

SERFF Tracking Number: MADS-126448217 State: Arkansas  
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 44547  
Company Tracking Number: G-A-1209  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other  
Product Name: Application  
Project Name/Number: Application and Enrollment/G-A-1209

## Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: Application

SERFF Tr Num: MADS-126448217 State: Arkansas

TOI: H11G Group Health - Disability Income

SERFF Status: Closed-Approved-  
Closed State Tr Num: 44547

Sub-TOI: H11G.004 Other

Co Tr Num: G-A-1209

State Status: Approved-Closed

Filing Type: Form

Author: Julie Guess

Reviewer(s): Rosalind Minor

Date Submitted: 01/13/2010

Disposition Date: 01/15/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Application and Enrollment

Status of Filing in Domicile: Authorized

Project Number: G-A-1209

Date Approved in Domicile: 12/21/2009

Requested Filing Mode:

Domicile Status Comments: The status of the forms in our state of domicile (Wisconsin) is "filed" and we are allowed to use them beginning 01/16/2010.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small

Overall Rate Impact:

Group Market Type: Employer, Trust

Filing Status Changed: 01/15/2010

Explanation for Other Group Market Type:

State Status Changed: 01/15/2010

Deemer Date:

Created By: Julie Guess

Submitted By: Julie Guess

Corresponding Filing Tracking Number:

Filing Description:

The forms included in this filing are new and do not replace any forms currently in use. Form G-A-1209 is a group application that will be used by groups to apply for coverage for group members. Group coverage will be issued either directly to employers or issued through a trust. Form G-E-1209 is an individual enrollment form that individual members of the group complete to enroll in the group coverage.

The forms will be used to apply for or enroll in coverage in our Group Long- and Short-Term Disability Income, Group

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 Term Life, Group Dental, and Group Vision products.

The group application form (G-A-1209) is a matrix filing - while it is one document, it is divided into 5 sections and each section has been assigned a number/section. The first two and last three pages are not variable - they will be included with every application. The Life/AD&D insert (G-A-TLI-1209), Short Term Disability insert (G-A-STDI-1209), Long Term Disability insert (G-A-LTDI-1209), and Dental/Vision insert (G-DENVIS-A) are bracketed because those pages may or may not be included, depending on what coverage the group is interested in purchasing. If any section needs to be revised because of statute or rule changes or because of industry updates, a replacement section will be filed versus refiling the entire Application.

A Statement of Variability is included under the "Supporting Documentation" tab.

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

Julie Guess, Compliance Specialist jag@madisonlife.com  
 PO Box 5008 800-356-9601 [Phone] 2062 [Ext]  
 Madison, WI 53705 608-830-2700 [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

| COMPANY                                       | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|--------|----------------|---------------|
| Madison National Life Insurance Company, Inc. | \$0.00 | 01/13/2010     |               |

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Madison National Life Insurance Company, Inc. \$100.00 01/15/2010 33562321

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## Correspondence Summary

### Dispositions

| Status          | Created By     | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 01/15/2010 | 01/15/2010     |

### Objection Letters and Response Letters

| Objection Letters         |                |            |                | Response Letters |            |                |
|---------------------------|----------------|------------|----------------|------------------|------------|----------------|
| Status                    | Created By     | Created On | Date Submitted | Responded By     | Created On | Date Submitted |
| Pending Industry Response | Rosalind Minor | 01/14/2010 | 01/14/2010     | Julie Guess      | 01/15/2010 | 01/15/2010     |

### Filing Notes

| Subject     | Note Type        | Created By  | Created On | Date Submitted |
|-------------|------------------|-------------|------------|----------------|
| Fee         | Note To Reviewer | Julie Guess | 01/15/2010 | 01/15/2010     |
| Filing fee? | Note To Reviewer | Julie Guess | 01/13/2010 | 01/13/2010     |

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## Disposition

Disposition Date: 01/15/2010

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 | Approved-Closed      | Yes           |
| Supporting Document | Application          | Approved-Closed      | Yes           |
| Form                | Group Application    | Approved-Closed      | Yes           |
| Form                | Enrollment form      | Approved-Closed      | Yes           |

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 01/14/2010  
Submitted Date 01/14/2010  
Respond By Date  
Dear Julie Guess,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Group Application, G-A-1209 (Form)
- Enrollment form, G-3-1209 (Form)

Comment: As required by Rule 57, Subsection II, Category "B" (a)(6), please submit a filing fee in the amount of \$100 (\$50.00 for each form).

You may access Rule 57 at: <http://insurance.arkansas.gov/LEGAL%20DATASERVICES/rnrpage.htm>.

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 01/15/2010  
Submitted Date 01/15/2010

Dear Rosalind Minor,

### Comments:

Thank you for the quick response. I apologize for not including the fee as an EFT. I will order the check today and it will be mailed on Monday.

### Response 1

Comments: Check will be ordered today and will be sent on Monday.

### Related Objection 1

Applies To:

SERFF Tracking Number: MADS-126448217 State: Arkansas  
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Product Name: Application  
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- Group Application, G-A-1209 (Form)
- Enrollment form, G-3-1209 (Form)

**Comment:**

As required by Rule 57, Subsection II, Category "B" (a)(6), please submit a filing fee in the amount of \$100 (\$50.00 for each form).

You may access Rule 57 at: <http://insurance.arkansas.gov/LEGAL%20DATASERVICES/rnrpage.htm>.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Julie Guess

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**Note To Reviewer**

**Created By:**

Julie Guess on 01/15/2010 09:02 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

01/15/2010 10:26 AM

**Subject:**

Fee

**Comments:**

It appears that it is possible to send a fee via EFT after the filing has been submitted. So I won't be mailing a check afterall. I've submitted the \$100 fee via EFT. Again, I apologize for my fumbling.

Please contact me if you have any questions.

Julie Guess

Compliance Specialist

800-356-9601, ext 2062

jag@madisonlife.com

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**Note To Reviewer**

**Created By:**

Julie Guess on 01/13/2010 02:45 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

01/15/2010 10:26 AM

**Subject:**

Filing fee?

**Comments:**

The General Instructions say that Arkansas is a "retaliatory" state. Our state of domicile (Wisconsin) does not charge a filing fee, so I did not include a fee with the filing. But the state status says "pending fees", so I'm afraid I misunderstood the filing fee requirement.

Should I be sending a check? Please let me know.

I apologize for any inconvenience this may cause.

Julie Guess

jag@madisonlife.com

800-356-9601, ext 2062

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## Form Schedule

### Lead Form Number: G-A-1209

| Schedule Item                     | Form Number | Form Type Form Name                                  | Action  | Action Specific Data | Readability | Attachment   |
|-----------------------------------|-------------|--|---------|----------------------|-------------|--------------|
| Approved-<br>Closed<br>01/15/2010 | G-A-1209    | Application/ Group Application<br>Enrollment<br>Form | Initial |                      |             | G-A-1209.pdf |
| Approved-<br>Closed<br>01/15/2010 | G-3-1209    | Application/ Enrollment form<br>Enrollment<br>Form   | Initial |                      |             | G-E-1209.pdf |

# MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

PO Box 5008, Madison, WI 53705 • 1-800-356-9601 (Phone)

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

## GROUP APPLICATION [THROUGH [NAME] TRUST]

### EMPLOYER GROUP INFORMATION

|  |          |  |                                  |                    |
|--|----------|--|----------------------------------|--------------------|
| Legal Name of Employer: (Please print)   |          |  | Requested Effective Date:<br>/ / | IRS Tax ID No.:    |
| Street Address:  |          |  | PO Box No.:                      | SIC No.:           |
| City:  | State:   | Zip Code:  | Nature of Business:              |                    |
| Group Contact Name:  |          | Title:   | Phone No.:<br>( )                |                    |
| Employer Email Address:  |          |  |                                  |                    |
| Business Type: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Non-Profit <input type="checkbox"/> Other: |          |  |                                  | Years in Business: |
| Subsidiaries Included:   |          |  |                                  |                    |
| Bill Type: <input type="checkbox"/> List Bill <input type="checkbox"/> Self Bill   |          | Bill Frequency: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Other: |                                  |                    |
| Will this coverage replace existing coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No<br>If "Yes", please complete the following:           |          |  |                                  |                    |
| Coverage:  | Insurer: |  | Termination Date:<br>/ /         |                    |
| Coverage:  | Insurer: |  | Termination Date:<br>/ /         |                    |

(A copy of the current Insurer's policy/booklet and the most recent billing statement must accompany this Application.)

### EMPLOYEE ELIGIBILITY INFORMATION

Please note that temporary, seasonal, part-time Employees, retirees, and Employees residing outside of the United States are generally excluded unless specifically identified by the Employer and approved by Madison National Life Insurance Company, Inc.

Employees must work the following minimum number of hours per week:  30  40  Other: \_\_\_\_\_

On the Requested Effective Date, current Employees  are eligible immediately  must satisfy the Employee Waiting Period as specified below

#### Employee Waiting Period:

Date of hire (eligible immediately)

First day of the month coinciding with or following  \_\_\_\_\_ days  \_\_\_\_\_ months of employment

Other: \_\_\_\_\_

On the Requested Effective Date, are there any Employees not actively at work?  Yes  No

If "Yes", please complete the "Actively-at-Work Statement" section of this Application.

### FOR INSURER USE ONLY

|                             |           |  |       |
|-----------------------------|-----------|--|-------|
| Underwriting Decision:      | Notes:    |  |       |
| Effective Date of Coverage: | Plan No.: |  |       |
| Underwriter's Signature:    |           |  | Date: |



**BASIC LIFE AND AD&D INSURANCE**

**PROPOSAL ATTACHED FOR BASIC LIFE AND AD&D INFORMATION**  
**(OR COMPLETE FIELDS BELOW)**

| Class | Class Description | Basic Life Benefit | Basic AD&D Benefit | Basic Dependent Life |                          |                           |
|-------|-------------------|--------------------|--------------------|----------------------|--------------------------|---------------------------|
|       |                   |                    |                    | Spouse               | Child 6 months and older | Child 14 days to 6 months |
| 1     |                   | \$                 | \$                 | \$                   | \$                       | \$                        |
| 2     |                   | \$                 | \$                 | \$                   | \$                       | \$                        |
| 3     |                   | \$                 | \$                 | \$                   | \$                       | \$                        |

| Employee Insurance |                 |               | Dependent Insurance |               |
|--------------------|-----------------|---------------|---------------------|---------------|
| Class              | Guarantee Issue | Maximum Issue | Guarantee Issue     | Maximum Issue |
| 1                  |                 |               |                     |               |
| 2                  |                 |               |                     |               |
| 3                  |                 |               |                     |               |

**Insurance Reduction Schedule**

- Benefits reduce 35% at age 65, 50% at age 70 and terminate at retirement  
 Other: \_\_\_\_\_

**Group Basic Life and AD&D Optional Benefits**

**Life Insurance Options**

- Waiver of Premium Benefit       Accelerated Death Benefit/Living Benefit       Other \_\_\_\_\_

**AD&D Insurance Options**

- Seat Belt Benefit       Air Bag Benefit  
 Other AD&D Optional Benefits: \_\_\_\_\_

**Critical Illness Rider**

- Employee only      Amount: \$ \_\_\_\_\_  
 Employee + family      Amount: \$ \_\_\_\_\_

**SUPPLEMENTAL LIFE AND AD&D INSURANCE**

**PLEASE ATTACH PROPOSAL FOR SUPPLEMENTAL LIFE AND AD&D INSURANCE INFORMATION**  
**AND COMPLETE FIELDS BELOW**

Please "✓" the Supplemental Life insurance coverage being applied for:

- Employee Supplemental Life       Spouse Supplemental Life       Child Supplemental Life  
 Employee Supplemental AD&D       Spouse Supplemental AD&D       Child Supplemental AD&D

**PREMIUM CONTRIBUTIONS**

| Class | Employee Basic Life and AD&D Insurance |                       | Basic Dependent Life Insurance |                       |
|-------|--|-----------------------|--------------------------------|-----------------------|
|       | Employer Contribution                  | Employee Contribution | Employer Contribution          | Employee Contribution |
| 1     |  |                       |                                |                       |
| 2     |  |                       |                                |                       |
| 3     |  |                       |                                |                       |

Please complete the information below, based on the coverage(s) elected:

| Coverages:                        | Total Number of Eligible Employees | Total Number of Enrolled Employees |
|-----------------------------------|------------------------------------|------------------------------------|
| Basic Life/AD&D:                  |                                    |                                    |
| Basic Dependent Life:             |                                    |                                    |
| Supplemental Life/AD&D:           |                                    |                                    |
| Dependent Supplemental Life/AD&D: |                                    |                                    |

If Benefits are based on Earnings, Earnings are defined as:

- Base Salary Only     
  Base Salary plus Commissions (using a 12-month rolling average)  
 Base Salary plus Bonuses (using a 36-month rolling average)   
  Other: \_\_\_\_\_

**GROUP TERM LIFE AND AD&D PREMIUM RATES**

|   |   |  |
|---|---|--|
| <u>Basic Life</u><br>- per \$1,000 of coverage<br>\$                                  | <u>Basic AD&amp;D</u><br>- per \$1,000 of coverage<br>\$        | <u>Basic Dependent Life</u><br>- per family unit<br>\$   |
| <u>Supplemental Life</u><br>- per \$1,000 of coverage or attached rate schedule<br>\$ | <u>Supplemental AD&amp;D</u><br>- per \$1,000 of coverage<br>\$ | <u>Dependent Supplemental Life/AD&amp;D</u><br>- per \$1,000 of coverage or attached rate schedule<br>\$ |

Rate Guarantee Period:  \_\_\_\_\_ months  \_\_\_\_\_ years

| FOR INSURER USE ONLY |
|----------------------|
| Notes:               |

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**SHORT TERM DISABILITY INSURANCE**

**PROPOSAL ATTACHED FOR SHORT TERM DISABILITY INFORMATION**  
**(OR COMPLETE FIELDS BELOW)**

| Class | Class Description | Benefit Percentage | Flat Benefit/Max Benefit | Elimination Period Accident / Sickness | Maximum Duration |
|-------|-------------------|--------------------|--------------------------|--|------------------|
| 1     |                   | %                  | \$                       | days / days                            | wks              |
| 2     |                   | %                  | \$                       | days / days                            | wks              |
| 3     |                   | %                  | \$                       | days / days                            | wks              |

| Class | Employer Contribution | Employee Contribution   |
|-------|-----------------------|---|
| 1     | %                     | % made <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax |
| 2     | %                     | % made <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax |
| 3     | %                     | % made <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax |

Does the Employer gross up the Employee's salary in order to contribute toward premium?  Yes  No

Total Number of Eligible Employees: \_\_\_\_\_ Total Number of Enrolled Employees: \_\_\_\_\_

**If Benefits are based on Earnings, Earnings are defined as:**

- Base Salary Only       Base Salary plus Commissions (using a 12-month rolling average)  
 Base Salary plus Bonuses (using a 36-month rolling average)  Other: \_\_\_\_\_

**Short Term Disability Coverage Design**

**Definition of Disability**  Total  Partial  Zero Day Residual

**Minimum Benefit** Specify: \_\_\_\_\_ **Pre-existing Condition Exclusion**  3/12  6/12  12/12  
 Other \_\_\_\_\_  None

**Short Term Disability Coverage Optional Benefits**

- First Day Hospital**  In-patient only  **Reasonable Accommodation Benefit** \$ \_\_\_\_\_  
 Out-patient included
- Survivor Benefit**  **Waiver of Premium Benefit**

**If there are other Employer requirements for this coverage, please describe:** \_\_\_\_\_

**Short Term Disability Coverage Rate**

**Rate** \$ \_\_\_\_\_ per \$10 Weekly Benefit      **Rate Guarantee Period**  \_\_\_\_\_ months  \_\_\_\_\_ years

**FOR INSURER USE ONLY**

**Notes:**

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**LONG TERM DISABILITY INSURANCE**

**PROPOSAL ATTACHED FOR LONG TERM DISABILITY COVERAGE  
(OR COMPLETE FIELDS BELOW)**

| Class | Class Description | Benefit Percentage | Maximum Benefit | Guarantee Issue |
|-------|-------------------|--------------------|-----------------|-----------------|
| 1     |                   | %                  | \$              | \$              |
| 2     |                   | %                  | \$              | \$              |
| 3     |                   | %                  | \$              | \$              |

| Class | Elimination Period   | Own-Occupation Period  | Benefit Duration  |
|-------|--|--|---|
| 1     | <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other: | <input type="checkbox"/> 2 years <input type="checkbox"/> Other: | <input type="checkbox"/> SSNRA <input type="checkbox"/> To age 65 <input type="checkbox"/> Other: |
| 2     | <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other: | <input type="checkbox"/> 2 years <input type="checkbox"/> Other: | <input type="checkbox"/> SSNRA <input type="checkbox"/> To age 65 <input type="checkbox"/> Other: |
| 3     | <input type="checkbox"/> 90 days <input type="checkbox"/> 180 days <input type="checkbox"/> Other: | <input type="checkbox"/> 2 years <input type="checkbox"/> Other: | <input type="checkbox"/> SSNRA <input type="checkbox"/> To age 65 <input type="checkbox"/> Other: |

| Class | Employer Contribution | Employee Contribution   |
|-------|-----------------------|---|
| 1     | %                     | % made <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax |
| 2     | %                     | % made <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax |
| 3     | %                     | % made <input type="checkbox"/> Pre-tax <input type="checkbox"/> Post-tax |

Does the Employer gross up the Employee's salary in order to contribute toward premium?  Yes  No

Total Number of Eligible Employees: \_\_\_\_\_ Total Number of Enrolled Employees: \_\_\_\_\_

**If Benefits are based on Earnings, Earnings are defined as:**

- Base Salary Only       Base Salary plus Commissions (using a 12-month rolling average)  
 Base Salary plus Bonuses (using a 36-month rolling average)  Other: \_\_\_\_\_

**Long Term Disability Coverage Design**

- Definition of Disability**  Total  Partial  Zero Day Residual
- Minimum Benefit**  Greater of 10% or \$100      **Integration with income from other sources**  Full Family  
 Flat \$100       Primary Only  
 Other \_\_\_\_\_       Other \_\_\_\_\_ % All Sources
- Integration with Work Earnings**  Proportionate Formula      **Pre-existing Condition Exclusion**  3/12       6/12  
 50%       12/12       12/24  
 Other \_\_\_\_\_

**Long Term Disability Coverage Optional Benefits**

- Conversion of Insurance**       **Reasonable Accommodation Benefit** \$ \_\_\_\_\_
- Survivor Benefit**       3 month       GMB       **Work Incentive Benefit**  12 months  
 6 month       LMB       24 months  
 12 month
- Cost of Living Adjustment**       \_\_\_\_\_ % for \_\_\_\_\_ years  
 Other \_\_\_\_\_
- Buy Up** (please describe) \_\_\_\_\_
- Other optional benefits** (please attach proposal which describes other benefits) \_\_\_\_\_

**Long Term Disability Coverage Rate**

**Rate** \$ \_\_\_\_\_ per \$100 Monthly Covered Payroll      **Rate Guarantee Period**  \_\_\_\_\_ months  \_\_\_\_\_ years

**FOR INSURER USE ONLY**

Notes:

**[[Dental]]/[Vision] Coverage**

**PREMIUM / MONTHLY COST**

**Select one tier structure:**

**Dental Option 1**

- Composite rate: \$\_\_\_\_\_
- Two tier rates: Single \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Three tier rates: Single \$\_\_\_\_\_ Employee + One Dependent \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Four tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + Child(ren) \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + 1 Child \$\_\_\_\_\_ Employee + Children \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + 1 Child \$\_\_\_\_\_ Employee + 2 or 3 dependents \$\_\_\_\_\_ Employee + 4 or more dependents \$\_\_\_\_\_

**Dental Option 2**

- Composite rate: \$\_\_\_\_\_
- Two tier rates: Single \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Three tier rates: Single \$\_\_\_\_\_ Employee + One Dependent \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Four tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + Child(ren) \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + 1 Child \$\_\_\_\_\_ Employee + Children \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + 1 Child \$\_\_\_\_\_ Employee + 2 or 3 dependents \$\_\_\_\_\_ Employee + 4 or more dependents \$\_\_\_\_\_

**Dental Option 3**

- Composite rate: \$\_\_\_\_\_
- Two tier rates: Single \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Three tier rates: Single \$\_\_\_\_\_ Employee + One Dependent \$\_\_\_\_\_ Family: \$\_\_\_\_\_
- Four tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + Child(ren) \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + 1 Child \$\_\_\_\_\_ Employee + Children \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Five tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + 1 Child \$\_\_\_\_\_ Employee + 2 or 3 dependents \$\_\_\_\_\_ Employee + 4 or more dependents \$\_\_\_\_\_

**Vision**

- Two tier rates: Single \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Three tier rates: Single \$\_\_\_\_\_ Employee + One Dependent \$\_\_\_\_\_ Family \$\_\_\_\_\_
- Four tier rates: Single \$\_\_\_\_\_ Employee + Spouse \$\_\_\_\_\_ Employee + Child(ren) \$\_\_\_\_\_ Family \$\_\_\_\_\_

Will the Employees be required to contribute toward the cost of the insurance?  Yes  No

If yes, indicate the percentage of the cost of each coverage the Employee will pay.

| Coverage                    | Employee Dental | Dependent Dental | Employee Vision | Dependent Vision |
|-----------------------------|-----------------|------------------|-----------------|------------------|
| Employee % or Dollar amount |                 |                  |                 |                  |

Note: If the Employer pays the entire cost for the **Employees**, then 100% of the eligible Employees **must** apply for coverage.

**DENTAL COVERAGE INFORMATION**

**Employee Plan Option 1:** \_\_\_\_\_

Select One

|                 | <b>Benefit<br/>Waiting<br/>Period</b> | <b>Deductible Amount<br/>per Person<br/>(check one)</b><br><input type="checkbox"/> Annual<br><input type="checkbox"/> Lifetime | <input type="checkbox"/><br><b>Indemnity<br/>Coinsurance<br/>Percentage</b> | <input type="checkbox"/><br><b>PPO Coinsurance<br/>Percentage<br/>In Network/Out of Network</b> |
|-----------------|---------------------------------------|---|---|---|
| Preventive Care | _____                                 | _____   | _____   | _____   |
| Diagnostic Care | _____                                 | _____   | _____   | _____   |
| Basic Care      | _____                                 | _____   | _____   | _____   |
| Major Care      | _____                                 | _____   | _____   | _____   |
| Orthodontics    | _____                                 | _____   | _____   | _____   |

Office Visit Co-pay: \$ \_\_\_\_\_

Other Co-pays \$ \_\_\_\_\_ Applied to: \_\_\_\_\_

Dental Maximum (except ortho) Calendar Year  Plan Year  Amount \$ \_\_\_\_\_  
 Orthodontics  Yes  No If Yes, Calendar Year Limit \$ \_\_\_\_\_ Lifetime Maximum \$ \_\_\_\_\_  
 Dental PPO  Yes  No Network \_\_\_\_\_

**Optional Benefits (additional premium may be required)**

Deductible credit/Annual maximum credit (only available on calendar year plans):  Yes  No  
 Cosmetic Procedures (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
 Posterior Composites (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
**Posterior Porcelain Crowns ("Yes" must be checked and additional premium paid to add this coverage)**  Yes  No

**Employee Plan Option 2:** \_\_\_\_\_

Select One

|                 | <b>Benefit<br/>Waiting<br/>Period</b> | <b>Deductible Amount<br/>per Person<br/>(check one)</b><br><input type="checkbox"/> Annual<br><input type="checkbox"/> Lifetime | <input type="checkbox"/><br><b>Indemnity<br/>Coinsurance<br/>Percentage</b> | <input type="checkbox"/><br><b>PPO Coinsurance<br/>Percentage<br/>In Network/Out of Network</b> |
|-----------------|---------------------------------------|---|---|---|
| Preventive Care | _____                                 | _____   | _____   | _____   |
| Diagnostic Care | _____                                 | _____   | _____   | _____   |
| Basic Care      | _____                                 | _____   | _____   | _____   |
| Major Care      | _____                                 | _____   | _____   | _____   |
| Orthodontics    | _____                                 | _____   | _____   | _____   |

Office Visit Co-pay: \$ \_\_\_\_\_

Other Co-pays \$ \_\_\_\_\_ Applied to: \_\_\_\_\_

Dental Maximum (except ortho) Calendar Year  Plan Year  Amount \$ \_\_\_\_\_  
 Orthodontics  Yes  No If Yes, Calendar Year Limit \$ \_\_\_\_\_ Lifetime Maximum \$ \_\_\_\_\_  
 Dental PPO  Yes  No Network \_\_\_\_\_

**Optional Benefits (additional premium may be required)**

Deductible credit/Annual maximum credit (only available on calendar year plans):  Yes  No  
 Cosmetic Procedures (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
 Posterior Composites (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
**Posterior Porcelain Crowns ("Yes" must be checked and additional premium paid to add this coverage)**  Yes  No

Employee Plan Option 3: \_\_\_\_\_

Select One

|                 | Benefit Waiting Period | Deductible Amount per Person (check one)<br><input type="checkbox"/> Annual<br><input type="checkbox"/> Lifetime | <input type="checkbox"/> Indemnity Coinsurance Percentage | <input type="checkbox"/> PPO Coinsurance Percentage In Network/Out of Network |
|-----------------|------------------------|--|---|---|
| Preventive Care | _____                  | _____  | _____   | _____   |
| Diagnostic Care | _____                  | _____  | _____   | _____   |
| Basic Care      | _____                  | _____  | _____   | _____   |
| Major Care      | _____                  | _____  | _____   | _____   |
| Orthodontics    | _____                  | _____  | _____   | _____   |

Office Visit Co-pay: \$ \_\_\_\_\_

Other Co-pays \$ \_\_\_\_\_ Applied to: \_\_\_\_\_

Dental Maximum (except ortho) Calendar Year  Plan Year  Amount \$ \_\_\_\_\_  
 Orthodontics  Yes  No If Yes, Calendar Year Limit \$ \_\_\_\_\_ Lifetime Maximum \$ \_\_\_\_\_  
 Dental PPO  Yes  No Network \_\_\_\_\_

**Optional Benefits (additional premium may be required)**

Deductible credit/Annual maximum credit (only available on calendar year plans):  Yes  No  
 Cosmetic Procedures (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
 Posterior Composites (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
 Posterior Porcelain Crowns (this box needs to be checked and additional premium paid to add this coverage)  Yes  No  
**Posterior Porcelain Crowns ("Yes" must be checked and additional premium paid to add this coverage)**  Yes  No

**OPTIONAL COVERAGE INFORMATION**

**Vision:**

Clear 12 \$0 Co-Pay  Clear 24 \$0 Co Pay  
 Clear 12 \$20 Co-Pay  Clear 24 \$20 Co Pay  
 Clear 12 \$35 Co-Pay  Clear 24 \$35 Co Pay]

]

## Terms and Conditions

- [The Employer understands that this is an application for participation in the Trust, and hereby acknowledges and agrees to the terms of the Trust.]
- The Employer agrees that any insurance applied for shall not become effective unless this Application and any attached page(s) are received, accepted and approved by Madison National Life Insurance Company, Inc. (hereinafter referred to as “Insurer”). The Employer further agrees that insurance applied for shall not become effective or remain effective unless the Employer: a) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and b) meets the participation and contribution requirements.
- The Employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If [a Joinder Agreement and] Certificates of Insurance are issued from this Application, and are accepted by the Employer, we will apply the premium deposit to the first premium due for such coverage. If no coverage is put into force, the premium deposit will be refunded.
- Your agent or broker cannot change or waive any provision of this Application or the Policy or policies without the written approval of an officer of the Insurer.
- The Employer acknowledges and understands that if this Application is approved, the Group Policy, [Joinder Agreement] and Certificates will determine the rights and benefits, and that this Application is subject to the terms and conditions of such contract documents.
- The Employer agrees to offer and allow all eligible Employees to apply for coverage in accordance with, and within, the Employer’s rules regarding classes eligible for coverage at the time of hire and during his/her probationary (waiting) period. The Employer will require that any Employee, who declines to apply at this time, sign a statement to that effect, which will be maintained by the Employer. Should the Insurer’s guidelines require an Employee to submit evidence of insurability, such Employee must complete and submit to the Insurer an Evidence of Insurability form. No coverage shall be in effect for said Employees until Insurer approves and accepts the enrollment form and Evidence of Insurability form.
- The Employer agrees to timely notify the Insurer of any Employee termination, status change, or other material changes that may affect the eligibility of Employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The Employer agrees to notify Employees and other Insured Persons who cease to be eligible for coverage under its policies(s) of their right, if any, to continue group coverage and their right, if any, to apply to Insurer for an individual conversion policy. The Employer shall provide such Employees and other insured persons with the forms and applications necessary to continue group coverage or to apply for such conversion coverage as may then be available.
- The Employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The Employer understands that coverage may also be terminated for other reasons as provided in the Group Policy [and/or Joinder Agreement].
- The person signing this form below certifies that he or she is fully authorized by the Employer to execute this Agreement on the Employer’s behalf.
- The person signing this form has personally reviewed all answers to the questions on this application and represent that all of the information provided is true and complete. It is the Employer’s responsibility to provide truthful, complete and accurate information. The person signing this form understands that any material misstatements or failure to report information may be used as the basis of rescission or termination of coverage.
- If the Employer is unable maintain any minimum Employee participation requirement under this plan, then coverage may cease.

**IMPORTANT: Please review the Fraud Warning page before signing this Application.**

**The undersigned Employer hereby makes application [to join the Trust and] for insurance coverages described within this Application. This Application is subject to [acceptance by the Trust Administrator and] the Terms and Conditions stated above.**

---

**Printed Name of Authorized Employer Representative**

---

**Title**

---

**Signature of Authorized Employer Representative**

---

**Date**

**AGENT'S STATEMENT**

Is the insurance being applied for replacing any insurance now in force?  Yes  No

I have fully explained to the Employer the coverage and provisions of the selected group insurance product benefits. I have also fully explained to the Employer that completing this Application does not guarantee insurance and does not bind Madison National Life Insurance Company, Inc. (hereinafter referred to as "Insurer") to issue a contract or otherwise extend any insurance. I understand I have no authority to alter this Application to bind the Insurer by making any promise and/or representation, or to waive or change the terms, conditions and/or provisions of any insurance contract or other requirement imposed by the Insurer.

**I hereby certify that either the Employer fully completed this Application on its own, or that I have truly and accurately recorded in this Application the information supplied to me by the Employer.**

|   |  |
|---|--|
|   |  |
| <b>Agent's Name as printed on the license</b> | <b>State of license and Agent license number</b> |
| <b>Signature of Licensed Agent</b>            | <b>Date</b>                                      |

## **FRAUD WARNING:**

**The following Fraud Warning applies to residents of all states except those states listed separately below.**

**[FRAUD 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.]

### **STATE-SPECIFIC FRAUD WARNINGS**

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

**COLORADO WARNING:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

**FLORIDA WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

**NEBRASKA 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 may be subject to fines, confinement in prison and/or denial of insurance benefits.

**NEW HAMPSHIRE WARNING:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim or an application for insurance containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NEW JERSEY WARNING:** Any person who knowingly files an application or a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NEW MEXICO 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 is guilty of a crime and may be subject to civil fines, and criminal penalties.

**OREGON WARNING:** Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

**PENNSYLVANIA WARNING:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**WASHINGTON WARNING:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.]

**MADISON NATIONAL LIFE INSURANCE COMPANY, INC.**

**Home Office Phone:** [1-800-356-9601  
1241 John Q. Hammons Drive, Madison, WI 53717]

**Return to:** [Attention: Group Billing Dept.  
PO Box 5008, Madison, WI 53705]

**EMPLOYER NAME** \_\_\_\_\_ **PLAN NUMBER** \_\_\_\_\_

**EMPLOYEE INFORMATION**

|  |                                |   |
|--|--------------------------------|---|
| <b>Name of Employee:</b> (Last, First, MI) | <b>Social Security Number:</b> | <b>Date of Birth:</b><br>/ /  |
| <b>Employee Street Address:</b>            |                                | <b>Hours per Week:</b>  |
| <b>City:</b>                               | <b>State:</b>                  | <b>Zip:</b>   |
| <b>Class:</b>                              | <b>Date of Hire:</b><br>/ /    | <input type="checkbox"/> Female <input type="checkbox"/> Single<br><input type="checkbox"/> Male <input type="checkbox"/> Married |
| <b>Job Title:</b>                          | <b>Annual Salary:</b><br>\$    | <b>US Citizen?</b><br><input type="checkbox"/> Yes <input type="checkbox"/> No – If no, attach a copy of the Employee's Visa.     |

**Late Enrollees** – Reason for late enrollment:  Change in Marital Status/Date \_\_\_\_\_  Add dependent(s)/Date \_\_\_\_\_  
 Other \_\_\_\_\_/Date \_\_\_\_\_

**Beneficiaries:** Indicate your beneficiary designation in the space below. If you need more space, please use another sheet.

- If you are married, a primary beneficiary designation of a person or organization other than your spouse may not be valid under your state law. Please consult your legal advisor before making such a designation.
- You may designate more than one primary or secondary beneficiary. Please be sure to indicate the percentage share that each beneficiary should receive. The total within each class – primary and secondary – must equal 100%.

**Primary Beneficiary (ies)**

| Name (Last, First, MI) | Relationship | Percent of Benefit |
|------------------------|--------------|--------------------|
|                        |              |                    |
|                        |              |                    |

**Secondary Beneficiary (ies)**

| Name (Last, First, MI) | Relationship | Percent of Benefit |
|------------------------|--------------|--------------------|
|                        |              |                    |
|                        |              |                    |

\_\_\_\_\_  
**Spouse Signature (if required)** \_\_\_\_\_  
**Date**

**Insurance Coverage Election**

The following coverages are only available if your Employer offers them. Please “” the applicable insurance coverage(s) you are electing. NOTE: If you decline coverages, please complete the Employee Waiver of Insurance section of this form.

[Effective date if eligibility is contingent upon Employee's acceptance of health coverage offered by employer: \_\_\_\_\_ ]

**LIFE [AD&D] COVERAGE**

|   |   |  |
|---|---|--|
| <input type="checkbox"/> Employee Basic Life[AD&D]  | <input type="checkbox"/> Employee Supplemental Life[AD&D] \$ _____                  | <input type="checkbox"/> Employee Voluntary Life[AD&D] \$ _____                  |
| <input type="checkbox"/> Dependent Basic Life[AD&D] – Family  | <input type="checkbox"/> Dependent Supplemental Life[AD&D] – Family                 | <input type="checkbox"/> Dependent Voluntary Life[AD&D] – Family                 |
| <input type="checkbox"/> Dependent Basic Life[AD&D] – Spouse  | <input type="checkbox"/> Dependent Supplemental Life[AD&D] – Spouse \$ _____        | <input type="checkbox"/> Dependent Voluntary Life[AD&D] – Spouse \$ _____        |
| <input type="checkbox"/> Dependent Basic Life[AD&D] – Child(ren)]   | <input type="checkbox"/> Dependent Supplemental Life[AD&D] – Child(ren)] \$ _____ ] | <input type="checkbox"/> Dependent Voluntary Life[AD&D] – Child(ren)] \$ _____ ] |
| <input type="checkbox"/> Retiree Basic Life[AD&D]   | <input type="checkbox"/> Retiree Supplemental Life[AD&D] \$ _____ ]                 | <input type="checkbox"/> Retiree Voluntary Life[AD&D] \$ _____ ]                 |
| <input type="checkbox"/> Critical Illness Rider<br><input type="checkbox"/> Employee only<br><input type="checkbox"/> Employee + family]] |   |  |

**SHORT TERM DISABILITY COVERAGE**

|   |  |  |
|---|--|--|
| <input type="checkbox"/> Short Term Disability Coverage | <input type="checkbox"/> Short Term Disability Buy-up<br>\$ _____ ]] | <input type="checkbox"/> Voluntary Short Term Disability<br>\$ _____ ] |
|---|--|--|

**LONG TERM DISABILITY COVERAGE**

|  |   |   |
|--|---|---|
| <input type="checkbox"/> Long Term Disability Coverage | <input type="checkbox"/> Long Term Disability Buy-up<br>\$ _____ ]] | <input type="checkbox"/> Voluntary Long Term Disability<br>\$ _____ ] |
|--|---|---|

**DENTAL/VISION COVERAGE**

|                                 |                                   |                                  |  |
|---------------------------------|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Dental | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse] | <input type="checkbox"/> Dependent Child(ren)] |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Employee | <input type="checkbox"/> Spouse] | <input type="checkbox"/> Dependent Child(ren)] |

**Dependent Coverage Information:**

| Name | Birth Date | Relationship         | Social Security Number | U.S. Citizen?   |
|------|------------|----------------------|------------------------|---|
|      |            | Spouse               |                        | <input type="checkbox"/> Yes <input type="checkbox"/> No – if No, attach a copy of the Spouse’s Visa        |
| N/A  | N/A        | Dependent Child(ren) | N/A                    | <input type="checkbox"/> Yes <input type="checkbox"/> No – if No, attach a copy of the child(ren)’s Visa(s) |

**EMPLOYEE COVERAGE AUTHORIZATION**

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 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 received and read the Fraud Warning page of this enrollment form.

\_\_\_\_\_  
Employee/Applicant Signature

\_\_\_\_\_  
Date

**EMPLOYEE WAIVER OF INSURANCE**

I have been given the opportunity to apply for the group insurance plan coverage as presented to me, but do NOT wish to enroll in the insurance plans offered. Coverage not elected in the Insurance Coverage Election portion of this form is assumed to be coverage that I have refused.

I understand that if my dependents or I decide to apply for this group insurance plan at a later date, Evidence of Insurability will be required at my own expense. The Evidence of Insurability must be approved by Madison National Life Insurance company, Inc.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

## **FRAUD WARNING:**

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SERFF Tracking Number: MADS-126448217 State: Arkansas  
 Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 44547  
 Company Tracking Number: G-A-1209  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.004 Other  
 Product Name: Application  
 Project Name/Number: Application and Enrollment/G-A-1209

## Supporting Document Schedules

|   | <b>Item Status:</b> | <b>Status<br/>Date:</b> |
|---|---------------------|-------------------------|
| <b>Satisfied - Item:</b> Flesch Certification   | Approved-Closed     | 01/15/2010              |
| <b>Comments:</b>  |                     |                         |
| Aside from the Readability Certification, the rest of the bulletins listed above do not apply to this filing. |                     |                         |
| <b>Attachment:</b>  |                     |                         |
| READABILITY CERTIFICATION.pdf   |                     |                         |

|  | <b>Item Status:</b> | <b>Status<br/>Date:</b> |
|--|---------------------|-------------------------|
| <b>Bypassed - Item:</b> Application            | Approved-Closed     | 01/15/2010              |
| <b>Bypass Reason:</b> This is the application. |                     |                         |
| <b>Comments:</b>                               |                     |                         |

## READABILITY CERTIFICATION

To: Department of Insurance  
RE: Forms G-A-1209 and G-E-1209

I hereby certify that that the forms referenced above meet the minimum requirements of the Flesch reading ease policy simplification test and are at least 10-point type or larger.

| <b>Form Number</b> | <b>Description</b>       | <b>Score</b> |
|--------------------|--------------------------|--------------|
| G-A-1209           | Group Application        | 40.3         |
| G-E-1209           | Employee Enrollment Form | 44.2         |



Robert J. Stubbe  
Executive Vice President – Operations  
Madison National Life Insurance Company, Inc.  
Dated: January 11, 2010