

State: Arkansas **Filing Company:** Madison National Life Insurance Company, Inc.
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: IWFL App 0113-AR
Project Name/Number: /

Filing at a Glance

Company: Madison National Life Insurance Company, Inc.
Product Name: IWFL App 0113-AR
State: Arkansas
TOI: L08 Life - Other
Sub-TOI: L08.000 Life - Other
Filing Type: Form
Date Submitted: 01/15/2013
SERFF Tr Num: MADS-128850051
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: IWFL APP 0113-AR

Implementation: On Approval
Date Requested:
Author(s): Sue Long, Andrea Greiber
Reviewer(s): Linda Bird (primary)
Disposition Date: 01/22/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: IWFL App 0113-AR
 Project Name/Number: /

Filing Company: Madison National Life Insurance Company, Inc.

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	Individual Market Type:
Overall Rate Impact:	Filing Status Changed: 01/22/2013
	State Status Changed: 01/22/2013
Deemer Date:	Created By: Andrea Greiber
Submitted By: Andrea Greiber	Corresponding Filing Tracking Number: MADS-126646065

Filing Description:
 INDIVIDUAL WHOLE LIFE INSURANCE:

We are filing this application your review and approval. This application form will REPLACE the application form (form number IWLF-A-0710-AR), SERFF Tracking No. MADS-126705059, approved by your Department on July 6, 2010. The current application (IWLF-A-0710-AR) will remain in use until we can switch over to using all new applications being filed in various states.

This application will be used with the forms filed under 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 is we are in the process of streamlining our life product applications in order to provide consistency in the format in which information is asked and presented.

As with the current application, this application can be used either in the traditional paper format, electronically using a digital signature, 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:
(800) 356-9601 ext. [Phone]	FEIN Number: 39-0990296	

Filing Fees

State: Arkansas Filing Company: Madison National Life Insurance Company, Inc.
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: IWFL App 0113-AR
Project Name/Number: /

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

Company	Amount	Date Processed	Transaction #
Madison National Life Insurance Company, Inc.	\$50.00	01/15/2013	66555361

SERFF Tracking #:

MADS-128850051

State Tracking #:

Company Tracking #:

IWFL APP 0113-AR

State:

Arkansas

Filing Company:

Madison National Life Insurance Company, Inc.

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

IWFL App 0113-AR

Project Name/Number:

/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/22/2013	01/22/2013

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: IWFL App 0113-AR
Project Name/Number: /

Filing Company: Madison National Life Insurance Company, Inc.

Disposition

Disposition Date: 01/22/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Application in John Doe form (3)		Yes
Supporting Document	For refernece, some Supporting Documents (Non-Filed forms) - Time of Application		Yes
Supporting Document	Variability Statement		Yes
Form	INDIV. WHOLE LIFE INS APPLICATION		Yes

State: Arkansas
 TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
 Product Name: IWFL App 0113-AR
 Project Name/Number: /

Filing Company: Madison National Life Insurance Company, Inc.

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		INDIV. WHOLE LIFE INS APPLICATION	IWLF-A- 0113-AR	AEF	Initial		54.500	IWLF-A-0113- AR.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

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)]

[Reference No. _____]

INDIVIDUAL WHOLE LIFE INSURANCE APPLICATION

I. PROPOSED INSURED		
Name (First, Middle, Last)	Date of Birth (month/day/year)	
Age	In the last 12 months, has the Proposed Insured used tobacco of any kind? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Gender <input type="checkbox"/> M <input type="checkbox"/> F	Height (feet, inches)	Weight (lbs.)
Street Address (City, State, Zip or Country)		
Phone No.(s)	Email Address	
SSN or Tax ID No.	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", Country of Citizenship)	
II. OWNER, if other than the Proposed Insured		
Name (First, Middle, Last)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Relationship to Proposed Insured (there must be an insurable interest meeting state laws)		
Street Address (City, State, Zip or Country)		
Phone No.(s)	Email Address	
SSN or Tax ID No.	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (if "No", Country of Citizenship)	
Mail Policy Documents to: <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Agent (N/A for telephone sales)	Mailing Address (if different than shown for the Proposed Insured or Owner)	

III. HEALTH QUESTIONS

The terms “diagnosed”, “advised” and “treated” mean any diagnosis, advice or treatment received by a member of the medical profession. Treatment includes prescription medication. Please answer “Yes” or “No” to the following questions.

PART 1:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

1	Is the Proposed Insured currently confined to a hospital or a psychiatric, nursing, or correctional facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Does the Proposed Insured 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
3	Does the Proposed Insured currently receive, or has the Proposed Insured been advised by a medical professional to receive:	
3.1	assistance with the activities of daily living such as taking medications, bathing, dressing, eating or toileting?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.2	home health care or hospice care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4	In the last 12 months, has the Proposed Insured:	
4.1	used, or been advised to use, oxygen equipment to assist with breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.2	received kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.3	had a diagnostic test for which results are pending or been advised to have a diagnostic test or surgery (except those tests related to Human Immunodeficiency Virus (AIDS virus))?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.4	been advised by a medical professional to receive hospitalization which has not yet been started or completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5	In the last 12 months has the Proposed Insured been hospitalized, received treatment, been advised to receive treatment or prescribed medication by a medical professional for:	
5.1	alcohol or drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5.2	schizophrenia, bipolar disorder or attempted suicide?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6	In the last 24 months has the Proposed Insured been diagnosed by a medical professional 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
7	In the last 24 months has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
7.1	heart or circulatory surgery or a pacemaker or defibrillator implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.2	a heart attack, congestive heart failure or cardiomyopathy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.3	a stroke, a transient ischemic attack (TIA), an aneurysm or a brain tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.4	complications due to diabetes, including insulin shock, nephropathy (disease of or damage to a kidney), neuropathy, a diabetic coma, or an amputation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7.5	cirrhosis of the liver or complications due to cirrhosis of the liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	In the last 3 years has the Proposed Insured been diagnosed with, treated, been advised to receive treatment or prescribed medication by a medical professional for cancer (excluding basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9	In the last 5 years has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
9.1	an organ or tissue transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.2	Alzheimer’s disease, dementia, or amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.3	human immunodeficiency virus (AIDS Virus)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9.4	acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If “Yes” was marked to one of the above questions, the Proposed Insured is not eligible for this insurance. If the answer to all the above questions is “No”, please complete Part 2 below.

III. HEALTH QUESTIONS *continued...*

The terms “diagnosed”, “advised” and “treated” mean any diagnosis, advice or treatment received by a member of the medical profession. Treatment includes prescription medication. Please answer “Yes” or “No” to the following questions.

PART 2:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

10	In the last 24 months has the Proposed Insured been diagnosed with, been advised to have treatment, or prescribed medication by a medical professional for:		
10.1	Parkinson’s disease or systemic lupus erythematosus (SLE)?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10.2	chronic hepatitis, jaundice, or liver disorders other than cirrhosis of the liver?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10.3	kidney or renal insufficiency or a kidney disease?		<input type="checkbox"/> Yes <input type="checkbox"/> No
10.4	chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis or tuberculosis?		<input type="checkbox"/> Yes <input type="checkbox"/> No

If “Yes” was marked to one of the above questions, the Proposed Insured is eligible for the Graded Whole Life Policy.

If the answer is “No” to all questions in Parts 1 and 2, the Proposed Insured is eligible for the Level Whole Life Policy.

IV. INSURANCE COVERAGE

Please select the Whole Life Insurance Policy you are eligible for:

Level Policy Graded Policy

If you selected “Level Policy”, would you like to purchase the optional Rider with an Accidental Death Benefit to age 70? Yes No

Life Insurance Benefit Amount \$	<i>Administrative Endorsements/Notes</i> MNL Use Only
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V. PREMIUM

Payment Mode <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	Do you elect the whole life Automatic Premium Loan Option? <input type="checkbox"/> Yes <input type="checkbox"/> No
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MODE PREMIUM (Whole Life): \$	PREMIUM (Accidental Rider, if applicable): \$
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ALL PREMIUM PAYMENTS MUST BE MADE PAYABLE TO MADISON NATIONAL LIFE INSURANCE.

As a Proposed Insured 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.

Would you like to designate another person to receive notice if the Policy is going to lapse due to nonpayment of premium? Yes No

If “Yes” the agent will complete for you the designee contact information.

VI. BENEFICIARY(IES)**- If multiple beneficiaries are named and a % is not provided, proceeds are to be paid equally to each individual.**

<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	

VII. CERTIFICATION AND SIGNATURE

Proposed Insured and Owner:

Does the Proposed Insured have any existing life insurance policies or annuity contracts? Yes No

If “Yes”, does the Proposed Insured intend to replace any existing life insurance policy or annuity contract? Yes No

- I certify that all answers to the questions in all parts of this Application are true and complete to the best of my knowledge and belief.
- I have read and understand the conditions relating to this Application, any supplement to the Application (if any), and the Authorization for Release of Medical Information.
- 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 numbers allows them to verify my identity.
- I understand that no insurance will be effective until this Application is approved, premium is received, and the Policy is issued.
- I understand that I (or my authorized representative) may receive a copy of this Certification.
- 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 certify that the Owner has an insurable interest in the life of the Proposed Insured.
- I understand that if I choose to sign this Application electronically or telephonically, I also have the right to withdraw my authorization to use of my electronic or voice signature.

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.

Proposed Insured Signature	Signature Date	Dated at this City & State

Proposed Insured: I understand the conditions relating to the Notice To Proposed Insured regarding the Federal Fair Credit Reporting Act and the MIB organization. I authorize Madison National Life Insurance Company, Inc., or its reinsurer, to make a brief report of my personal health information to MIB Group, Inc.

Proposed Insured Signature	Signature Date

[Proposed Insured e-signature documentation]

VIII. AGENT CONFIRMATION AND SIGNATURE

To the best of your knowledge,

1	Does the Proposed Insured have any existing life insurance policies or annuities in force?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2	Is the life insurance applied for intended to replace any existing life insurance or annuity?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.1	If the Proposed Insured or Owner indicates above that there is an existing policy or contract, you must present and read to the Proposed Insured or Owner the required Replacement information. Did you complete this?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
3	Did you complete this Application with the Proposed Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.1	If "Yes", did you accurately record the Application? (If "No" on question "3", please choose "N/A".)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4	For a paper application: Did you witness the Proposed Insured sign this Application? (If the Application was not signed in your presence, or it's not paper, choose "N/A".)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5	For an electronic application: Did the Proposed Insured verbally or electronically authenticate his or her electronic signature in your presence? (If the Application was not signed in your presence, or it's not electronic, choose "N/A".)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6	Did you receive a signed "Authorization for Release of Medical Information" from the Proposed Insured?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7	Did you inform the Proposed Insured that a telephone interview will be needed to verify answers to the "Health Questions" section?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8	Please verify you provided the "Notice to Proposed Insured" (written or electronic).	<input type="checkbox"/> Yes
9	Did you use sales material with the Proposed Insured or Owner? (If "Yes", you must leave a copy of the materials with, or provide a copy of the materials to, the Owner or Proposed Insured.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
10	Is the Proposed Insured or Owner your immediate family member or family relative?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10.1	If "Yes", what is your relation? <i>(write/type here)</i> :	

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>	<small>MNL Use Only</small>
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State: Arkansas

TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other

Product Name: IWFL App 0113-AR

Project Name/Number: /

Filing Company:

Madison National Life Insurance Company, Inc.

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
Readability Cert 54.5.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application in John Doe form (3)		
Comments:	John Doe Paper, Wet signature John Doe Electronic, Electronic signature John Doe Electronic, Voice signature		
Attachment(s):			
IWLF-A-0113-AR JDoe Paper.pdf IWLF-A-0113-AR JDoe Elec.pdf IWLF-A-0113-AR JDoe Voice.pdf			

		Item Status:	Status Date:
Satisfied - Item:	For refernece, some Supporting Documents (Non-Filed forms) - Time of Application		
Comments:	- (HIPAA) Authorization for Release of Medical Information - Conditional Receipt (when applicable) - Third-Party Notice Request Form (used when indicated "yes" in the application)		
Attachment(s):			
AR Supp Doc Attachment.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Variability Statement		

SERFF Tracking #:

MADS-128850051

State Tracking #:

Company Tracking #:

IWFL APP 0113-AR

State:

Arkansas

Filing Company:

Madison National Life Insurance Company, Inc.

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

IWFL App 0113-AR

Project Name/Number:

/

Comments:

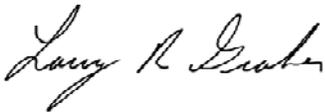
Attachment(s):

Variability Stmt-Application.pdf

FLESCH SCORE CERTIFICATION

I hereby certify that the application form 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 with resulting scores of:

Form No.	Description	Score
ICC13-IWLF-A-0113	Individual Application for Whole Life Insurance	54.5



Larry R. Graber
January 11, 2013

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)]

Reference No. 12345666

INDIVIDUAL WHOLE LIFE INSURANCE APPLICATION

I. PROPOSED INSURED		
Name (<i>First, Middle, Last</i>) <i>John Allen Doe</i>	Date of Birth (<i>month/day/year</i>) <i>January 2, 1953</i>	
Age <i>50</i>	In the last 12 months, has the Proposed Insured used tobacco of any kind? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Height (<i>feet, inches</i>) <i>6'3"</i>	Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Street Address (<i>City, State, Zip or Country</i>) <i>1234 Deming Way, Madison, WI 53717</i>		
Phone No.(s) <i>608-258-8552</i>	Email Address <i>johnallendoe@yahoo.com</i>	
SSN or Tax ID No. <i>123-33-3322</i>	U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (<i>if "No", Country of Citizenship</i>)	
II. OWNER, if other than the Proposed Insured		
Name (<i>First, Middle, Last</i>)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Relationship to Proposed Insured (there must be an insurable interest meeting state laws)		
Street Address (<i>City, State, Zip or Country</i>)		
Phone No.(s)	Email Address	
SSN or Tax ID No.	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if "No", Country of Citizenship</i>)	
Mail Policy Documents to: <input checked="" type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Agent (<i>N/A for telephone sales</i>)	Mailing Address (<i>if different than shown for the Proposed Insured or Owner</i>)	

III. HEALTH QUESTIONS

The terms “diagnosed”, “advised” and “treated” mean any diagnosis, advice or treatment received by a member of the medical profession. Treatment includes prescription medication. Please answer “Yes” or “No” to the following questions.

PART 1:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

1	Is the Proposed Insured currently confined to a hospital or a psychiatric, nursing, or correctional facility?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	Does the Proposed Insured currently use a wheelchair (other than for a temporary impairment expected to last less than two months)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3	Does the Proposed Insured currently receive, or has the Proposed Insured been advised by a medical professional to receive:	
3.1	assistance with the activities of daily living such as taking medications, bathing, dressing, eating or toileting?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3.2	home health care or hospice care?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4	In the last 12 months, has the Proposed Insured:	
4.1	used, or been advised to use, oxygen equipment to assist with breathing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.2	received kidney dialysis?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.3	had a diagnostic test for which results are pending or been advised to have a diagnostic test or surgery (except those tests related to Human Immunodeficiency Virus (AIDS virus))?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.4	been advised by a medical professional to receive hospitalization which has not yet been started or completed?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	In the last 12 months has the Proposed Insured been hospitalized, received treatment, been advised to receive treatment or prescribed medication by a medical professional for:	
5.1	alcohol or drug abuse?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5.2	schizophrenia, bipolar disorder or attempted suicide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6	In the last 24 months has the Proposed Insured been diagnosed by a medical professional with a terminal illness which is a medical condition that is expected to result in death within 24 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7	In the last 24 months has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
7.1	heart or circulatory surgery or a pacemaker or defibrillator implant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.2	a heart attack, congestive heart failure or cardiomyopathy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.3	a stroke, a transient ischemic attack (TIA), an aneurysm or a brain tumor?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.4	complications due to diabetes, including insulin shock, nephropathy (disease of or damage to a kidney), neuropathy, a diabetic coma, or an amputation?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.5	cirrhosis of the liver or complications due to cirrhosis of the liver?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8	In the last 3 years has the Proposed Insured been diagnosed with, treated, been advised to receive treatment or prescribed medication by a medical professional for cancer (excluding basal cell carcinoma)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9	In the last 5 years has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
9.1	an organ or tissue transplant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.2	Alzheimer’s disease, dementia, or amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.3	human immunodeficiency virus (AIDS Virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.4	acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

If “Yes” was marked to one of the above questions, the Proposed Insured is not eligible for this insurance. If the answer to all the above questions is “No”, please complete Part 2 below.

III. HEALTH QUESTIONS *continued...*

The terms “diagnosed”, “advised” and “treated” mean any diagnosis, advice or treatment received by a member of the medical profession. Treatment includes prescription medication. Please answer “Yes” or “No” to the following questions.

PART 2:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

10 In the last 24 months has the Proposed Insured been diagnosed with, been advised to have treatment, or prescribed medication by a medical professional for:

10.1	Parkinson’s disease or systemic lupus erythematosus (SLE)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.2	chronic hepatitis, jaundice, or liver disorders other than cirrhosis of the liver?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.3	kidney or renal insufficiency or a kidney disease?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.4	chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis or tuberculosis?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

If “Yes” was marked to one of the above questions, the Proposed Insured is eligible for the Graded Whole Life Policy.

If the answer is “No” to all questions in Parts 1 and 2, the Proposed Insured is eligible for the Level Whole Life Policy.

IV. INSURANCE COVERAGE

Please select the Whole Life Insurance Policy you are eligible for:

Level Policy Graded Policy

If you selected “Level Policy”, would you like to purchase the optional Rider with an Accidental Death Benefit to age 70? Yes No

Life Insurance Benefit Amount \$10,000.00	<i>Administrative Endorsements/Notes</i> MNL Use Only
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V. PREMIUM

Payment Mode <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly	Do you elect the whole life Automatic Premium Loan Option? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
--	--

MODE PREMIUM (Whole Life): \$ 480.00	PREMIUM (Accidental Rider, if applicable): \$ 0.00
--	--

ALL PREMIUM PAYMENTS MUST BE MADE PAYABLE TO MADISON NATIONAL LIFE INSURANCE.

As a Proposed Insured 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.

Would you like to designate another person to receive notice if the Policy is going to lapse due to nonpayment of premium? Yes No
If “Yes” the agent will complete for you the designee contact information.

VI. BENEFICIARY(IES)**- If multiple beneficiaries are named and a % is not provided, proceeds are to be paid equally to each individual.**

<input checked="" type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary	<i>Jane E. Doe</i>		<i>75</i> %
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
<i>1/1/1953</i>	<i>Wife</i>	<i>608-258-8552</i>	
Address (Street, City, State)		Email Address:	
<i>1234 Deming Way, Madison, WI 53717</i>		<i>janeellendoe@yahoo.com</i>	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input checked="" type="checkbox"/> Contingent Beneficiary	<i>Jarod P. Doe</i>		<i>25</i> %
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
<i>11/1/1999</i>	<i>Son</i>	<i>608-258-1442</i>	
Address (Street, City, State)		Email Address:	
<i>1988 Sunset View, Madison, WI 53705</i>		<i>jarpdphillipndoe@yahoo.com</i>	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary			%
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary			%
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary			%
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	

VII. CERTIFICATION AND SIGNATURE

Proposed Insured and Owner:

Does the Proposed Insured have any existing life insurance policies or annuity contracts? Yes No

If "Yes", does the Proposed Insured intend to replace any existing life insurance policy or annuity contract? Yes No

- I certify that all answers to the questions in all parts of this Application are true and complete to the best of my knowledge and belief.
- I have read and understand the conditions relating to this Application, any supplement to the Application (if any), and the Authorization for Release of Medical Information.
- 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 numbers allows them to verify my identity.
- I understand that no insurance will be effective until this Application is approved, premium is received, and the Policy is issued.
- I understand that I (or my authorized representative) may receive a copy of this Certification.
- 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 certify that the Owner has an insurable interest in the life of the Proposed Insured.
- I understand that if I choose to sign this Application electronically or telephonically, I also have the right to withdraw my authorization to use of my electronic or voice signature.

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.

Proposed Insured Signature <i>John A. Doe</i>	Signature Date <i>1/4/2012</i>	Dated at this City & State <i>Madison, WI</i>
---	--	---

Proposed Insured: I understand the conditions relating to the Notice To Proposed Insured regarding the Federal Fair Credit Reporting Act and the MIB organization. I authorize Madison National Life Insurance Company, Inc., or its reinsurer, to make a brief report of my personal health information to MIB Group, Inc.

Proposed Insured Signature <i>John A. Doe</i>	Signature Date <i>1/4/2012</i>
---	--

VIII. AGENT CONFIRMATION AND SIGNATURE

To the best of your knowledge,

1	Does the Proposed Insured have any existing life insurance policies or annuities in force?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Is the life insurance applied for intended to replace any existing life insurance or annuity?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2.1	If the Proposed Insured or Owner indicates above that there is an existing policy or contract, you must present and read to the Proposed Insured or Owner the required Replacement information. Did you complete this?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
3	Did you complete this Application with the Proposed Insured?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.1	If "Yes", did you accurately record the Application? (If "No" on question "3", please choose "N/A".)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4	For a paper application: Did you witness the Proposed Insured sign this Application? (If the Application was not signed in your presence, or it's not paper, choose "N/A".)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
5	For an electronic application: Did the Proposed Insured verbally or electronically authenticate his or her electronic signature in your presence? (If the Application was not signed in your presence, or it's not electronic, choose "N/A".)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
6	Did you receive a signed "Authorization for Release of Medical Information" from the Proposed Insured?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Did you inform the Proposed Insured that a telephone interview will be needed to verify answers to the "Health Questions" section?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Please verify you provided the "Notice to Proposed Insured" (written or electronic).	<input checked="" type="checkbox"/> Yes
9	Did you use sales material with the Proposed Insured or Owner? (If "Yes", you must leave a copy of the materials with, or provide a copy of the materials to, the Owner or Proposed Insured.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	Is the Proposed Insured or Owner your immediate family member or family relative?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.1	If "Yes", what is your relation? <i>(write/type here):</i>	

Name of Agent (typed/printed)	Agent Signature		Agent % Split
<i>Scott McDonald</i>	<i>Scott McDonald</i>		<i>100</i>
Dated at this City & State	Date	MNL Agent No.	Phone No.
<i>Madison, WI</i>	<i>1/4/2012</i>	<i>4277863</i>	<i>608-885-7521</i>
Name of Agent (typed/printed)	Agent Signature		Agent % Split
Dated at this City & State	Date	MNL Agent No.	Phone No.

Agent Comments/Notes:

MNL Use Only

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)]

Reference No. 12345666

INDIVIDUAL WHOLE LIFE INSURANCE APPLICATION

I. PROPOSED INSURED		
Name (<i>First, Middle, Last</i>) John Allen Doe	Date of Birth (<i>month/day/year</i>) January 2, 1953	
Age 50	In the last 12 months, has the Proposed Insured used tobacco of any kind? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Height (<i>feet, inches</i>) 6'3"	Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Street Address (<i>City, State, Zip or Country</i>) 1234 Deming Way, Madison, WI 53717		
Phone No.(s) 608-258-8552	Email Address johnallendoe@yahoo.com	
SSN or Tax ID No. 123-33-3322	U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (<i>if "No", Country of Citizenship</i>)	
II. OWNER, if other than the Proposed Insured		
Name (<i>First, Middle, Last</i>)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Relationship to Proposed Insured (there must be an insurable interest meeting state laws)		
Street Address (<i>City, State, Zip or Country</i>)		
Phone No.(s)	Email Address	
SSN or Tax ID No.	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if "No", Country of Citizenship</i>)	
Mail Policy Documents to: <input checked="" type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Agent (<i>N/A for telephone sales</i>)	Mailing Address (<i>if different than shown for the Proposed Insured or Owner</i>)	

III. HEALTH QUESTIONS

The terms “diagnosed”, “advised” and “treated” mean any diagnosis, advice or treatment received by a member of the medical profession. Treatment includes prescription medication. Please answer “Yes” or “No” to the following questions.

PART 1:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

1	Is the Proposed Insured currently confined to a hospital or a psychiatric, nursing, or correctional facility?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	Does the Proposed Insured currently use a wheelchair (other than for a temporary impairment expected to last less than two months)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3	Does the Proposed Insured currently receive, or has the Proposed Insured been advised by a medical professional to receive:	
3.1	assistance with the activities of daily living such as taking medications, bathing, dressing, eating or toileting?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3.2	home health care or hospice care?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4	In the last 12 months, has the Proposed Insured:	
4.1	used, or been advised to use, oxygen equipment to assist with breathing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.2	received kidney dialysis?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.3	had a diagnostic test for which results are pending or been advised to have a diagnostic test or surgery (except those tests related to Human Immunodeficiency Virus (AIDS virus))?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.4	been advised by a medical professional to receive hospitalization which has not yet been started or completed?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	In the last 12 months has the Proposed Insured been hospitalized, received treatment, been advised to receive treatment or prescribed medication by a medical professional for:	
5.1	alcohol or drug abuse?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5.2	schizophrenia, bipolar disorder or attempted suicide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6	In the last 24 months has the Proposed Insured been diagnosed by a medical professional with a terminal illness which is a medical condition that is expected to result in death within 24 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7	In the last 24 months has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
7.1	heart or circulatory surgery or a pacemaker or defibrillator implant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.2	a heart attack, congestive heart failure or cardiomyopathy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.3	a stroke, a transient ischemic attack (TIA), an aneurysm or a brain tumor?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.4	complications due to diabetes, including insulin shock, nephropathy (disease of or damage to a kidney), neuropathy, a diabetic coma, or an amputation?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.5	cirrhosis of the liver or complications due to cirrhosis of the liver?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8	In the last 3 years has the Proposed Insured been diagnosed with, treated, been advised to receive treatment or prescribed medication by a medical professional for cancer (excluding basal cell carcinoma)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9	In the last 5 years has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
9.1	an organ or tissue transplant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.2	Alzheimer’s disease, dementia, or amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.3	human immunodeficiency virus (AIDS Virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.4	acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

If “Yes” was marked to one of the above questions, the Proposed Insured is not eligible for this insurance. If the answer to all the above questions is “No”, please complete Part 2 below.

VI. BENEFICIARY(IES)**- If multiple beneficiaries are named and a % is not provided, proceeds are to be paid equally to each individual.**

<input checked="" type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary	<i>Jane E. Doe</i>		<i>75 %</i>
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
<i>1/1/1953</i>	<i>Wife</i>	<i>608-258-8552</i>	
Address (Street, City, State)		Email Address:	
<i>1234 Deming Way, Madison, WI 53717</i>		<i>janeellendoe@yahoo.com</i>	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input checked="" type="checkbox"/> Contingent Beneficiary	<i>Jarod P. Doe</i>		<i>25 %</i>
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
<i>11/1/1999</i>	<i>Son</i>	<i>608-258-1442</i>	
Address (Street, City, State)		Email Address:	
<i>1988 Sunset View, Madison, WI 53705</i>		<i>jarpdphillipndoe@yahoo.com</i>	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary			%
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary			%
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		
<input type="checkbox"/> Contingent Beneficiary			%
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	

VII. CERTIFICATION AND SIGNATURE

Proposed Insured and Owner:

Does the Proposed Insured have any existing life insurance policies or annuity contracts? Yes No

If "Yes", does the Proposed Insured intend to replace any existing life insurance policy or annuity contract? Yes No

- I certify that all answers to the questions in all parts of this Application are true and complete to the best of my knowledge and belief.
- I have read and understand the conditions relating to this Application, any supplement to the Application (if any), and the Authorization for Release of Medical Information.
- 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 numbers allows them to verify my identity.
- I understand that no insurance will be effective until this Application is approved, premium is received, and the Policy is issued.
- I understand that I (or my authorized representative) may receive a copy of this Certification.
- 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 certify that the Owner has an insurable interest in the life of the Proposed Insured.
- I understand that if I choose to sign this Application electronically or telephonically, I also have the right to withdraw my authorization to use of my electronic or voice signature.

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.

Proposed Insured Signature <i>John A. Doe</i>	Signature Date <i>1/4/2012</i>	Dated at this City & State <i>Madison, WI</i>
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Proposed Insured: I understand the conditions relating to the Notice To Proposed Insured regarding the Federal Fair Credit Reporting Act and the MIB organization. I authorize Madison National Life Insurance Company, Inc., or its reinsurer, to make a brief report of my personal health information to MIB Group, Inc.

Proposed Insured Signature <i>John A. Doe</i>	Signature Date <i>1/4/2012</i>
---	--

Adopt Your Signature

Signature: **John Doe**

Yes, adopt this signature as my signature* No, use voice signature

* By clicking YES I agree that the signature I have selected above will be the electronic representation of my signature for the purpose of this authentication, just the same as a pen-and-paper signature.

On 24 Sep 2013 at 14:31 The signature above was adopted by John Doe

VIII. AGENT CONFIRMATION AND SIGNATURE

To the best of your knowledge,

1	Does the Proposed Insured have any existing life insurance policies or annuities in force?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Is the life insurance applied for intended to replace any existing life insurance or annuity?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2.1	If the Proposed Insured or Owner indicates above that there is an existing policy or contract, you must present and read to the Proposed Insured or Owner the required Replacement information. Did you complete this?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
3	Did you complete this Application with the Proposed Insured?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.1	If "Yes", did you accurately record the Application? (If "No" on question "3", please choose "N/A".)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4	For a paper application: Did you witness the Proposed Insured sign this Application? (If the Application was not signed in your presence, or it's not paper, choose "N/A".)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
5	For an electronic application: Did the Proposed Insured verbally or electronically authenticate his or her electronic signature in your presence? (If the Application was not signed in your presence, or it's not electronic, choose "N/A".)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6	Did you receive a signed "Authorization for Release of Medical Information" from the Proposed Insured?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Did you inform the Proposed Insured that a telephone interview will be needed to verify answers to the "Health Questions" section?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Please verify you provided the "Notice to Proposed Insured" (written or electronic).	<input checked="" type="checkbox"/> Yes
9	Did you use sales material with the Proposed Insured or Owner? (If "Yes", you must leave a copy of the materials with, or provide a copy of the materials to, the Owner or Proposed Insured.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	Is the Proposed Insured or Owner your immediate family member or family relative?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.1	If "Yes", what is your relation? <i>(write/type here)</i> :	

Name of Agent (typed/printed)	Agent Signature		Agent % Split
Scott McDonald	Scott McDonald		100
Dated at this City & State	Date	MNL Agent No.	Phone No.
Madison, WI	1/4/2012	4277863	608-885-7521
Name of Agent (typed/printed)	Agent Signature		Agent % Split
Dated at this City & State	Date	MNL Agent No.	Phone No.

Agent Comments/Notes:

MNL Use Only

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)]

Reference No. 12345666

INDIVIDUAL WHOLE LIFE INSURANCE APPLICATION

I. PROPOSED INSURED		
Name (<i>First, Middle, Last</i>) John Allen Doe	Date of Birth (<i>month/day/year</i>) January 2, 1953	
Age 50	In the last 12 months, has the Proposed Insured used tobacco of any kind? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Height (<i>feet, inches</i>) 6'3"	Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Street Address (<i>City, State, Zip or Country</i>) 1234 Deming Way, Madison, WI 53717		
Phone No.(s) 608-258-8552	Email Address johnallendoe@yahoo.com	
SSN or Tax ID No. 123-33-3322	U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No (<i>if "No", Country of Citizenship</i>)	
II. OWNER, if other than the Proposed Insured		
Name (<i>First, Middle, Last</i>)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	
Relationship to Proposed Insured (there must be an insurable interest meeting state laws)		
Street Address (<i>City, State, Zip or Country</i>)		
Phone No.(s)	Email Address	
SSN or Tax ID No.	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No (<i>if "No", Country of Citizenship</i>)	
Mail Policy Documents to: <input checked="" type="checkbox"/> Proposed Insured <input type="checkbox"/> Owner <input type="checkbox"/> Agent (<i>N/A for telephone sales</i>)	Mailing Address (<i>if different than shown for the Proposed Insured or Owner</i>)	

III. HEALTH QUESTIONS

The terms “diagnosed”, “advised” and “treated” mean any diagnosis, advice or treatment received by a member of the medical profession. Treatment includes prescription medication. Please answer “Yes” or “No” to the following questions.

PART 1:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

1	Is the Proposed Insured currently confined to a hospital or a psychiatric, nursing, or correctional facility?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2	Does the Proposed Insured currently use a wheelchair (other than for a temporary impairment expected to last less than two months)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3	Does the Proposed Insured currently receive, or has the Proposed Insured been advised by a medical professional to receive:	
3.1	assistance with the activities of daily living such as taking medications, bathing, dressing, eating or toileting?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3.2	home health care or hospice care?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4	In the last 12 months, has the Proposed Insured:	
4.1	used, or been advised to use, oxygen equipment to assist with breathing?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.2	received kidney dialysis?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.3	had a diagnostic test for which results are pending or been advised to have a diagnostic test or surgery (except those tests related to Human Immunodeficiency Virus (AIDS virus))?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4.4	been advised by a medical professional to receive hospitalization which has not yet been started or completed?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5	In the last 12 months has the Proposed Insured been hospitalized, received treatment, been advised to receive treatment or prescribed medication by a medical professional for:	
5.1	alcohol or drug abuse?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
5.2	schizophrenia, bipolar disorder or attempted suicide?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
6	In the last 24 months has the Proposed Insured been diagnosed by a medical professional with a terminal illness which is a medical condition that is expected to result in death within 24 months?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7	In the last 24 months has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
7.1	heart or circulatory surgery or a pacemaker or defibrillator implant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.2	a heart attack, congestive heart failure or cardiomyopathy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.3	a stroke, a transient ischemic attack (TIA), an aneurysm or a brain tumor?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.4	complications due to diabetes, including insulin shock, nephropathy (disease of or damage to a kidney), neuropathy, a diabetic coma, or an amputation?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7.5	cirrhosis of the liver or complications due to cirrhosis of the liver?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
8	In the last 3 years has the Proposed Insured been diagnosed with, treated, been advised to receive treatment or prescribed medication by a medical professional for cancer (excluding basal cell carcinoma)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9	In the last 5 years has the Proposed Insured been diagnosed with, received or been advised to receive treatment or prescribed medication by a medical professional for:	
9.1	an organ or tissue transplant?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.2	Alzheimer’s disease, dementia, or amyotrophic lateral sclerosis (ALS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.3	human immunodeficiency virus (AIDS Virus)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9.4	acquired immune deficiency syndrome (AIDS)?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No

If “Yes” was marked to one of the above questions, the Proposed Insured is not eligible for this insurance. If the answer to all the above questions is “No”, please complete Part 2 below.

VI. BENEFICIARY(IES)**- If multiple beneficiaries are named and a % is not provided, proceeds are to be paid equally to each individual.**

<input checked="" type="checkbox"/> Primary Beneficiary	Name (First, MI, Last) <i>Jane E. Doe</i>		75 %
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year) <i>1/1/1953</i>	Relationship To Proposed Insured <i>Wife</i>	Telephone No.(s) <i>608-258-8552</i>	
Address (Street, City, State) <i>1234 Deming Way, Madison, WI 53717</i>		Email Address: <i>janeellendoe@yahoo.com</i>	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last) <i>Jarod P. Doe</i>		25 %
<input checked="" type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year) <i>11/1/1999</i>	Relationship To Proposed Insured <i>Son</i>	Telephone No.(s) <i>608-258-1442</i>	
Address (Street, City, State) <i>1988 Sunset View, Madison, WI 53705</i>		Email Address: <i>jarpdphillipndoe@yahoo.com</i>	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	
<input type="checkbox"/> Primary Beneficiary	Name (First, MI, Last)		%
<input type="checkbox"/> Contingent Beneficiary			
Date of Birth (month/day/year)	Relationship To Proposed Insured	Telephone No.(s)	
Address (Street, City, State)		Email Address:	

VII. CERTIFICATION AND SIGNATURE

Proposed Insured and Owner:

Does the Proposed Insured have any existing life insurance policies or annuity contracts? Yes No

If "Yes", does the Proposed Insured intend to replace any existing life insurance policy or annuity contract? Yes No

- I certify that all answers to the questions in all parts of this Application are true and complete to the best of my knowledge and belief.
- I have read and understand the conditions relating to this Application, any supplement to the Application (if any), and the Authorization for Release of Medical Information.
- 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 numbers allows them to verify my identity.
- I understand that no insurance will be effective until this Application is approved, premium is received, and the Policy is issued.
- I understand that I (or my authorized representative) may receive a copy of this Certification.
- 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 certify that the Owner has an insurable interest in the life of the Proposed Insured.
- I understand that if I choose to sign this Application electronically or telephonically, I also have the right to withdraw my authorization to use of my electronic or voice signature.

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.

Proposed Insured Signature 123554 Voice Signature John Doe	Signature Date 01/04/2012	Dated at this City & State Madison, WI
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Proposed Insured: I understand the conditions relating to the Notice To Proposed Insured regarding the Federal Fair Credit Reporting Act and the MIB organization. I authorize Madison National Life Insurance Company, Inc., or its reinsurer, to make a brief report of my personal health information to MIB Group, Inc.

Proposed Insured Signature 123554 Voice Signature John Doe	Signature Date 01/04/2012
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Adopt Your Signature

Signature:

- Yes, adopt this signature as my signature* No, use voice signature

* By clicking YES I agree that the signature I have selected above will be the electronic representation of my signature for the purpose of this authentication, just the same as a pen-and-paper signature.

On _____ at _____ The signature above was adopted by _____

VIII. AGENT CONFIRMATION AND SIGNATURE

To the best of your knowledge,

1	Does the Proposed Insured have any existing life insurance policies or annuities in force?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2	Is the life insurance applied for intended to replace any existing life insurance or annuity?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2.1	If the Proposed Insured or Owner indicates above that there is an existing policy or contract, you must present and read to the Proposed Insured or Owner the required Replacement information. Did you complete this?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
3	Did you complete this Application with the Proposed Insured?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3.1	If "Yes", did you accurately record the Application? (If "No" on question "3", please choose "N/A".)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
4	For a paper application: Did you witness the Proposed Insured sign this Application? (If the Application was not signed in your presence, or it's not paper, choose "N/A".)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> N/A
5	For an electronic application: Did the Proposed Insured verbally or electronically authenticate his or her electronic signature in your presence? (If the Application was not signed in your presence, or it's not electronic, choose "N/A".)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
6	Did you receive a signed "Authorization for Release of Medical Information" from the Proposed Insured?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
7	Did you inform the Proposed Insured that a telephone interview will be needed to verify answers to the "Health Questions" section?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
8	Please verify you provided the "Notice to Proposed Insured" (written or electronic).	<input checked="" type="checkbox"/> Yes
9	Did you use sales material with the Proposed Insured or Owner? (If "Yes", you must leave a copy of the materials with, or provide a copy of the materials to, the Owner or Proposed Insured.)	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10	Is the Proposed Insured or Owner your immediate family member or family relative?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10.1	If "Yes", what is your relation? <i>(write/type here)</i> :	

Name of Agent (typed/printed)	Agent Signature		Agent % Split
Scott McDonald	Scott McDonald		100
Dated at this City & State	Date	MNL Agent No.	Phone No.
Madison, WI	1/4/2012	4277863	608-885-7521
Name of Agent (typed/printed)	Agent Signature		Agent % Split
Dated at this City & State	Date	MNL Agent No.	Phone No.

Agent Comments/Notes:

MNL Use Only

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)

Authorization for Release of Medical Information HIPAA Compliant

Applicant's Name

Applicant's Date-of-Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider (hereinafter collectively referred to as "*Providers*") that has provided payment, treatment or services to me or on my behalf within the past 10 years to disclose my entire medical record, prescription history, medications prescribed and any other protected health information concerning me to Madison National Life Insurance Company, Inc. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By giving my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any *Providers* to release and disclose my entire medical record without restriction. This protected health information is to be disclosed under this Authorization so Madison National Life Insurance Company, Inc. can:

1. underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations;
2. obtain reinsurance;
3. administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4. administer coverage; and
5. conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Madison National Life Insurance Company, Inc.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that any authorized representative or I have the right to receive a copy of this Authorization and we have the right to revoke this authorization in writing, at any time, by providing written request for revocation to: Madison National Life Insurance Company, Inc., Attention: Policy Owner Services, PO Box 5008, Madison, WI 53705.

I understand that a revocation is not effective to the extent that any of my *Providers* has already relied on this Authorization to disclose information about me or to the extent that Madison National Life Insurance Company, Inc. has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that my *Providers* may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Madison National Life Insurance Company, Inc. may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Signature of Applicant/Insured

Date

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Admin. Address: PO Box 2867, Clinton, IA 52733-2867 • Phone: 1-800-356-9601

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

CONDITIONAL RECEIPT OF PREMIUM

This Conditional Receipt must only be used with the life insurance Application when payment of the first premium has been made at the time of application. If premium is not received at the time of application, this Conditional Receipt is not applicable.

Premium payment has been received in connection with the Application for life insurance which bears the same date as this Conditional Receipt.

- **If the Application is not approved, the premium payment evidenced by this Conditional Receipt will be returned.**
- **If the Application is approved, the policy will be effective with the date of the Application, unless otherwise indicated in the Application.**

\$ _____
Amount of premium received

Date premium was received

Name of the person the premium was received from

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Admin. Address: PO Box 2867, Clinton, IA 52733-2867 • Phone: 1-800-356-9601

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

THIRD-PARTY NOTICE REQUEST FORM

As a proposed policyholder of a Madison National Life Insurance Company, Inc. 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 your Policy. This person is known as a "third party," and this person would not receive regular premium billings or other Policy correspondence.

Please complete this form if you would like to designate a third-party to receive notice if your Policy is going to lapse due to nonpayment of premium.

Proposed Insured Name

Full Name of Designee

Designee Phone No.(s)

Designee Address

APPLICATION HEADER (AREAS) ON FIRST PAGE

There are no variables used in the text of the application, just in the header areas on the first page where our company name and address is shown, and a reference number..

(1) The variable is our PO Box address because this PO Box is an administration PO Box and it may change in the future if we change administrative mail processing vendors.

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)]

(2) There are brackets around the Reference No. which is an internal number assigned to each application. While we use this number for each application, we are bracketing it in case of process changes in the future where we may not need to assign numbers.

[Reference No.]