MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Home Office: [1241 John Q. Hammons Drive, Madison, WI 53717 • 1-800-356-9601]
[Administered By: [Bay Bridge Administrators, LLC, P.O. Box 161690, Austin, Texas 78716 • (800) 845-7519]

Enrollment Form
Group Voluntary Term Life Insurance To Age 120

Applicant Information

Name of Group Policyholder	**Group No.**

Please check the applicable box:

☐ New to Group Policyholder | ☐ Open Enrollment | ☐ Change/Modification to Existing Insurance

Applicant Name *(Last, First, Middle)*	**Social Security No.**

Street Address *(City, State, Zip)*

Home Phone No.	**Work Phone No.**	**Email Address** ☐ Home or ☐ Work

Date of Birth	**Gender** ☐ Male ☐ Female	**Marital Status** ☐ Single ☐ Married
Date of Hire	**Class**	**Hours Worked per Week**

1	Have you used tobacco in any form during the past twelve months or are you currently using nicotine in any form?	☐ Yes ☐ No
2	If you are applying for Dependent insurance, has your spouse used tobacco in any form during the past twelve months or is he or she currently using nicotine in any form?	☐ Yes ☐ No

If you are applying for Dependent insurance, please complete the below information. ("Spouse includes state recognized Domestic Partnerships and Civil Unions.) *(If you need to add more Dependents, please use another sheet.)*

Dependent Names		**Birth Dates**	**SSNs**
	Spouse		
	Child		
	Child		
	Child		
	Child		
	Child		

Are all applicants listed above U.S. Citizens? ☐ Yes ☐ No If "No", name the Country of Citizenship:
(additional information may be requested)

Benefit Elections

Please "☑" the applicable insurance benefits you're applying for: *(if the Group Policyholder is offering)*

☐ Term Life Insurance (specify amount) $________________________
☐ Accelerated Life Benefit
☐ Accidental Death Benefit
☐ Waiver of Premium
☐ Spouse [Conditional] [Guarantee Issue] Term Life Insurance[[1]]$________________________ (amount cannot exceed 50% of the Applicant's amount)
[☐ Spouse Term Life Insurance* $________________________ (amount cannot exceed [50-100]% of the Applicant's amount) *Must complete the Evidence of Insurability Form]
☐ Child(ren) Term Life Insurance [(amounts pre-determined by us or the Group Policyholder)]
[$ (ages 15 days to 6 months) and $ (ages 6 months to 25 years)]

[[1]	Within the past 12 months, has your spouse been (a) admitted to a hospital or (b) missed 5 or more consecutive days of work for any reason other than vacation, colds, flu, pregnancy, allergies, back or knee disorder? *(If "Yes" your spouse must complete the Evidence of Insurability Form.)	☐ Yes* ☐ No]

Applicant's Beneficiary Designations:

- The Applicant will be the beneficiary for Dependent insurance, unless otherwise noted.
- If you live in a community property state, your spouse may have a legal claim for a portion of the life insurance benefit under state law. If you name someone other than your spouse as beneficiary, the death benefit payment may be delayed until your spouse's claim is resolved.
- The percentage ("%") allocations assigned to all Primary Beneficiaries must equal 100% and the % allocations assigned to all Contingent Beneficiaries must equal 100%.
- If multiple beneficiaries are named and a % is not provided, proceeds are to be paid equally to each beneficiary.
- Contingent Beneficiaries only receive a benefit if there is no surviving Primary Beneficiary.

Please indicate your beneficiary designation(s). If you need more space, please use another sheet.

☐ Primary ☐ Contingent	**Name** *(Last, First, Middle)*		**Date of Birth**
%	**Relationship to Applicant**	**Address** *(Street, City, State)*	
☐ Primary ☐ Contingent	**Name** *(Last, First, Middle)*		**Date of Birth**
%	**Relationship to Applicant**	**Address** *(Street, City, State)*	
☐ Primary ☐ Contingent	**Name** *(Last, First, Middle)*		**Date of Birth**
%	**Relationship to Applicant**	**Address** *(Street, City, State)*	

Applicant Agreement

By signing this Enrollment Form, I understand and agree that:

- All statements and answers I have given are complete and true to the best of my knowledge and belief.
- No insurance will be effective until Madison National Life Insurance Company, Inc. ("Madison National Life"): (a) approves this Enrollment Form, (b) receives the required premium, and (c) issues the Certificate of Insurance; and that my effective date will be delayed if I am not in active service on the date insurance under the Certificate is to otherwise to take effect.
- I can obtain any Certificate(s) of Insurance and any riders or amendments from the Group Policyholder or Madison National Life.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.
- I authorize the Group Policyholder to make any required deductions, if any, to pay the premium for my insurance in effect.

Applicant Agreement *continued…*

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 Signature	**Date of Signature**

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Applicant Waiver of Voluntary Insurance

I wish to waive the Group Term Life Insurance to age 120. **By signing this Waiver, I understand and agree** I was given the opportunity to apply for the group voluntary insurance as presented to me, but do NOT wish to enroll in the insurance offered. Insurance not elected in this Form is assumed to be insurance I have refused. I understand that if I decide to apply for this group insurance at a later date, Evidence of Insurability will be required at my own expense. The Evidence of Insurability must first be approved by Madison National Life Insurance Company, Inc.

Signature	**Date of Signature**

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