Madison National Life Insurance Company
Independence Holding Group

Employee Enrollment Form

Return to:
National Insurance Services
250 S. Executive Drive, Suite 300
Brookfield, WI 53005-4273
Attn: Billing Department
1-800-627-3660

EMPLOYEE INFORMATION

NAME OF EMPLOYER			GROUP NUMBER
NAME OF EMPLOYEE (LAST, FIRST, MIDDLE INITIAL)	SOCIAL SECURITY #	☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE
HOME ADDRESS OF EMPLOYEE (STREET, CITY, STATE, ZIP CODE)	**U.S. CITIZEN?** ☐ YES ☐ NO-*(SEE ☑ BELOW)*	DATE OF BIRTH	EMPLOYMENT DATE
JOB TITLE	JOB DUTIES	HOURS WORKED PER WEEK	ANNUAL SALARY

COVERAGE(S) ELECTED

☐	BASIC LIFE*	Amount	$ or multiple of salary	
☐	BASIC AD&D*	Amount	$ or multiple of salary	
☐	SUPPLEMENTAL LIFE*	Amount	$ or multiple of salary	
☐	SUPPLEMENTAL AD&D*	Amount	$ or multiple of salary	
☐	DEPENDENT LIFE**	Option		
☐	LONG-TERM DISABILITY			
☐	LONG-TERM DISABILITY – SUPPLEMENTAL	Option		
☐	SHORT-TERM DISABILITY	Amount		

*Beneficiary designation is on the reverse side.

**If your spouse and/or child(ren) are to be covered, please provide the following information. Attach additional pages if necessary.

Dependent Names	***Full-Time Student?***		**Birth Date**	**Social Security No.**	**U.S. Citizen?** If "No", see ☑ below
		Spouse			☐ Yes ☐ No
	☐Yes ☐No	**Child**			☐ Yes ☐ No
	☐Yes ☐No	**Child**			☐ Yes ☐ No
	☐Yes ☐No	**Child**			☐ Yes ☐ No
	☐Yes ☐No	**Child**			☐ Yes ☐ No
	☐Yes ☐No	**Child**			☐ Yes ☐ No

☑ If an enrollee is not a United States citizen, please attach a copy of his or her Visa.

Form continues on Page 2.

EMPLOYEE COVERAGE AUTHORIZATION

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. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

By signing this Application I understand and agree that:

- I authorize my Employer to make any required deductions, if any, from my salary to pay the premium of my insurance coverage 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 final approval is given by Madison National Life Insurance Company, Inc.
- No person, except an officer of Madison National Life, is authorized to vary or modify a contract.

Employee/Applicant Signature	**Date**

EMPLOYEE WAIVER OF INSURANCE

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

Employee/Applicant Signature	**Date**

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.)

YOUR DEATH BENEFITS ARE TO BE PAID TO: **PRIMARY BENEFICIARY(IES)**			*IF PRIMARY BENEFICIARY(IES) IS/ARE NOT LIVING AT THE TIME OF YOUR DEATH, BENEFITS ARE TO BE PAID TO:* **SECONDARY BENEFICIARY(IES)**		
NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP	PERCENT OF BENEFIT	NAME (LAST, FIRST, MIDDLE)	RELATIONSHIP	PERCENT OF BENEFIT
* SPOUSE'S SIGNATURE			SIGNATURE DATE:		

Mail the original of the form to the address in top right corner of Page 1. A copy goes to the insured employee and also to the group administrator to be retained.

FOR NATIONAL INSURANCE SERVICES USE ONLY:		
Notes:		
Date Received:	**Effective Date of Coverage:**	**Plan No.**