EXTENDED LIFE INSURANCE (PREMIUM WAIVER) APPLICATION

This form should be completed in full by the employee, employer and physician and mailed to:

Madison National Life

INSURANCE COMPANY, INC.
P.O. Box 5008, Madison, WI 53705

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

All questions on this from should be fully answered by the insured if competent to do so. If not, and if no guardian has been appointed, the form may be completed by the beneficiary or a close relative. If a guardian has been appointed, the form should be completed by the guardian and a certified copy of letters of guardianship forwarded. By furnishing this form the insurance company is not held to admit the validity of any claim or to waive the breach of any condition of the policy.

I make the following statement in support of my claim for extended life insurance (premium waiver) benefits provided in the policy of insurance identified herein. Such information is submitted with the understanding that the insurance company may rely thereon, and I represent that all statements and answers are true and complete. I understand that the insurance company reserves the right to require, as proofs of disability, all documentary evidence, in addition to the items submitted, which it may reasonably deem necessary.

INSURED'S STATEMENT

NAME-Last | First | Middle | Home Telephone Number

( )

Address

Street | City | State | Zip Code

Occupation at time of disability | Date you first became disabled (Month Day Year) | Last date worked (Month Day Year)

Principal cause of disability | Height | Weight

Present Limitations

What physicians have you consulted during your present disability?

Name	Address	Date From	Date To

On what date do you expect to be able to return to work? _____

AUTHORIZATION

I hereby authorize any hospital, physician, insurance company, employer, or organization to furnish to the insurance company providing this form, or its representative, any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A photostatic copy of this authorization shall be considered as valid as the original.

Dated | Employee Signature

EMPLOYER'S STATEMENT

Name of Insured | Social Security No. | Amount of Insurance $

Name of Employer | Madison National Life Policy Number: | Annual Salary:

Address of Employer

Street | City | State | Zip Code

Date of Birth (Month Day Year) | Date Employed (Month Day Year)

Was he or she employed at time disability began? ☐ Yes ☐ No | Date of enrollment under this policy (Month Day Year)

When did employee stop work? (Month Day Year Time A.M. P.M.) | When do you expect the Employee to return to work? (Month Day Year)

What is the employee's job title and principal duties?

Other Remarks: _____

Authorized Individual (Type or Print) Title/Position _____

Signature _____ Date Month Day Year

ATTENDING PHYSICIAN'S STATEMENT

Patient's Name	Age

1. Diagnosis and concurrent conditions (If diagnosis code other than ICDA* used, give name):

2. Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No	3. Does the patient's injury or illness prevent him/her from being able to perform the duties of a sedentary occupation?	☐ Yes ☐ No

Report of services (or attach itemized bill) (If previous form submitted to this carrier, you need show only dates and services since last report)

Date of services	Place of services	Description of surgical or medical services rendered	Procedure Code—If used (If code other than CPT** used, give name)

‡ O – Doctor's Office IH – Inpatient Hospital NH – Nursing Home
H – Patient's Home OH – Outpatient Hospital OL – Other Location
*ICDA – International Classification of Diseases
**CPT – Current Procedural Terminology (current edition)

If inability to work is the result of mental, emotional, or behavioral problems, please indicate current GAF score

4. Date symptoms first appeared or accident happened. Month Day Year

5. Date patient first consulted you for this condition. Month Day Year

6. Patient ever had same or similar condition? ☐ Yes ☐ No If yes when: Month Day Year

7. Describe:

Patient still under your care for this condition? ☐ Yes ☐ No

8. Patient was continuously unable to work From: Month Day Year Thru: Month Day Year

9. Patient was partially unable to work From: Month Day Year Thru: Month Day Year

10. If still unable to work, date patient should be able to return to work. Month Day Year

11. Patient was house confined From: Month Day Year Thru: Month Day Year

12. Planned Course of Treatment: (please include expected duration, surgeries, therapy, etc)

13. If inability to work is the result of mental, emotional, or behavioral problems, please indicate GAF scores from the previous six months.

14. Please state patient's physical, mental and cognitive limitations in regards to work abilities.

Frequency of visitations specifically regarding disability

Weekly Monthly Yearly Other (specify)

Physician's Name (Type or Print)			Physician's Social Security No.
Physician's Signature	Degree	Date	Telephone No.

Street Address (Type or Print)	City or Town	State or Province	Zip Code