

Why Take a Chance When You Can Make a Choice?

Protect Your Future Today with NIS Options Voluntary Insurance Plans



NIS Options



Every day, the choices we make affect our quality of life. From what we eat to where we work, what we choose matters.

But some of our most important decisions are the ones we least want to consider.

No one wants to think about a short or long-term disability that prevents them from working, or a premature death that leaves a family on their own.

Unfortunately, these things can and do happen.

Making good choices today will ensure you and your loved ones are protected if life takes an unexpected turn.





Tom, a music teacher from the Midwest, was just 46 when he suffered a fatal heart attack. But thanks to his careful planning, Tom's family didn't have to worry about adequate Life Insurance. "Tom always took care of us, and still is," says his wife. "His planning made a very hard situation a little bit easier."*

Life Insurance Options

Having Life Insurance can provide peace of mind for you, as well as for those you love. If the worst should happen, don't add to the burden your loved ones face by leaving them financially unprepared. Enroll in your Life Insurance Options plan today. Your family will be grateful.

Plan	Covers	Minimum Coverage	Maximum Coverage
Mandatory Life Insurance Coverage Basic Life and AD&D Insurance	Employee only	\$5,000	\$10,000
Basic-Plus Life Insurance Plan Dependent Life Insurance (Family Unit Plan)	Spouse/Dependent only	\$2,000	\$5,000
Optimum Life Insurance Plan Optional Life and AD&D Insurance for you and Optional Life Insurance for your Dependents	Employee, Spouse and Dependent (AD&D Insurance for Employee only)	Employee: \$5,000 Spouse: \$0 Child/ren: \$0	Employee: \$300,000 or five times salary Spouse: \$150,000 Child/ren: \$20,000

Mandatory Life Insurance Coverage

Basic Life and AD&D Insurance. Covers you only.



This plan is required in order to participate in any of the other Options plans and is employer-paid.

What It Is:

A no-frills, basic Life Insurance policy that pays a flat cash amount to a beneficiary of your choice in the event of your death.

If your death was caused by an accident, the AD&D Insurance may pay your beneficiary an additional benefit. Also, the AD&D Insurance may pay you if an accident resulted in the loss of a limb, hand, foot or eye.

Coverage Choices:

- **Plan 1:** \$5,000
- **Plan 2:** \$10,000

End of Coverage:

Early retirees may continue coverage until age 65 if your employer has selected the retiree option. See your HR department for more information.

Medical Questionnaire:

Not required.

Basic-Plus Life Insurance Plan

Dependent Life Insurance (Family Unit Plan). Covers your Spouse and Dependent(s) only.



When to Choose This Option:

You may choose to purchase this minimal plan as an add-on to the mandatory Basic Life and AD&D Insurance plan if you would like to add coverage for your spouse and child/ren. If you want more coverage, choose the Supplemental Life Insurance plan instead or choose both plans.

What It Is:

Simple, basic Life Insurance plan that pays a flat cash amount to you in the event of the death of your spouse or child.

Coverage Choices:

- **Plan 1:** \$2,000 Spouse and \$2,000 Child¹
- **Plan 2:** \$5,000 Spouse and \$2,500 Child¹

End of Coverage:

When employee's coverage ends.

Medical Questionnaire:

- **Plan 1:** Not required during initial open enrollment or within 30 days of eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.
- **Plan 2:** Required. If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts.

¹Children ages 14 days to age 19 (or 25 if a full-time student)

Optimum Life Insurance Plan

Optional Life and AD&D Insurance for you and Optional Life Insurance for your Dependents



When to Choose This Option:

If you would like to add more coverage than is offered in the mandatory Basic Life and AD&D Insurance and Dependent Life Insurance (Family Unit) plans, choose this premium plan.

What It Is:

Supplemental Life Insurance allows you to choose additional Life Insurance coverage at group rates for yourself, your spouse and/or your child/ren.

Coverage Choices:

- **Employee Life and AD&D Insurance:** Choose coverage in \$1,000 increments, not to exceed five times your annual salary. Minimum: \$5,000. Maximum: \$300,000.
- **Spousal Life Insurance (No AD&D):** Choose up to 50% of your elected coverage, not to exceed \$150,000.
- **Child/ren Life Insurance (No AD&D) ¹:** Choose up to 25% of your elected coverage, not to exceed \$20,000.

End of Coverage:

Coverage reduces based on age and terminates at retirement.

Medical Questionnaire:

Required.² If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts.

¹Children ages 14 days to age 19 (or 25 if a full-time student)

²Note: Coverage may be increased by 10% without medical questions in the event of a “qualifying event” such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details. Subject to plan maximums.





Janet, a teacher in her late 30s, never imagined giving up her career in the classroom until she got a devastating diagnosis from her doctor: multiple sclerosis. Single and living far away from family, Janet wonders how she's going to make it when she can no longer teach.*

Disability Insurance Options

Many people think the chances of a disabling illness or accident are slim, but statistics show that 1 in 3 employees entering the workforce today will need to use their disability benefits before they reach retirement.¹

And illnesses such as arthritis and heart conditions are the culprit more often than accidents. If you couldn't work, how would you pay the mortgage, buy food or pay bills?

Protect your income today by enrolling in your Short and Long-Term Disability Insurance Options plan.

Plan	Benefit Duration	Minimum Coverage	Maximum Coverage
Short-Term Income Insurance Protection Plan A Short-Term Disability Insurance	52 weeks*	\$20 per week	\$1,200, or a percentage of your salary, per week
Short-Term Income Insurance Protection Plan B Coordinated Short-Term Disability Insurance	Coordinated to end when your employer-paid Long-Term Disability benefits begin	66.67% of salary	\$1,200 per week
Long-Term Income Insurance Protection Plan Long-Term Disability Insurance	Choice of 5 years** or until age 70	\$100	60% of salary

*Plus an additional 52 weeks at half the elected benefit amount if employee is confined to a hospital and not covered under any Long-Term Disability plan.

**May be less than five years depending upon the employee's age at the onset of a covered disability.

¹Source: Social Security Administration Website, www.ssa.gov/pubs/10029.html

Short-Term Income Insurance Protection Plan A

Short-Term Disability Insurance



When to Choose This Option:

If your employer does not provide Short-Term Disability Insurance, this plan is for you. If you have enough savings or accumulated sick leave pay to stay afloat without your income for about a year, then you do not need this coverage.

Coverage Choices:

Choose your coverage amount in \$10 increments, subject to a maximum based on your annual wages (see rate sheet to calculate maximum) or \$1,200/week, whichever amount is lower.

Also choose the wait time before benefits begin (Elimination Period):

- **7-Day Wait:** Benefits start immediately if accident, after seven days if illness.
- **28-Day Wait:** Benefits start immediately if accident, after 28 days if illness.

Benefit Duration:

Benefits continue for 52 weeks (plus an additional 52 weeks at half the benefit amount if you are confined to a hospital and not covered under any Long-Term Disability plan).

Medical Questionnaire:

Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.¹

¹Note: Coverage may be increased by 10% without medical questions in the event of a "qualifying event" such as childbirth, adoption, marriage, divorce, job change, etc. If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current coverage amounts. See your HR department for details.

Short-Term Income Insurance Protection Plan B

Coordinated Short-Term Disability Insurance



When to Choose This Option:

If your employer provides an employer-paid Long-Term Disability Insurance plan, this plan will cover you from the time that you are out of work due to a covered accident, or 15 days after the start of a covered illness, until the time your Long-Term Disability Insurance payments begin. If you have enough savings or accumulated sick leave pay to stay afloat without your income for 60-180 days, then you do not need this coverage.

Coverage Choices:

The coverage amount is set at 66.67% of your weekly salary, not to exceed \$1,200/week.

Benefit Duration:

Benefits continue until your employer-paid Long-Term Disability Insurance benefits begin. 60, 90, 120 or 180-day plans are available.

Medical Questionnaire:

Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.¹

If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current coverage amounts.

¹Note: Coverage may be increased by 10% without medical questions in the event of a "qualifying event" such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details.

Long-Term Income Insurance Protection Plan

Long-Term Disability Insurance



When to Choose This Option:

If you are not covered by Long-Term Disability Insurance, this plan is for you.

Coverage Choices:

Choose the coverage amount in \$100 increments, not to exceed 60% of your salary. Also choose a benefit duration of five years¹ or until age 70.

Benefit Duration:

Benefits begin after 52 weeks or at the end of your Short-Term Disability Insurance plan, whichever is later. Benefits continue for five years¹ or until age 70 based on your choice of plan.

Medical Questionnaire:

Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire.²

If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts.

¹May be less than five years depending upon your age at the onset of a covered disability.

²Note: Coverage may be increased by 10% without medical questions in the event of a "qualifying event" such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details.





Life Insurance Limitations

Age Reductions and Plan Termination:

Basic Life and AD&D Insurance and Dependent Life Insurance (Family Unit Plan) benefits do not reduce due to age. Early retirees may continue coverage until age 65 if elected by the employer. With the Optional Life/AD&D for Employees and Dependents plan, the amount of coverage reduces 50% at age 70 and terminates at retirement.

AD&D Insurance Exclusions

AD&D coverage is for the employee only. Spousal and dependent Life Insurance does not include AD&D.

No AD&D Benefit is payable if the loss is caused or contributed to by any of the following:

- war, declared or undeclared, or any act of war
- intentionally self-inflicted injuries or attempted suicide, while sane or insane
- committing or attempting to commit a felony, engaging in illegal activity or actively participating in a violent disorder or riot
- any injury sustained while under the voluntary use or consumption of any poison, illegal drugs or controlled substance
- physical disease existing at the time of the accident
- medical negligence and malpractice
- bacterial infections
- while you are in the armed forces of any country or international authority
- any loss incurred while operating, riding in or descending from any aircraft, except as a fare-paying passenger on a commercial aircraft

Disability Insurance Exclusions

The policy does not cover any disability that is caused or contributed to by any of the following:

- war, declared or undeclared, or any act of war
- as a result of committing or attempting to commit a felony, other criminal conduct, engaging in illegal activity or actively participating in a violent disorder or riot
- while you are in the armed forces of any country or international authority
- while you are imprisoned or under house arrest
- as a result of intentionally self-inflicted injuries or

attempted suicide, while sane or insane

- as a result of an occupational disability arising out of the course of any employment for wage or profit (This applies to Short-Term Disability Insurance plans, but does not apply to the Long-Term Disability Insurance plan).
- **Pre-Existing Conditions:** Disabilities that are caused by a pre-existing condition or exist due to medical or surgical treatment of a pre-existing condition are not covered for the first 12 months, unless you have been continuously covered under a prior plan (and satisfied that plan's pre-existing condition limitation). Pre-existing limitations also apply to increases in Disability Benefits.

Disability Insurance Limitations

- Payment of Disability Benefits is limited to six months if you reside outside of the United States or Canada.
- Disability Insurance benefits may not exceed 100% of pre-disability earnings.
- As with most all Disability Insurance plans, benefits are reduced by other income you may receive during a disability, including Social Security or State Retirement Disability.
- **Mental Disorders and Substance Abuse:** Disabilities related to mental or emotional illness are limited to 24 months of coverage for each period of disability. After the 24-month period, benefit payments are made only if you are still totally disabled and confined as an inpatient in a facility qualified to treat that illness. This limitation does not apply to the Short-Term Disability Insurance plans.
- **Substance Abuse:** If your disability is caused by substance abuse, you must be participating in a rehabilitative program recommended by a physician. Benefits will cease upon any of following events (whichever comes first):
 - the maximum benefit period is achieved as stated in your certificate
 - you no longer participate in the rehabilitative program
 - you refuse to participate in an available rehabilitative program
 - you complete the rehabilitative program

The substance abuse limitation does not apply to the Short-Term Disability Insurance plans.





This brochure is not the insurance contract. It is a brief description of Life and Disability Insurance.



Administered by:

NATIONAL  **INSURANCE**
S E R V I C E S

Corporate Headquarters
250 South Executive Drive, Suite 300, Brookfield, WI 53005
Offices Nationwide
800.627.3660

As a specialist in public sector employee benefits since 1969, NIS (National Insurance Services of Wisconsin, Inc.) helps employers align their unique and complex benefit challenges with the hard-to-understand language and practices of insurance and investment products.

Our expertise results in innovative benefit solutions that help:

- Use taxpayer dollars efficiently
- Build bridges between bargaining units, boards and employers
- Avoid employer liability and grievances

Underwritten by:

 **Madison National**
Life Insurance Company
Independence Holding Group
PO Box 5008, Madison, WI 53705

Madison National Life Insurance Company, Inc. is a Wisconsin Insurance company and a Member of the IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for over 25 years. For information on Independence Holding Company and the IHC Group, see independenceholding.com.

Options Plan - Employee Enrollment Form

(Return to your Human Resources office or Benefit Administrator)

Employee Information

Name of Employer			Group #
Name of Employee (Last, First, Middle Initial)	Social Security #	<input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
Home Address of Employee (Street, City, State, Zip)		Date of Birth	Employment Date
Job Title	Job Duties	Hours Worked Per Week	Annual Salary

Primary Beneficiary(ies)

Name (Last, First, Middle)	Relationship	% of Benefit

Secondary Beneficiary(ies)

Name (Last, First, Middle)	Relationship	% of Benefit

Spouse's Signature (If required)

Warning:

Any person who 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.

Select Your Life Insurance Coverage

Basic-Plus Life Plan

Dependent Life Insurance (Family Unit Plan)

Decline

Request (Please choose **one** of the following options)

Plan 1: Spouse \$2,000/Child \$2,000

Plan 2: Spouse \$5,000/Child \$2,500

Optimum Life Plan

Optional Life and AD&D Insurance for Employee and Optional Life Insurance for Dependents

Decline

Request

Employee Life and AD&D Insurance Amount: \$ _____
Choose coverage in \$1,000 increments, not to exceed five times your salary.
Minimum: \$5,000. Maximum: \$300,000.

Decline

Request

Spousal Life Insurance Amount: \$ _____
Choose up to 50% of your elected coverage, not to exceed \$150,000.
Note: In order to elect spousal coverage, you must elect coverage for yourself.

Decline

Request

Child/ren Life Insurance Amount: \$ _____
Choose up to 25% of your elected coverage, not to exceed \$20,000 per child*.
Note: In order to elect child/ren coverage, you must elect coverage for yourself.

*Each child will receive the same coverage amount, but the rate covers all children in your family, regardless of the number of children you have.

Select Your Disability Insurance Coverage

Short-Term Income Protection Plan A

Short-Term Disability Insurance

Decline

Request

Monthly Benefit Amount: \$ _____

Choose your coverage amount in \$10 increments, subject to a maximum based on your annual wages (see rate sheet to calculate maximum) or \$1,200/week, whichever amount is higher.

Choose one of the following Elimination Periods:

(The time between when a covered disability begins and the time the policy pays a benefit.)

7 Days 28 Days

Short-Term Income Protection Plan B

Coordinated Short-Term Disability Insurance

Decline

Request

Choose your Benefit Duration: *(Must match your employer-paid Long-Term Disability Insurance Elimination Period.* If you are unsure about your Elimination Period, please ask your HR department or Benefit Administrator.)*

60 Days 90 Days 120 Days 180 Days

**Elimination Period is the time between when a covered disability begins and the time the policy pays a benefit.)*

Long-Term Income Protection Plan

Long-Term Disability Insurance

Decline

Request

Monthly Benefit Amount: \$ _____

(Choose your coverage amount in \$100 increments, not to exceed 60% of your salary.)

Choose your Benefit Duration:

5 Years* to age 70

**May be less than five years depending upon your age at the onset of a covered disability.*

Sign Here If You Are Waiving Coverage

I have been given the opportunity to apply to Madison National Life Insurance Company, Inc. for voluntary group insurance as presented to me, but do NOT wish to take the options listed on this enrollment form. I understand that if my dependents or I decide to apply for this group insurance plan at a later date, Evidence of Insurability (medical questions) will be required at our own expense, and must be approved by Madison National Life Insurance Company, Inc.

Dated this _____ day of _____, 20_____

Applicant's Signature

Sign Here If You Are Enrolling in Coverage

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

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium for my insurance in effect.
- 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 after final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life Insurance Company, inc. is authorized to vary or modify a contract.
- I have read the Fraud Warning on this enrollment form.

Dated this _____ day of _____, 20_____

Applicant's Signature

For National Insurance Services Use Only

Effective Date	Date Received	Life Insurance Amount	Disability Amount
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NIS Options - Life Insurance Rates

Mandatory Coverage

Basic Life and AD&D Insurance

This plan is required in order to participate in any of the other Options plans and is employer-paid. It is a no-frills, basic Life Insurance policy that pays a flat cash amount to a beneficiary of your choice in the event of your death. If your death was caused by an accident, the AD&D Insurance may pay an additional benefit. Also, the AD&D Insurance may pay you if an accident resulted in the loss of a limb, hand, foot or eye.

Basic-Plus Life Plan

Dependent Life Insurance (Family Unit Plan)

You may choose to purchase this minimal plan as an add-on to the Basic Life and AD&D Insurance if you would like to add coverage for your spouse and child/ren. If you want more coverage, choose the Supplemental Life Insurance plan instead or choose both plans. It is a simple, basic Life Insurance plan that pays a flat cash amount to you in the event of the death of your spouse or child. AD&D is not included with this plan.

- Plan 1: \$2,000 Spouse, \$2,000 Child/ren coverage, monthly cost \$1.00 per family regardless of number of children.
- Plan 2: \$5,000 Spouse, \$2,500 Child/ren coverage, monthly cost \$2.00 per family regardless of number of children.

Optimum Life Plan

Optional Life and AD&D Insurance for Employee and Optional Life Insurance for Dependents

If you would like to add more coverage than is offered in the Basic Life and AD&D Insurance and Dependent Life Insurance (Family Unit) plans, choose this premium plan. Supplemental Life Insurance allows you to choose additional Life Insurance coverage at group rates for yourself, your spouse and/or your child/ren.

Employee (Life and AD&D Insurance)

Choose your coverage in \$1,000 increments, not to exceed five times your annual salary. Minimum: \$5,000. Maximum: \$300,000.

Monthly rate per \$1,000 of Life and AD&D Insurance coverage

Age	Rate
≤39	\$0.09
40-49	\$0.23
50-59	\$0.58
60-64	\$1.03
65-69	\$1.63
70-74	\$2.98
75+	\$4.03

Calculate your monthly cost for your coverage:

$$\begin{array}{r}
 \$ \quad \boxed{} \boxed{} \boxed{} , \boxed{} \boxed{} \boxed{} \text{ Amount of Coverage} \\
 \div 1,000 \\
 = \\
 \times \$ \quad \boxed{} \boxed{} \boxed{} \boxed{} \text{ Rate} \\
 = \$ \quad \boxed{} \boxed{} \boxed{} \boxed{} \boxed{} \text{ Monthly Cost}
 \end{array}$$

Spouse (Life Insurance Coverage)

Choose up to 50% of your elected coverage, not to exceed \$150,000.

Monthly rate per \$1,000 of Life Insurance coverage

Spouse's Age	Rate
≤39	\$0.06
40-49	\$0.20
50-59	\$0.55
60-64	\$1.00
65-69	\$1.60
70-74	\$2.95
75+	\$4.00

Calculate your monthly cost for Spousal coverage:

$$\begin{array}{r}
 \$ \quad \boxed{} \boxed{} \boxed{} , \boxed{} \boxed{} \boxed{} \text{ Amount of Coverage} \\
 \div 1,000 \\
 = \\
 \times \$ \quad \boxed{} \boxed{} \boxed{} \boxed{} \text{ Rate} \\
 = \$ \quad \boxed{} \boxed{} \boxed{} \boxed{} \boxed{} \text{ Monthly Cost}
 \end{array}$$

Child/ren (Life Insurance Coverage)

Choose up to 25% of your elected coverage, not to exceed \$20,000.

Monthly rate \$0.15 per \$1,000 of Life Insurance coverage, regardless of the number of children.

Calculate your monthly cost for Child/ren coverage:

$$\begin{array}{r}
 \$ \quad \boxed{} \boxed{} , \boxed{} \boxed{} \boxed{} \text{ Amount of Coverage} \\
 \div 1,000 \\
 = \boxed{} \boxed{} \\
 \times \$0.15 \text{ Rate} \\
 = \$ \quad \boxed{} \boxed{} \boxed{} \text{ Monthly Cost}
 \end{array}$$

NIS Options - Disability Insurance Rates

Short-Term Income Protection Plan A

Short-Term Disability Insurance

You may select any amount of weekly benefit from the tables below as long as your contracted annual school salary is at least as great as the amount shown in the annual salary column.

Annual Salary	Weekly Benefit	Monthly Cost		Annual Salary	Weekly Benefit	Monthly Cost		Annual Salary	Weekly Benefit	Monthly Cost		Annual Salary	Weekly Benefit	Monthly Cost	
		7 Day Elim	28 Day Elim			7 Day Elim	28 Day Elim			7 Day Elim	28 Day Elim			7 Day Elim	28 Day Elim
\$1,300	\$20	\$2.00	\$1.40	\$23,000	\$320	\$32.00	\$22.40	\$45,500	\$620	\$62.00	\$43.40	\$68,343	\$920	\$92.00	\$64.40
\$1,950	\$30	\$3.00	\$2.10	\$23,751	\$330	\$33.00	\$23.10	\$46,234	\$630	\$63.00	\$44.10	\$69,086	\$930	\$93.00	\$65.10
\$2,600	\$40	\$4.00	\$2.80	\$24,500	\$340	\$34.00	\$23.80	\$47,000	\$640	\$64.00	\$44.80	\$69,829	\$940	\$94.00	\$65.80
\$3,250	\$50	\$5.00	\$3.50	\$25,260	\$350	\$35.00	\$24.50	\$47,734	\$650	\$65.00	\$45.50	\$70,571	\$950	\$95.00	\$66.50
\$3,900	\$60	\$6.00	\$4.20	\$26,000	\$360	\$36.00	\$25.20	\$48,500	\$660	\$66.00	\$46.20	\$71,314	\$960	\$96.00	\$67.20
\$4,550	\$70	\$7.00	\$4.90	\$26,759	\$370	\$37.00	\$25.90	\$49,235	\$670	\$67.00	\$46.90	\$72,057	\$970	\$97.00	\$67.90
\$5,200	\$80	\$8.00	\$5.60	\$27,500	\$380	\$38.00	\$26.60	\$50,000	\$680	\$68.00	\$47.60	\$72,800	\$980	\$98.00	\$68.60
\$5,850	\$90	\$9.00	\$6.30	\$28,251	\$390	\$39.00	\$27.30	\$50,735	\$690	\$69.00	\$48.30	\$73,543	\$990	\$99.00	\$69.30
\$6,500	\$100	\$10.00	\$7.00	\$29,000	\$400	\$40.00	\$28.00	\$51,500	\$700	\$70.00	\$49.00	\$74,286	\$1,000	\$100.00	\$70.00
\$7,241	\$110	\$11.00	\$7.70	\$29,725	\$410	\$41.00	\$28.70	\$52,243	\$710	\$71.00	\$49.70	\$75,029	\$1,010	\$101.00	\$70.70
\$8,000	\$120	\$12.00	\$8.40	\$30,500	\$420	\$42.00	\$29.40	\$53,000	\$720	\$72.00	\$50.40	\$75,771	\$1,020	\$102.00	\$71.40
\$8,723	\$130	\$13.00	\$9.10	\$31,226	\$430	\$43.00	\$30.10	\$53,734	\$730	\$73.00	\$51.10	\$76,514	\$1,030	\$103.00	\$72.10
\$9,500	\$140	\$14.00	\$9.80	\$32,000	\$440	\$44.00	\$30.80	\$54,471	\$740	\$74.00	\$51.80	\$77,257	\$1,040	\$104.00	\$72.80
\$10,196	\$150	\$15.00	\$10.50	\$32,727	\$450	\$45.00	\$31.50	\$55,214	\$750	\$75.00	\$52.50	\$78,000	\$1,050	\$105.00	\$73.50
\$11,000	\$160	\$16.00	\$11.20	\$33,500	\$460	\$46.00	\$32.20	\$56,000	\$760	\$76.00	\$53.20	\$78,743	\$1,060	\$106.00	\$74.20
\$11,709	\$170	\$17.00	\$11.90	\$34,228	\$470	\$47.00	\$32.90	\$56,735	\$770	\$77.00	\$53.90	\$79,486	\$1,070	\$107.00	\$74.90
\$12,500	\$180	\$18.00	\$12.60	\$35,000	\$480	\$48.00	\$33.60	\$57,471	\$780	\$78.00	\$54.60	\$80,229	\$1,080	\$108.00	\$75.60
\$13,262	\$190	\$19.00	\$13.30	\$35,729	\$490	\$49.00	\$34.30	\$58,214	\$790	\$79.00	\$55.30	\$80,971	\$1,090	\$109.00	\$76.30
\$14,000	\$200	\$20.00	\$14.00	\$36,500	\$500	\$50.00	\$35.00	\$59,000	\$800	\$80.00	\$56.00	\$81,714	\$1,100	\$110.00	\$77.00
\$14,757	\$210	\$21.00	\$14.70	\$37,230	\$510	\$51.00	\$35.70	\$60,000	\$810	\$81.00	\$56.70	\$82,457	\$1,110	\$111.00	\$77.70
\$15,500	\$220	\$22.00	\$15.40	\$38,000	\$520	\$52.00	\$36.40	\$60,734	\$820	\$82.00	\$57.40	\$83,200	\$1,120	\$112.00	\$78.40
\$16,272	\$230	\$23.00	\$16.10	\$38,731	\$530	\$53.00	\$37.10	\$61,471	\$830	\$83.00	\$58.10	\$83,943	\$1,130	\$113.00	\$79.10
\$17,000	\$240	\$24.00	\$16.80	\$39,500	\$540	\$54.00	\$37.80	\$62,214	\$840	\$84.00	\$58.80	\$84,686	\$1,140	\$114.00	\$79.80
\$17,760	\$250	\$25.00	\$17.50	\$40,231	\$550	\$55.00	\$38.50	\$63,000	\$850	\$85.00	\$59.50	\$85,429	\$1,150	\$115.00	\$80.50
\$18,500	\$260	\$26.00	\$18.20	\$41,000	\$560	\$56.00	\$39.20	\$63,734	\$860	\$86.00	\$60.20	\$86,171	\$1,160	\$116.00	\$81.20
\$19,246	\$270	\$27.00	\$18.90	\$41,732	\$570	\$57.00	\$39.90	\$64,471	\$870	\$87.00	\$60.90	\$86,914	\$1,170	\$117.00	\$81.90
\$20,000	\$280	\$28.00	\$19.60	\$42,500	\$580	\$58.00	\$40.60	\$65,214	\$880	\$88.00	\$61.60	\$87,657	\$1,180	\$118.00	\$82.60
\$20,743	\$290	\$29.00	\$20.30	\$43,233	\$590	\$59.00	\$41.30	\$66,000	\$890	\$89.00	\$62.30	\$88,400	\$1,190	\$119.00	\$83.30
\$21,500	\$300	\$30.00	\$21.00	\$44,000	\$600	\$60.00	\$42.00	\$66,734	\$900	\$90.00	\$63.00	\$89,143	\$1,200	\$120.00	\$84.00
\$22,250	\$310	\$31.00	\$21.70	\$44,733	\$610	\$61.00	\$42.70	\$67,500	\$910	\$91.00	\$63.70				

Short-Term Income Protection Plan B

Coordinated Short-Term Disability Insurance

This plan is only available if your employer provides employer-paid Long-Term Disability Insurance. The weekly benefit is 66.67% of your salary to a maximum of \$1,200. The benefit duration must match your Long-Term Disability Insurance Elimination Period (time between when you first become disabled and benefits start).

Calculate your monthly cost:

$$\frac{\text{Weekly Salary}}{\text{Rate (see chart)}} \div 10 \times \text{Monthly Cost} = \text{Monthly Cost}$$

Age	60-day	90-day	120-day	180-day
<30	\$0.59	\$0.69	\$0.76	\$0.86
30-34	\$0.59	\$0.69	\$0.76	\$0.86
35-39	\$0.59	\$0.69	\$0.76	\$0.86
40-44	\$0.59	\$0.69	\$0.76	\$0.86
45-49	\$0.59	\$0.69	\$0.76	\$0.86

Age	60-day	90-day	120-day	180-day
50-54	\$0.72	\$0.86	\$0.94	\$1.07
55-59	\$0.72	\$0.86	\$0.94	\$1.07
60-64	\$0.95	\$1.10	\$1.22	\$1.40
64+	\$0.95	\$1.10	\$1.22	\$1.40

Long-Term Income Protection Plan

Long-Term Disability Insurance

If you are not covered by Long-Term Disability Insurance, this plan is for you. Choose your coverage amount in \$100 increments, not to exceed 60% of your salary. Also choose a benefit duration of five years or until age 70. Benefits begin after 52 weeks or at the end of your Short-Term Disability Insurance plan, whichever is later. Benefits continue for five years or until age 70 based on your choice of plan.

- Plan 1: Provides benefits for up to 5 years if disabled prior to age 66.
- Plan 2: Provides benefits up to age 70, if disabled prior to age 69.

Age	Teachers Included*		Age	Teachers Excluded*	
	Plan 1	Plan 2		Plan 1	Plan 2
<39	\$0.18	\$0.27	<39	\$0.23	\$0.36
40-49	\$0.45	\$0.72	40-49	\$0.55	\$0.96
50+	\$1.20	\$1.68	50+	\$1.33	\$1.93

*If you are not certain if Teachers are included or excluded, please see your HR profession or Benefit Administrator.

Calculate your monthly cost:

$$\frac{\text{Elected Monthly Benefit}}{\text{Rate (see chart)}} \div 100 \times \text{Monthly Cost} = \text{Monthly Cost}$$

Do I Need to Fill Out the Attached Medical Questionnaire (Evidence of Insurability) Form?

To identify whether or not you are required to submit the attached medical questionnaire (Evidence of Insurability), follow the instructions under the plan(s) you have chosen.

NIS Options - Life Insurance Plans

Mandatory Coverage

Basic Life and AD&D Insurance

Not required.

Basic-Plus Life Plan

Dependent Life Insurance (Family Unit Plan)

Plan 1: Not required during initial open enrollment or within 30 days of eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire (submit a separate form for each person applying for coverage).

Plan 2: Required. Please submit a separate form for each person applying for coverage. Note: If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current coverage amounts.

Optimum Life Plan

Optional Life and AD&D Insurance for Employee and Optional Life Insurance for Dependents

Required. If your coverage under this plan is being transferred from another insurance company, you will not be required to answer medical questions on current amounts. Note: Coverage may be increased by 10% without medical questions in the event of a "qualifying event" such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details. Subject to plan maximums. Please submit a separate form for each person applying for coverage.

NIS Options - Disability Insurance Plans

(Short-Term Disability, Coordinated Short-Term Disability and/or Long-Term Income Protection)

Not required during the initial open enrollment period or within 30 days of your eligibility date. If you are applying for coverage at any other time, please fill out the medical questionnaire. Note: Coverage may be increased by 10% without medical questions in the event of a "qualifying event" such as childbirth, adoption, marriage, divorce, job change, etc. See your HR department for details. Subject to plan maximums.

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Mailing: PO Box 5008, Madison, WI 53705 • Phone: 1-800-356-9601
 Home Office: 1241 John Q. Hammons Drive, Madison, WI 53717

Return application to:
 National Insurance Services
 250 South Executive Drive, Suite 300
 Brookfield, WI 53005-4273
 Attention: Billing Department

Evidence of Insurability

(A separate form must be completed for each person seeking coverage.)

Check appropriate box(es): <input type="checkbox"/> Life: \$ _____ <input type="checkbox"/> Life/AD&D <input type="checkbox"/> Supp. Life:\$ _____ <input type="checkbox"/> Long Term Disability <input type="checkbox"/> AD&D:\$ _____ <input type="checkbox"/> Short Term Disability <input type="checkbox"/> AD&D:\$ _____		Reason for Applying: <input type="checkbox"/> New Hire <input type="checkbox"/> Late Enrollee <input type="checkbox"/> Increase in Coverage amount <input type="checkbox"/> Reinstatement <input type="checkbox"/> Adding Dependent(s) <input type="checkbox"/> Applying for coverage over GI <input type="checkbox"/> Other:		
APPLICANT INFORMATION				
Applicant's Name: Last, First, MI		Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Age:	Date of Birth: / /
Height:	Weight:	Applicant's Social Security No. - -	Already Enrolled? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Applicant's Home Address: (Street, City, State, Zip)			Applicant's Daytime Phone No. ()	
Applicant's Current Physician's Name:		Date Last Visited: / /	Reason for Visit:	
Physician's Address: (Street, City, State, Zip)			Physician's Phone No.	
Employee Member Name: (if different than Applicant)		Employee's Job Title:		
Employee's Date of Hire:	No. of Hours Employee Works Per Week:	Employee's Annual Salary: \$		
Employer Name:		Employer's Address: (Street, City, State, Zip)		

HEALTH QUESTIONS

Check Yes or No, circle all applicable "Yes" disorders or procedures and give details below.

I. Are you currently pregnant? Yes No **If "Yes", what is your expected due date:**

II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

A. HEART		D. PAIN & DISCOMFORT	
1. Heart ailment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Arthritis, bursitis or gout?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Chest pain, angina or shortness of breath?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Recurrent back pain or slipped disk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Irregular heart beat or heart murmur?	<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Disorder of the back, neck or spine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Rheumatic fever?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Disorder of the muscles, bones or joints?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Disease or abnormality of heart muscle, nerves or vessels?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Temporomandibular joint (TMJ) Disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Stress test; electrocardiogram or echocardiogram?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Recurrent abdominal pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. TUMORS/CYSTS		E. OTHER	
1. Cancer of any type?	<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Stroke, seizure disorder or epilepsy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Tumors, cysts, or polyps?	<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Migraine or persistent headaches?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1. High or low blood pressure or hypertension?	<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Dizziness or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Asthma, emphysema, breathing or lung disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Disorder of kidneys or bladder or kidney stones?	<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Indigestion, ulcers or irritable bowel?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Diabetes, high or low blood sugar?	<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Chronic fatigue?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Protein, blood or sugar in urine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Night sweats, persistent swollen glands or diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Aids Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
		10. Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

HEALTH QUESTIONS *continued...*

Check all applicable disorders and give details below.

III. In the past 5 years have you been diagnosed or treated by a medical professional for a disease or disorder of the:

A. Brain or nervous system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Prostate, ovaries or uterus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Eyes, ears, nose or throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No	E. Stomach, intestine, gallbladder or liver?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Skin or lymph nodes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	F. Thyroid, spleen or any gland?	<input type="checkbox"/> Yes <input type="checkbox"/> No

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	C. Been treated or evaluated in a hospital or medical or psychiatric facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Scheduled or undergone any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	D. Sustained illness requiring medical care or hospitalization?	<input type="checkbox"/> Yes <input type="checkbox"/> No

V. In the last 12 months, have you used tobacco of any kind? Yes No

VI. Please list all prescribed and non-prescribed medications you currently take:

If you answered "Yes" to any Health Questions in this form, please explain below. (Please use another sheet of paper if necessary.)

Dates	Conditions	Doctor Names and Addresses	Results

ACKNOWLEDGEMENTS, AUTHORIZATIONS & SIGNATURE

I understand all statements and answers I have given are to be relied upon and form the basis of any coverage issued to me and/or my dependents under the Group Policy. I understand that any misstatements or failure to report information which is material to the issuance of coverage may be used as a basis for rescission of my insurance and/or denial of payment of a claim. I agree to notify Madison National Life Insurance Company, Inc. of any change in my medical condition while my enrollment is pending. I agree that if my enrollment is approved by Madison National Life Insurance Company, Inc., the effective date of any coverage will be determined in accordance with the terms of the Group Policy, including any Actively at Work requirement.

I acknowledge this Evidence of Insurability form (when approved), the Group Policy, Certificate of Insurance, and any endorsement, amendment or rider hereto, are part of the insurance coverage(s) applied for. I understand that no insurance agent or broker, or persons other than officers of Madison National Life Insurance Company, Inc., can modify, waive or change this form, nor bind coverage or guarantee approval of this form.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, Veterans Administration Facility, or other medically related facility, state or local government agency, insurance or reinsurance company, consumer reporting agency, or employer, to give to Madison National Life Insurance Company, Inc., its legal representative or its reinsurers any and all such information to use for underwriting insurance. I agree that this authorization, in connection with this form, shall be valid for 24 months from my signature date and that I have the right to revoke this authorization at any time. I agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

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's Signature	Date
Parent/Guardian Signature (for Dependent enrollees under age 18)	Date

FOR INSURER USE ONLY:	Decision: <input type="checkbox"/> Approved <input type="checkbox"/> Postponed <input type="checkbox"/> Declined	Effective Date:
Underwriter's Signature:		Date: