/20/2009

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/29/2009

Explanation for Other Group Market Type:

State Status Changed: 10/29/2009

Deemer Date:

Created By: Andrea Greiber

Submitted By: Andrea Greiber

Corresponding Filing Tracking Number:

Filing Description:

Medical Questionnaires – Individual Life Insurance

Alcohol Questionnaire, Cysts/Tumors/Cancel Questionnaire, Diabetes Questionnaire, Drug Questionnaire, Heart Disease Questionnaire, High Blood Pressure Questionnaire, Physical History Questionnaire, Respiratory Questionnaire

These forms are new and will not replace any existing forms filed with your Department. These forms, when used, will become part of the application and policy.

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These forms are to be subsequently used in addition to our individual life insurance applications on our simplified issue products. Our individual life applications include medical questions. When an applicant completes the application, the applicant will mark "Yes", "No" or provide other medical information. Since we have a simplified underwriting process (we do not request medical records), we may need to require additional information about the stated medical condition. The agent will have the applicant complete an additional questionnaire providing specifics of the medical condition. We will underwrite based on this information.

These forms will be used with future individual life products, as well as three filings already approved by your Department. These filings are:

SERFF Tracking No. MADS-126049275 and State Filing No. 41642, approved 2/26/09, Individual Whole Life
 SERFF Tracking No. MADS-126125765 and State Filing No. 42177, approved 4/24/09, Individual Whole Life
 SERFF Tracking No. MADS-125750890 and State Filing No. 39775, approved 9/16/08, Individual Universal Life

We retain the right to change font, paper color and to correct grammar errors (as long as those corrections do not change the intent or purpose of this form filing).

Company and Contact

Filing Contact Information

Andrea Greiber, Compliance Specialist ALG@madisonlife.com
 PO Box 5008 800-356-9601 [Phone] 2059 [Ext]
 Madison, WI 53705 608-830-2704 [FAX]

Filing Company Information

Madison National Life Insurance Company, Inc. CoCode: 65781 State of Domicile: Wisconsin
 1241 John Q. Hammons Drive Group Code: 450 Company Type: Life and Health
 Madison, WI 53717 Group Name: State ID Number:
 (608) 830-2000 ext. [Phone] FEIN Number: 39-0990296

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|----------|----------------|---------------|
| Madison National Life Insurance Company, Inc. | \$0.00 | 10/23/2009 | |
| Madison National Life Insurance Company, Inc. | \$160.00 | 10/27/2009 | 31579595 |

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Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 10/29/2009 | 10/29/2009 |

Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|-------------|---------------|------------|------------|----------------|
| Filing Fees | Note To Filer | Linda Bird | 10/27/2009 | 10/27/2009 |

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Disposition

Disposition Date: 10/29/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|-----------------------------------|----------------------|---------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | No |
| Form | Alcohol Questionnaire | | Yes |
| Form | Cysts/Tumors/Cancer Questionnaire | | Yes |
| Form | Diabetes Questionnaire | | Yes |
| Form | Drug Questionnaire | | Yes |
| Form | Heart Disease Questionnaire | | Yes |
| Form | High Blood Pressure Questionnaire | | Yes |
| Form | Physical History Questionnaire | | Yes |
| Form | Respiratory Questionnaire | | Yes |

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Note To Filer

Created By:

Linda Bird on 10/27/2009 09:27 AM

Last Edited By:

Linda Bird

Submitted On:

10/29/2009 08:35 AM

Subject:

Filing Fees

Comments:

The filing fees were not included under EFT on this submission. Please refer to Arkansas Rule and Regulation 57 for Arkansas filing fees. If retaliatory fee is greater than Arkansas, then pay the greater fee. We will hold your filing in a pending status until the fee is received.

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Form Schedule

Lead Form Number:

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|----------------------|----------------|-----------|-----------------------------------|---------|----------------------|-------------|--------------------|
| | I-L-QALC-1009 | Other | Alcohol Questionnaire | Initial | | 57.200 | I-L-QALC-1009.pdf |
| | I-L-QCTC-1009 | Other | Cysts/Tumors/Cancer Questionnaire | Initial | | 65.400 | I-L-QCTC-1009.pdf |
| | I-L-QDIAB-1009 | Other | Diabetes Questionnaire | Initial | | 63.400 | I-L-QDIAB-1009.pdf |
| | I-L-QDRG-1009 | Other | Drug Questionnaire | Initial | | 52.900 | I-L-QDRG-1009.pdf |
| | I-L-QHD-1009 | Other | Heart Disease Questionnaire | Initial | | 49.000 | I-L-QHD-1009.pdf |
| | I-L-QHBP-1009 | Other | High Blood Pressure Questionnaire | Initial | | 65.300 | I-L-QHBP-1009.pdf |
| | I-L-QPH-1009 | Other | Physical History Questionnaire | Initial | | 46.800 | I-L-QPH-1009.pdf |
| | I-L-QRSP-1009 | Other | Respiratory Questionnaire | Initial | | 64.300 | I-L-QRSP-1009.pdf |

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

Supplement to Application Form No. _____, dated _____

Alcohol Questionnaire

| | | |
|---|----------------|----------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth |
| Does the Proposed Insured currently use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes: | Types? | Amounts/Frequencies? |
| If No: | Sobriety date: | |
| In the last 5 years, has the Proposed Insured received outpatient and/or inpatient treatment for alcohol/alcoholism? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes please provide the following: | | |
| Dates treated: | | |
| Type of treatments: | | |
| Name of facility(ies): | | |
| In the last 5 years, has the Proposed Insured used marijuana, cocaine or any illegal drug? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details: | | |
| Additional comments: | | |

To the best of my knowledge and belief, all the above statements are complete and true and I agree that they shall form a part of the Application and become a part of the Policy.

Signature of Proposed Insured

Date

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

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Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Supplement to Application Form No. _____, dated _____

Cysts/Tumors/Cancer Questionnaire

| | | | |
|---|---|---|-------------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth | |
| Date of Diagnosis? | Precise diagnosis, if known? (e.g. polyp, adenocarcinoma, sarcoma, lymphoma, leukemia, other?) | | |
| Type of cyst/tumor/cancer? | | Location on body: | |
| Was a biopsy performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what were the results? <input type="checkbox"/> Benign <input type="checkbox"/> Malignant If Malignant, what stage or grade, in known? | | | |
| Did it spread to any lymph nodes or any other areas? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, provide details: | | | |
| What type of treatment was received? (e.g. surgery, radiation, chemotherapy, other) | | What was the date of the last treatment? | |
| Was it completely removed? <input type="checkbox"/> Yes <input type="checkbox"/> No | | Any recurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Any current treatment or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details. | | | |
| Facility / Physician Name | Specialty <i>(e.g. Orthopedic)</i> | Why were you seen? | Date of Service: |
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Supplement to Application Form No. _____, dated _____

Diabetes Questionnaire

| | | | |
|--|---|---------------------------------------|-------------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth | |
| Date of Diagnosis? | How is the diabetes treated? (e.g. diet, oral medication, insulin, other?) | | |
| What medications are currently being taken and dosages? | | | |
| Does the Proposed Insurance check his/her own blood sugars? <input type="checkbox"/> Yes <input type="checkbox"/> No | If Yes, how often is it tested? | What are the average readings? | |
| What was the date of the last hemoglobin A1C test? | What was the result of the test? | | |
| In the last 5 years, has the Proposed Insured been hospitalized for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No (If Yes, please write the name, address and telephone number of the hospital/facility below.) | | | |
| Has there been any complications as a result of the diabetes? (e.g. heart disease circulatory problems, skin infections, eye problems, stroke, kidney problems, etc?) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the following: | | | |
| Facility / Physician Name | Specialty <i>(e.g. Orthopedic)</i> | Why were you seen? | Date of Service: |
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Supplement to Application Form No. _____, dated _____

Drug Questionnaire

| | | |
|--|------------------------------|----------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth |
| In the last 5 years, has the Proposed Insured used: | | |
| (a) Barbiturates, sedatives or tranquilizers habitually? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| (b) LSD, marijuana, or any amphetamines? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| (c) Cocaine, heroin, morphine or other illegal drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| If Yes to any, please list the types taken and the periods of use: | | |
| Types: | Dates Used (To-From): | Frequencies: |
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| What is the Proposed Insured's sobriety date? | | |
| In the last 5 years, has the Proposed Insured received outpatient and/or inpatient treatment for drug use/abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the following: | | |
| Dates treated: | | |
| Type of treatment: | | |
| Name of facility: | | |
| Does the Proposed Insured currently use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the types of alcohol and frequencies: | | |
| Additional comments: | | |

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Supplement to Application Form No. _____, dated _____

Heart Disease Questionnaire

| | | | |
|--|--|---------------------------|-------------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth | |
| Date of Diagnosis? | What is the diagnosis of the heart condition? (e.g. angina, pectoris, heart attack, coronary artery disease, congestive hear failure, other?) | | |
| Did it require bypass surgery, angioplasty, cardiac catheterization, stent placement, or any other cardiovascular procedure? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the date and reason of the hospitalization or treatment: (Also, please write the name, address and telephone number of the hospital/facility below.) | | | |
| In the last 5 years, or since this procedure, have there been any symptoms? (e.g. chest pain, shortness of breath, palpitations?) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what symptoms? | | | |
| What prescription and/or over-the-counter medications are currently being taken and dosages? | | | |
| In the last 5 years, have there been any follow-up cardiac tests? (e.g. EKGs, stress tests, echocardiograms, angiography, other?) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide the date and results of the procedure. (Also, please write the name, address and telephone number of the hospital/facility below.) | | | |
| Facility / Physician Name | Specialty <i>(e.g. Orthopedic)</i> | Why were you seen? | Date of Service: |
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Supplement to Application Form No. _____, dated _____

High Blood Pressure Questionnaire

| | | | |
|---|--|---|-------------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth | |
| Date of Diagnosis? | What medications are currently being taken and dosages? | | |
| Has there been any change in medication in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details: | | | |
| In the last 5 years, has the Proposed Insured been hospitalized or had emergency room treatment for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If Yes, Please write the name, address and telephone number of the hospital/facility below.)</i> | | | |
| In the last 5 years, has the Proposed Insured had any blood pressure related health problems? (e.g. kidney disease, enlarged heart, history of a stroke, other?) <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details: | | | |
| Is the blood pressure self monitored? <input type="checkbox"/> Yes <input type="checkbox"/> No | | If Yes, please provide the most recent readings: | |
| What is the date of the last blood pressure checkup with a physician? | | What was the reading? | |
| Facility / Physician Name | Specialty <i>(e.g. Orthopedic)</i> | Why were you seen? | Date of Service: |
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Supplement to Application Form No. _____, dated _____

Physical History Questionnaire

| | | | |
|---|---|--------------------------------------|-------------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth | |
| <input type="checkbox"/> Back, Neck, Spine; <input type="checkbox"/> Bones, Joints, Muscles; <input type="checkbox"/> Liver; <input type="checkbox"/> GI Tract; <input type="checkbox"/> Nervous System; <input type="checkbox"/> Stroke/TIA; <input type="checkbox"/> Other | | | |
| Date of Diagnosis? | Diagnosis/specific medical condition(s)? | | |
| Was surgery performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date-of-service: | | Describe: | |
| Was other treatment performed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, date-of-service: | | Describe: | |
| Was medication prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when: | | What medications and dosages? | |
| Was medical equipment prescribed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when: | | What equipment? | |
| Was any other treatment or services received? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: | | Describe: | |
| Currently being treated? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: | | For what condition? | |
| Has additional treatment or surgery been suggested? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes: | | For what condition? | |
| Facility / Physician Name | Specialty <i>(e.g. Orthopedic)</i> | Why were you seen? | Date of Service: |
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Supplement to Application Form No. _____, dated _____

Respiratory Questionnaire

| | | | |
|---|---|--|-------------------------|
| Name of Proposed Insured: <i>(First, Middle, Last)</i> | | Date of Birth | |
| Date of Diagnosis? | What is the specific diagnosis? (e.g. asthma, emphysema, COPD, other?) | | |
| In the last 5 years, how many episodes have occurred? | | What treatment was done for the episodes? | |
| What types of symptoms were experienced with this condition? (e.g. shortness of breath, wheezing, coughing, other?) | | | |
| Is any medication/treatment required between episodes or is a breathing machine or oxygen used ? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please provide details: | | | |
| In the last 5 years, has there been any special respiratory testing such as pulmonary function tests? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when and what type of testing was done? (Also, please write the name, address and telephone number of the hospital/facility below.) | | | |
| In the last 5 years, has the Proposed Insured been hospitalized or treated at an emergency room? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, when and what type of treatment was received? (Also, please write the name, address and telephone number of the hospital/facility below.) | | | |
| In the last 5 years, has the Proposed Insured lost time from work due to this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, what is the frequency, duration and dates? | | | |
| Facility / Physician Name | Specialty <i>(e.g. Orthopedic)</i> | Why were you seen? | Date of Service: |
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Supporting Document Schedules

| | Item Status: | Status Date: |
|--|--------------|--------------|
| Satisfied - Item: Flesch Certification Comments: Attachment: Readability Certification.pdf | | |

| | Item Status: | Status Date: |
|---|--------------|--------------|
| Bypassed - Item: Application Bypass Reason: There is no policy is this filing. Comments: | | |

CERTIFICATE OF READABILITY

I hereby certify that the forms meet the minimum requirements of the Flesch reading ease policy simplification test, are at least 10 point type or larger, and that the Flesch reading ease test has been applied to said forms individually or in combination with another, including removal of all tables, schedule pages, and/or legal or medical terminology, with resulting scores of:

| Form No. | Description | Score |
|-----------------|-----------------------------------|--------------|
| I-L-QALC-1009 | Alcohol Questionnaire | 57.2 |
| I-L-QCTS-1009 | Cysts/Tumors/Cancer Questionnaire | 65.4 |
| I-L-QDIAB-1009 | Diabetes Questionnaire | 63.4 |
| I-L-QDRG-1009 | Drug Questionnaire | 52.9 |
| I-L-QHD-1009 | Heart Disease Questionnaire | 49.0 |
| I-L-QHBP-1009 | High Blood Pressure Questionnaire | 65.3 |
| I-L-QPH-1009 | Physical History Questionnaire | 46.8 |
| I-L-QRSP-1009 | Respiratory Questionnaire | 64.3 |



Robert J. Stubbe
Executive Vice President
Madison National Life Insurance Company, Inc.
Dated: October 20, 2009