



- C. Within the past 10 years have you been diagnosed as having or treated by a member of the medical profession for:
- 6. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), obstructive airway disease or any other disorder of the respiratory system?  Yes  No
  - 7. Rheumatoid or Psoriatic Arthritis, Lupus (systemic or discoid) or any other collagen disorder, muscular or skeletal disorder?  Yes  No
  - 8. Alcoholism or abuse, Drug addiction or abuse?  Yes  No
  - 9. Abnormal medical test results?  Yes  No
- D. Within the past 10 years have you or any dependent applying for insurance tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?  Yes  No
- E. Have you been scheduled for treatment or testing for any medical condition within the last 6 months?  Yes  No
- Describe any "Yes" answers here: \_\_\_\_\_

**DEPENDENT INFORMATION**

SPOUSE NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? \_\_\_\_\_  
 IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: \_\_\_\_\_

**REFUSAL/WAIVER -- Complete Only if You Are Declining Coverage For Yourself Or Any Dependent**

I DECLINE DENTAL COVERAGE FOR:  MYSELF  MY SPOUSE  MY CHILDREN  
 REASON FOR REFUSAL: \_\_\_\_\_

I DECLINE VISION COVERAGE FOR:  MYSELF  MY SPOUSE  MY CHILDREN  
 REASON FOR REFUSAL: \_\_\_\_\_

I DECLINE LIFE COVERAGE FOR:  MYSELF  MY SPOUSE  MY CHILDREN  
 REASON FOR REFUSAL: \_\_\_\_\_

I DECLINE WEEKLY DISABILITY INCOME COVERAGE.  
 REASON FOR REFUSAL: \_\_\_\_\_

**ACKNOWLEDGMENT AND AUTHORIZATION**

I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. To the best of my knowledge and belief all answers are true and complete.

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.

DATE \_\_\_\_\_ CITY AND STATE \_\_\_\_\_

SIGNATURE OF EMPLOYEE \_\_\_\_\_

Agents Name (Printed, typed, or stamped) \_\_\_\_\_ Agents Florida license ID Number \_\_\_\_\_

Agents Signature \_\_\_\_\_