

SERFF Tracking Number: MADS-126705059 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 46112
Company Tracking Number: IWL-FE APP2
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: IWL-FE App2
Project Name/Number: /

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.

Product Name: IWL-FE App2

SERFF Tr Num: MADS-126705059 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 46112

Sub-TOI: L08.000 Life - Other

Co Tr Num: IWL-FE APP2

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Sue Long, Andrea Greiber Disposition Date: 07/06/2010

Date Submitted: 07/01/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

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: 07/06/2010

Explanation for Other Group Market Type:

State Status Changed: 07/06/2010

Deemer Date:

Created By: Andrea Greiber

Submitted By: Andrea Greiber

Corresponding Filing Tracking Number: IWLF-
A-0110-AR

Filing Description:

INDIVIDUAL WHOLE LIFE INSURANCE:

We are filing this product for your review and approval. This application form will REPLACE the application form (form number IWLF-A-0110-AR), SERFF Tracking No. MADS-126646065, approved by your Department on June 3, 2010.

The reasons we are replacing the previous application with this new application are:

1. We have decided to remove the blood pressure question from the medical history question section.
2. We decided to add height and weight questions to the first page.

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As with the original application, it can be used either in the traditional paper format, electronically using a digital signature via a pen pad, or completed over the telephone using voice signature, in accordance with the electronic transactions and signatures laws. The electronic application will look like the hard-copy application when it is printed out and attached to the Policy as part of the entire contract provision.

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Madison National Life Insurance Company, Inc.	\$50.00	07/01/2010	37701750

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/06/2010	07/06/2010

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Disposition

Disposition Date: 07/06/2010

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		Yes
Supporting Document	Application		Yes
Form	Individual Whole Life Insurance Application		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	IWLF-A-0710-AR	Application/ Individual Whole Life Enrollment Insurance Application Form	Revised	Replaced Form #: IWLF-A-0110-AR Previous Filing #: MADS-126646065	0.000	IWLF-A-0710-AR.pdf

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

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

Mailing: PO Box [2867, Clinton, IA 52733 (Admin. Office)]

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE

I. APPLICANT/INSURED				
Name (First, Middle, Last)			SSN or Tax ID No.	
Age	Date of Birth (mo/day/year)		U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", Country of Citizenship)	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height	ft.	in.	Weight lbs.
In the last 12 months, has the Applicant/Insured used tobacco of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Street Address (City, State, Zip or Country)			Phone No.(s)	
II. OWNER/PAYOR, if other than the Applicant/Insured				
Name (First, Middle, Last) <input type="checkbox"/> Owner <input type="checkbox"/> Payor <input type="checkbox"/> Owner & Payor			SSN or Tax ID No.	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Relationship to Applicant/Insured		U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", Country of Citizenship)	
Street Address (City, State, Zip or Country)			Phone No.(s)	
Mail Policy Documents to: <input type="checkbox"/> Agent <input type="checkbox"/> Applicant/Insured <input type="checkbox"/> Owner/Payor		Mailing Address, if different than shown for the Applicant or Owner		
III. BENEFICIARY(IES) - If multiple beneficiaries are named and a % is not provided, proceeds are to be paid equally to each individual.				
Primary, if living				
Name (First, MI, Last)	Age	%	Address	Relationship
Otherwise to:				
Name (First, MI, Last)	Age	%	Address	Relationship
Name (First, MI, Last)	Age	%	Address	Relationship
Name (First, MI, Last)	Age	%	Address	Relationship

IV. HEALTH QUESTIONS - The terms “diagnosed”, “advised” and “treatment” mean any diagnosis, advice or treatment received by a licensed medical professional or physician.	
Part 1: If the answer is “Yes” to any of the following, the Applicant is not eligible for this insurance.	
Is the Applicant currently confined to a hospital or a psychiatric, nursing, or correctional facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Applicant currently use a wheelchair (other than for a temporary impairment expected to last less than two months)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the Applicant currently receive, or has the Applicant been advised to receive:	
• assistance with the activities of daily living such as taking medications, bathing, dressing, eating or toileting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• home health care or hospice care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 5 years, has the Applicant been diagnosed with, received or been advised to receive, treatment for:	
• an organ or tissue transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• human immunodeficiency virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• Alzheimer’s disease, dementia, or amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 3 years, has the Applicant been diagnosed with, or treated for, cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 24 months, has the Applicant been diagnosed with a terminal illness which is a medical condition that is expected to result in death within 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 24 months, has the Applicant been diagnosed with, received or been advised to receive, treatment for:	
• heart or circulatory surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• a heart attack, congestive heart failure, cardiomyopathy, a stroke, a transient ischemic attack (TIA), an aneurysm or a brain tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• insulin shock, poorly controlled/uncontrolled blood sugar levels, a diabetic coma, or an amputation due to complications of diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
In the last 12 months, has the Applicant:	
• received treatment, or been advised to receive treatment, for alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• been advised to have a diagnostic test or surgery, or advised to receive hospitalization which has not yet been started, completed or for which results are not known?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• used or been advised to use oxygen equipment to assist with breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• received kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
→ If “Yes” is marked for any of the above answers, do not complete or submit this Application.	
→ If the answer to all the above questions is “No”, please complete Part 2 below.	
Part 2: If the answer is “Yes” to any of the following, the Applicant is eligible for the Graded Whole Life Policy.	
In the last 2 years, has the Applicant been diagnosed with, prescribed medication for, or been advised to have treatment for:	
• Parkinson’s disease or systemic lupus erythematosus (SLE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• cirrhosis of the liver, chronic hepatitis or another liver disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• kidney or renal failure or a kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
• chronic obstructive pulmonary disease (COPD) or emphysema?	<input type="checkbox"/> Yes <input type="checkbox"/> No
→ If “Yes” is marked for any of the above answers, select “Graded Policy” in section “V.”.	
→ If the answer is “No” to all questions in Parts 1 and 2, select “Level Policy” in section “V.”.	

V. WHOLE LIFE COVERAGE			
Please select the Whole Life Insurance Policy you are eligible for:			
<input type="checkbox"/> Level Policy with an accelerated death benefit		<input type="checkbox"/> Graded Policy	
If you selected "Level Policy" and would like to purchase the optional Rider, please select the Rider below:			
<input type="checkbox"/> Optional Rider - Accidental Death Benefit to age 70			
Life Insurance Benefit Amount		Administrative Endorsements/Notes:	
\$			
Death Benefit Payment Election (<i>choice to be made by Owner</i>)			
<input type="checkbox"/> Lump Sum \$ _____		<input type="checkbox"/> Annual Payments for 5 Years	
<input type="checkbox"/> Annual Payments of \$ _____, until proceeds are exhausted.		<input type="checkbox"/> Annual Payments for 10 Years	
VI. PREMIUM (payor information)			
MODE PREMIUM (Whole Life):		PREMIUM – Accidental Rider	
\$		\$	
Payment Mode		Do you elect the whole life Automatic Premium Loan Option?	
<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Payment Type			
<input type="checkbox"/> Bank Draft (please attach a voided check) <input type="checkbox"/> Debit Card <input type="checkbox"/> Credit Card <input type="checkbox"/> Other:			
Name of Financial Institution/Bank:		Street Address: (<i>City, State, Zip or Country</i>)	
Routing No.	Account No.	Is there a specific draft date? <input type="checkbox"/> No <input type="checkbox"/> Yes If "Yes" choose a day between the 3 rd and the 28 th :	
Card Account: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard	Account No.	Expiration Date:	
I authorize Madison National Life Insurance Company, Inc. (Madison Life) to initiate deductions for the purpose of paying life insurance premiums from the checking or savings account below and the named bank or financial institution (Bank) to charge such deductions to my account. This authority remains in effect until Madison Life and the Bank receives written notification from me of its termination in such a time and manner as to give Madison Life and the Bank a reasonable opportunity to act on it (30 days). I have the right to stop payment of a deduction for the purpose of paying life insurance premiums by notification to the Bank in time to give the Bank a reasonable opportunity to act on my request prior to charging my account. After my account has been charged, I have the right to have the amount of an erroneous deduction immediately credited to my account by the Bank, provided I send written notice of such erroneous deduction to the Bank within 15 days following issuance of the account statement or 45 days after posting, whichever occurs first.			
Payor Signature		Signature Date	
VII. THIRD-PARTY NOTICE REQUEST			
As an Applicant or Owner of a Policy, you have the right to designate another person to receive correspondence in the event any past due premiums could cause a possible lapse of the Policy. This person is known as a "third party" and this person would <u>not</u> receive regular premium billings or other Policy correspondence.			
Would you like to designate a third-party to receive notice if the Policy is going to lapse due to nonpayment of premium? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please complete the following:			
Name of Designee (<i>First, Middle, Last</i>)			
Address of Designee (<i>City, State, Zip or Country</i>)			

VIII. APPLICANT/INSURED CERTIFICATION AND SIGNATURE

Authorization for Receipt, Use and Disclosure of Information for Underwriting Insurance.

- I certify under penalty and perjury that my statements made on this Application are true, complete, and correct to the best of my knowledge and belief.
- I understand Madison National Life Insurance Company, Inc. is required to verify the identity of its members. Providing my name, address, date-of-birth and social security, or tax payor identification, number allows them to verify my identity.
- I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy provider, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, Medical Information Bureau, Inc., consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. Such information may include diagnosis, treatment and prognosis with respect to any physical or mental condition, employment, other insurance coverage, claims history and mode of living. I also know that if a consumer report about me is prepared, I may request a copy of the report. I also have the right to be interviewed as part of the application process and I may contact Madison National Life Insurance Company for further information.
- I understand that Madison National Life Insurance Company, Inc. may use this information for the purpose of evaluating my application; make eligibility, risk rating and policy issuance determinations; obtain reinsurance; and administer insurance benefits. I also understand that any information disclosed pursuant to this Authorization may be re-disclosed and no longer covered by Federal rules governing privacy and confidentiality of health information.
- I agree that this Authorization, in connection with this form, shall be valid for 24 months from my signature date. I understand that I, or my authorized representative, have the right to revoke this Authorization at any time. I understand that any revocation request of this Authorization will need to be in writing by sending a written request to Madison National Life Insurance Company, Inc. I realize that any such revocation may be a basis for denying the policy being applied for.
- I understand that any representative I appoint, prior to acting on my behalf, will need to submit power of attorney documents, or other legal documents, to Madison National Life Insurance Company, Inc.
- I realize such failure to sign an Authorization statement may impair the ability of a regulated insurance agency to process applications and may be a basis for denying this Application.
- I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.
- I acknowledge receipt of "Notice to Proposed Insured".

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/Insured Signature

Signature Date

Dated at this City & State

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO
MADISON NATIONAL LIFE INSURANCE CO., INC.
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

IX. EXISTING INSURANCE/REPLACEMENT - Questions & Signatures			
Applicant or Owner:			
• Does the Applicant/Insured have any existing life insurance policies or annuity contracts?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• If "Yes", does the Applicant/Insured intend to replace any existing life insurance policy or annuity contract?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Agent: To the best of your knowledge,			
• Does the Applicant/Insured have any existing life insurance policies or annuities in force?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• Is the life insurance applied for intended to replace any existing life insurance or annuity?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• If the Applicant or Owner indicates above that there is an existing policy or contract, you must present and read to the Applicant or Owner the required Replacement information. Did you complete this?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• Did you leave a copy of any sales materials used with the Applicant or Owner?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Please check "N/A" if no sales materials were used.			<input type="checkbox"/> N/A
Applicant or Owner Signature		Signature Date	
Agent Signature		Signature Date	
X. AGENT CERTIFICATION AND SIGNATURE			
To the best of your knowledge and belief:			
• Was the Applicant or Owner's signature witnessed by you?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• Did you truly and accurately record on this Application the information provided by the Applicant or Owner?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• Did you deliver the "Notice to Proposed Insured"?			<input type="checkbox"/> Yes <input type="checkbox"/> No
• Did you inform the Applicant or Owner that a telephone interview will be needed to verify answers to the Health Questions section?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Agent (typed/printed)	Agent Signature		Agent % Split
Dated at this City & State	Date	MNL Agent No.	Phone No.
Name of Agent (typed/printed)	Agent Signature		Agent % Split
Dated at this City & State	Date	MNL Agent No.	Phone No.
<i>Agent Comments/Notes:</i>			MNL Use Only

IWLF-A-0110

CONDITIONAL RECEIPT

(This receipt must not be completed unless payment of the first premium has been made at the time of application)

Received from _____, \$ _____
in connection with this Application for life insurance which bears the same date as the receipt. If this Application is not approved, the payment evidenced by this receipt will be returned. If this Application is approved, the policy will be effective with the date of Application, unless otherwise indicated herein. IWLF-A-0110

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification		
Comments: The flesch certification for the policy forms was filed with the policy forms.		

	Item Status:	Status Date:
Satisfied - Item: Application		
Comments: Application is in this filing, under the "Form Schedule" tab.		