MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

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

Mail to: National Insurance Services
250 So. Executive Drive, Suite 300, Brookfield, WI 53005-4273, Attn: Billing Department

APPLICATION FOR PORTABLE GROUP TERM LIFE INSURANCE

INSURED INFORMATION

Name: (Last, First, MI)	**Date of Birth:** / /	☐ **Female** ☐ **Male**	☐ **Single** ☐ **Married**
Social Security No.	**U.S. Citizen?** ☐ **Yes** ☐ **No** If you are not a United States citizen, please attach a copy of your Visa.		
Street Address, City, State, Zip Code:	**Phone Number:**		

Beneficiaries: * (If you are married, a primary beneficiary designation of someone other than your spouse may not be effective under your state law. Please consult with your legal advisor before making such a designation.) The sum of the percentages assigned to Primary and Secondary (if applicable) beneficiary(ies) must total 100%.

☐ **Primary** ☐ **Secondary**	**Name** (Last, First, Middle)	**Relationship:**	**Percent of Benefit:** %
☐ **Primary** ☐ **Secondary**	**Name** (Last, First, Middle)	**Relationship:**	**Percent of Benefit:** %
☐ **Primary** ☐ **Secondary**	**Name** (Last, First, Middle)	**Relationship:**	**Percent of Benefit:** %

*** Spouse's Signature**	**Signature Date**

COVERAGE ELECTIONS

Please check below the applicable insurance coverage(s) you are electing. You may only elect some or all of the insurance coverages each Insured Person actually had under the prior group term life insurance policy with Us, immediately preceding the requested effective date of this coverage.

☐ Life ☐ Life and AD&D ☐ Spouse Life ☐ Spouse Life and AD&D ☐ Dependent Life ☐Dependent Life and AD&D

Please list the benefit amount(s) you wish to continue as portable coverage. The elected amount must be less than or equal to the benefit amount each Insured Person had under the prior group term life insurance policy with Us, immediately preceding the requested effective date of this coverage.

Insured:	Spouse	Child	Family
$	$	$	$

Dependent Coverage: (if applicable)
Any dependents covered under your prior group term life insurance with Us, immediately preceding the requested effective date of this coverage, may elect this coverage. Please complete the following information:

Dependent Names	***Full-Time Student?***		**Birth Date**	**Social Security No.**	**U.S. Citizen?**
		Spouse			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*
	☐Yes ☐No	**Child**			☐ Yes ☐ No*

**If a Dependent is not a United States citizen, please attach a copy of his/her Visa.*

PREMIUM CALCULATION

Portable Coverage Monthly Premium Rate (per $1,000 of benefit):

Insured: $____________	Spouse: $___________	Child: $_____________	Family: $___________

Insured: (Benefit amount x Insured Monthly Premium Rate) ÷ 1,000 = $_________ +
Spouse: (Benefit amount x Spouse Monthly Premium Rate) ÷ 1,000 = $_________ +
Child: (Benefit amount x Child Monthly Premium Rate) ÷ 1,000 = $_________
Subtotal: $_________
Select one of the Billing Frequency Numbers shown below. x ________ (Billing Frequency Number)
Add administrative fee*. + $5.00
Total Premium Due: $ _________

Billing Frequency Number: ☐ Quarterly (3) ☐ Semi-Annual (6) ☐ Annual (12)
*An administrative fee of $5.00 is added to each billing statement.

INSURED COVERAGE AUTHORIZATION

By signing this Application I understand and agree that:

- This application must be completed and signed by me.
- This completed application must be sent to the Mailing Address on the first page of this application. I must include a check payable to Madison National Life Insurance Company, Inc. for the Total Premium Due. The application and check must be mailed within the 31-day period immediately following the date coverage ends under the Group Policy. If these requirements are not met, the coverage will not be issued.
- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- Coverage is not in effect until final approval is given by Madison National Life Insurance Company, Inc.
- Madison National Life Insurance Company, Inc., or its designee, will bill me directly for premium periods following the initial premium period after my application is approved.
- No person, except an officer of Madison National Life Insurance Company, Inc., is authorized to vary or modify a contract.
- I have received and reviewed the Fraud Warning page of this application form.

Applicant Signature	**Date**

EMPLOYER AUTHORIZATION OF EMPLOYEE ELIGIBILITY

EMPLOYER: Please complete the following information about your employee and his/her coverage.

Employer's Name:	**Group Plan No.**

EMPLOYEE'S EMPLOYMENT AND COVERAGE INFORMATION

Date of Hire:	**Effective Date of Coverage:**	**Date of Termination:**

Date Insurance Coverage Will End *(including extension, if applicable)*:	**Reason for Termination:**

AMOUNT OF (PORTABLE LIFE) ELIGIBLE COVERAGE CURRENTLY IN-FORCE:

Insured:	**Spouse**	**Child**	**Family**
$	**$**	**$**	**$**

Date Portability Coverage Information Was Given to Employee:

Name of Employer Representative completing this section:	**Title of Employer Representative:**

Telephone No.	**Fax No.**	**Email Address:**

Employer Representative Signature	**Date**

FOR INSURER USE ONLY:		
Notes:		
Date Received:	**Effective Date of Coverage:**	**Plan No.**

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

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits.

STATE-SPECIFIC FRAUD WARNINGS

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

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

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

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

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

KANSAS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

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

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

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

NEBRASKA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.

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

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

NEW MEXICO WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines, and criminal penalties.

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

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

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

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

RESIDENTS OF FLORIDA, GEORGIA, MAINE, NEW JERSEY, NEW YORK, OR VERMONT:

THIRD-PARTY NOTICE REQUEST

As an Applicant for this portable coverage, you have the right to designate another person to receive correspondence in the event any past due premiums could cause a possible termination of this coverage. This person is known as a "third party" and this person would not receive regular premium billings or other insurance correspondence.

Would you like to designate a third-party to receive notice if this coverage is going to terminate due to nonpayment of premium? ☐ **Yes** ☐ **No** If "Yes, please complete the following:

Name of Designee *(First, Middle, Last)*:

Address of Designee: