NIS
National Insurance Services

Madison National Life
a Horace Mann company

NIS Guide

Life and Disability Insurance Options

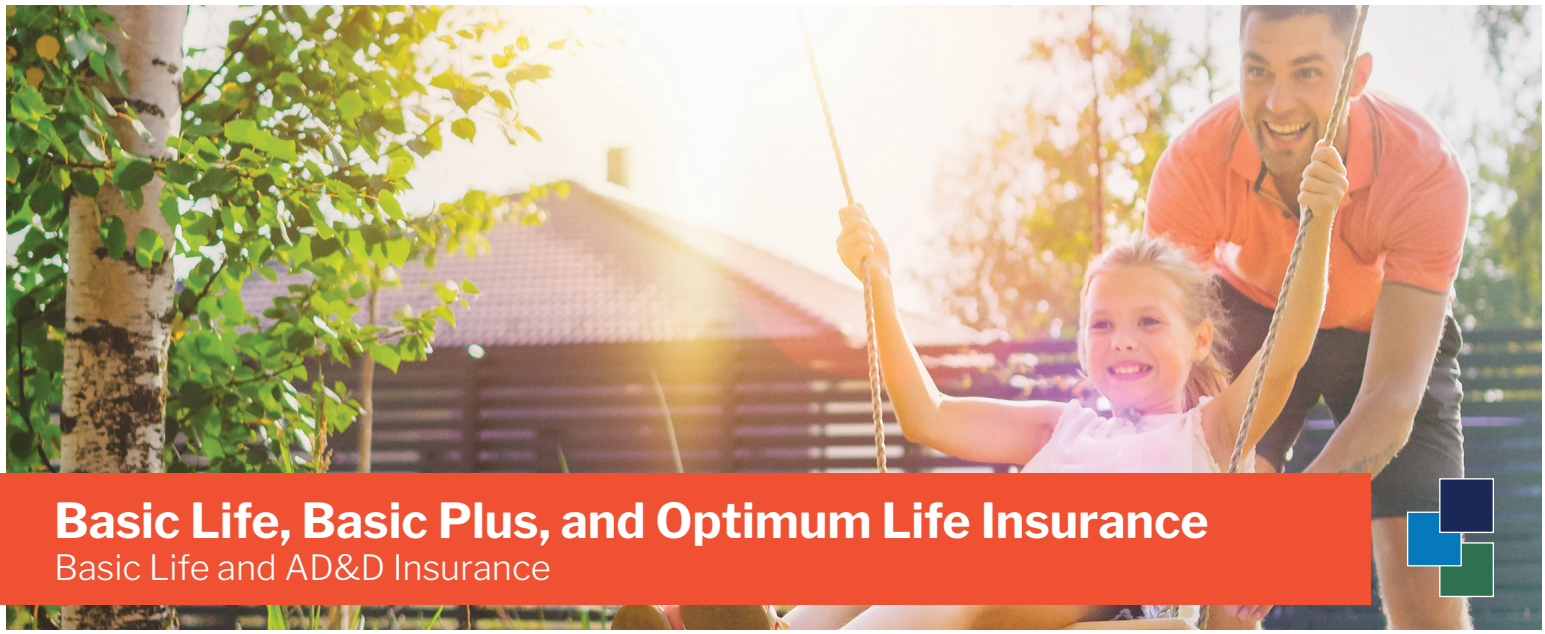
Every Day, the Choices We Make Affect Our Quality of Life. From What We Eat to Where We Work, What We Choose Matters.

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.

In This Guide, You'll Learn About:

- Life Insurance
- Long Term Disability Insurance
- Short Term Disability Insurance



Basic Life, Basic Plus, and Optimum Life Insurance

Basic Life and AD&D Insurance

This plan is required in order to participate in any of the other Option plans.*

What It Is:

A 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.

Basic Life Medical Questionnaire:

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. 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.

Plan	Covers	Plan 1	Plan 2
Mandatory Life Insurance Coverage Basic Life and AD&D Insurance	Employee only	$5,000	$10,000

* If you have Group Basic Term Life coverage through Madison National Life Insurance Company, Inc. – the mandatory $5,000 or $10,000 is covered under that separate policy, and not needed under NIS Options. Otherwise you must elect either $5,000 or $10,000 under NIS Options to participate in any of the NIS Options benefit provisions

Basic-Plus Life Insurance Coverage

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

When to Choose This Option:

You may choose to purchase this 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 Optimum 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 Child[1]
- **Plan 2**: $5,000 Spouse and $2,500 Child[1]

End of Coverage:

When employee's coverage ends.

Medical Questionnaire:

Plan 1 and Plan 2: 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. 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.

Plan	Covers	Plan 1	Plan 2
Basic-Plus Life Insurance Plan Optional Dependent Life Insurance	Spouse/Dependent only	Spouse: $2,000 Child/ren: $2,000	Spouse: $5,000 Child/ren: $2,500

[1] Children 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 plans, choose this premium plan.

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):** Spouse can choose up to 50% of the employee's elected and approved coverage, not to exceed $150,000
- **Child/ren Life Insurance (No AD&D):**[1] Children can be covered up to 25% of the employee's elected and approved coverage, not to exceed $20,000

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.

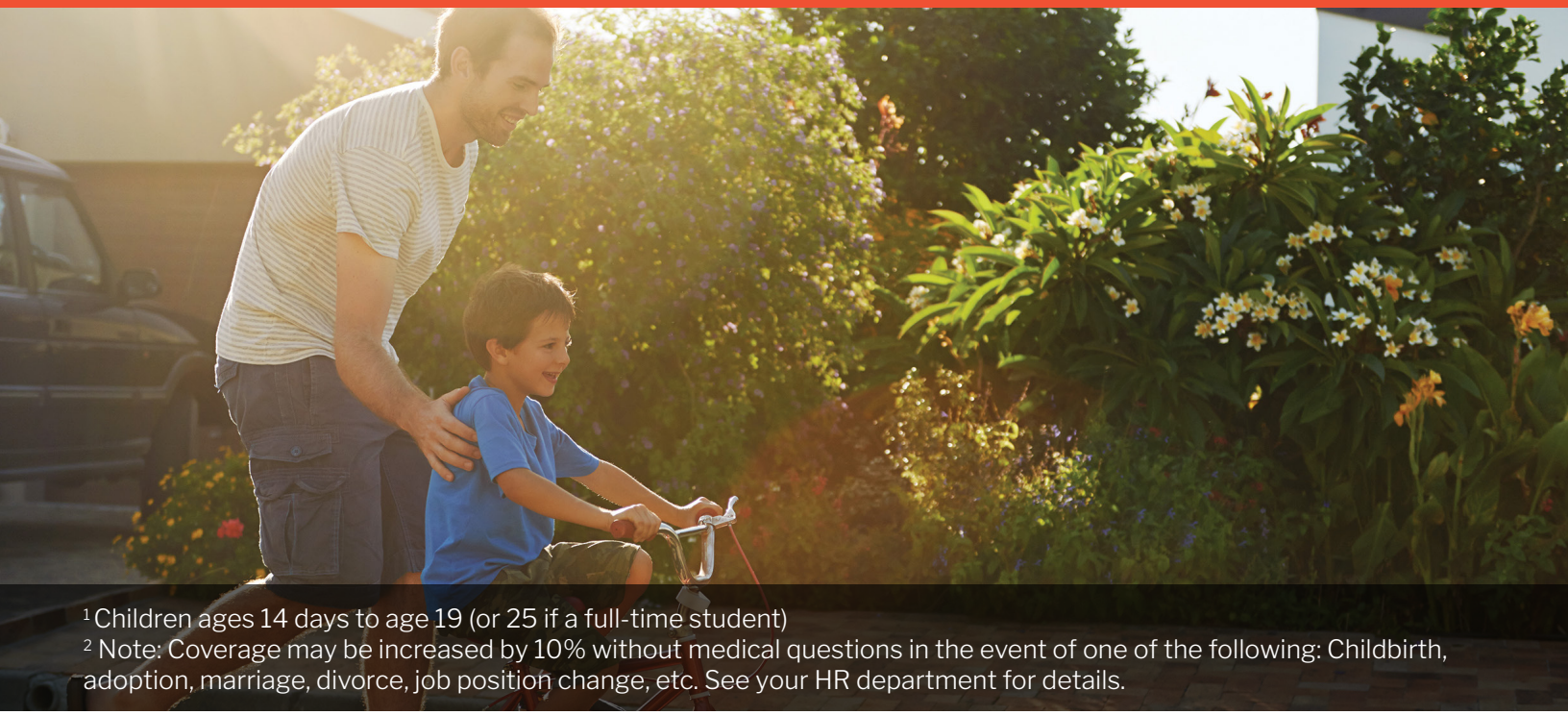
End of Coverage:

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.

Plan	Covers	Minimum Coverage	Maximum Coverage
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



[1] Children ages 14 days to age 19 (or 25 if a full-time student)
[2] Note: Coverage may be increased by 10% without medical questions in the event of one of the following: Childbirth, adoption, marriage, divorce, job position change, etc. See your HR department for details.

Short Term Income Insurance Protection Plan A

Short Term Disability Insurance: 52 Week Duration (For Those Who Don't Have Long Term Disability Coverage Through Their Employer)

When to Choose This Option:

If your employer does not provide Short Term Disability Insurance or Long 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 may 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 due to an injury, and after seven days if due to a physical disease.
- **28-Day Wait:** Benefits start immediately if due to an injury, and after 28 days if due to a physical disease.

Benefit Duration:

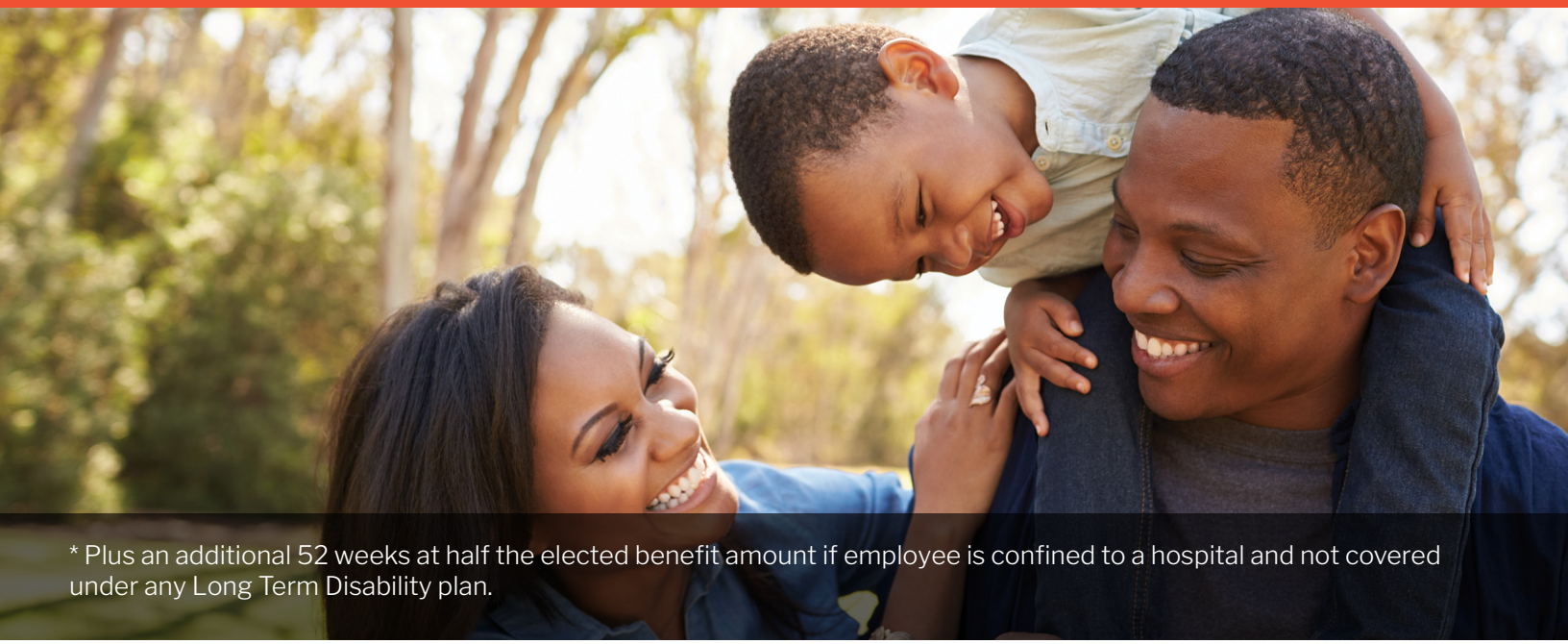
Benefits continue for 52 weeks (plus an additional 52 weeks at half the benefit amount if you are confined to a hospital and not covered under any Long Term Disability plan).

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]

[1] Note: Coverage may be increased by 10% without medical questions in the event of one of the following: Childbirth, adoption, marriage, divorce, job position 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.

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



* 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.

Short Term Income Insurance Protection Plan B

Coordinated Short Term Disability Insurance (For Those Who Do Have Long Term Disability Coverage Through Their Employer)

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 injury, or 15 days after the start of a covered physical disease, 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 may 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. 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.

Plan	Benefit Duration	Minimum Coverage	Maximum Coverage
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

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 years[1] or until age 70.

Benefit Duration:

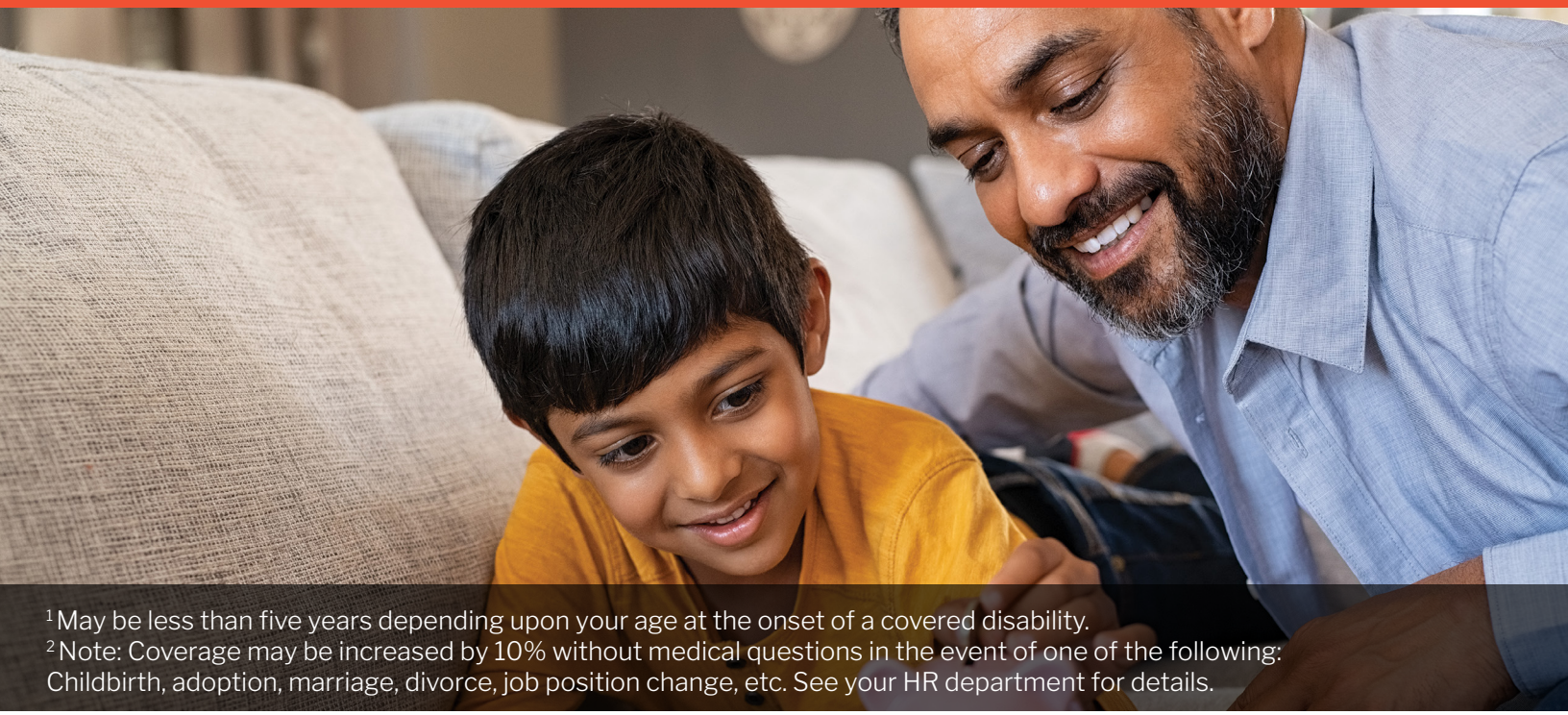
Benefits begin after 52 weeks or at the end of your Short Term Disability Insurance plan, whichever is later. Benefits continue for five years[1] or until age 70 based on your choice of plan.

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.

Plan	Benefit Duration	Minimum Coverage	Maximum Coverage
Long Term Income Insurance Protection Plan Long Term Disability Insurance	Choice of 5 years[1] or until age 70	$100 per month	$5,000, or 60% of salary



[1] May be less than five years depending upon your age at the onset of a covered disability.
[2] Note: Coverage may be increased by 10% without medical questions in the event of one of the following: Childbirth, adoption, marriage, divorce, job position change, etc. See your HR department for details.

Limitations and Exclusions

Life Insurance Age Reductions, Plan Termination, and Exclusions

Age Reductions and Plan Termination

Basic Life and AD&D Insurance and Dependent Life Insurance 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.

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: The policy will not cover any disability: 1) caused by, contributed to by, or resulting from a pre-existing condition; and 2) which begins in the first 12 months after your effective date. "Pre-existing condition" means a physical disease or injury for which you had received medical treatment, consultation, care or services including diagnostic measures, or had taken prescribed drugs or medicines in the 12 months prior to your effective date. If you are totally disabled due to a pre-existing condition on the day which is 12 months after your effective date; and after that day, return to active service for at least five days in a row; and again become disabled due to the same pre-existing condition; then this pre-existing condition exclusion shall not apply to the new period of disability.

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 disorder 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.

About National Insurance Services

Since 1969, National Insurance Services (NIS) has worked with public sector organizations such as schools, cities, counties, municipalities, libraries, and community mental health organizations providing employee benefit consulting services, as well as brokerage services for medical, dental, life, disability, and vision insurance benefits. NIS also specializes in early retiree benefit restructuring services, tax-free options for retiree payouts, as well as, on-site and near-site medical clinics.

NIS is trusted by over 2,500 public sector organizations and 500,000 insured individuals in 29 states. We are headquartered in Brookfield, Wisconsin with regional offices in Indiana, Iowa, Michigan, Minnesota, Nebraska, and Pennsylvania.

To learn more about NIS, visit our website NISBenefits.com

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National Insurance Services

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Underwritten by:

Madison National Life
a Horace Mann company

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Founded in 1961, Madison National Life Insurance Company, Inc is headquartered in Madison, the rapidly growing capital city of Wisconsin. Madison National Life is licensed in 49 states and specializes in group life, disability and specialty health insurance. The company is a wholly owned subsidiary of Horace Mann Educators Corporation (NYSE:HMN), the largest financial services company focused on providing America's educators and school employees with insurance and retirement solutions.

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Options Plan - 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. 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.

- **Plan 1:** $5,000, $1.90 monthly rate (includes Basic Term Life and AD&D)
- **Plan 2:** $10,000, $3.50 monthly rate (includes Basic Term Life and AD&D)

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.

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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:

$ ☐☐☐ , ☐☐☐ Amount of Coverage

÷1,000

= ☐☐☐

x $ ☐ . ☐☐ Rate

= $ ☐☐☐ . ☐☐ Monthly Cost

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:

$ ☐☐☐ , ☐☐☐ Amount of Coverage

÷1,000

= ☐☐☐

x $ ☐ . ☐☐ Rate

= $ ☐☐☐ . ☐☐ Monthly Cost

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:

$ ☐☐ , ☐☐☐ Amount of Coverage

÷1,000

= ☐☐

x $0.15 Rate

= $ ☐ . ☐☐ Monthly Cost

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Options Plan - 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	
		7 Day Elim	28 Day Elim
$1,300	$20	$2.00	$1.40
$1,950	$30	$3.00	$2.10
$2,600	$40	$4.00	$2.80
$3,250	$50	$5.00	$3.50
$3,900	$60	$6.00	$4.20
$4,550	$70	$7.00	$4.90
$5,200	$80	$8.00	$5.60
$5,850	$90	$9.00	$6.30
$6,500	$100	$10.00	$7.00
$7,241	$110	$11.00	$7.70
$8,000	$120	$12.00	$8.40
$8,723	$130	$13.00	$9.10
$9,500	$140	$14.00	$9.80
$10,196	$150	$15.00	$10.50
$11,000	$160	$16.00	$11.20
$11,709	$170	$17.00	$11.90
$12,500	$180	$18.00	$12.60
$13,262	$190	$19.00	$13.30
$14,000	$200	$20.00	$14.00
$14,757	$210	$21.00	$14.70
$15,500	$220	$22.00	$15.40
$16,272	$230	$23.00	$16.10
$17,000	$240	$24.00	$16.80
$17,760	$250	$25.00	$17.50
$18,500	$260	$26.00	$18.20
$19,246	$270	$27.00	$18.90
$20,000	$280	$28.00	$19.60
$20,743	$290	$29.00	$20.30
$21,500	$300	$30.00	$21.00
$22,250	$310	$31.00	$21.70

Annual Salary	Weekly Benefit	Monthly Cost	
		7 Day Elim	28 Day Elim
$23,000	$320	$32.00	$22.40
$23,751	$330	$33.00	$23.10
$24,500	$340	$34.00	$23.80
$25,260	$350	$35.00	$24.50
$26,000	$360	$36.00	$25.20
$26,759	$370	$37.00	$25.90
$27,500	$380	$38.00	$26.60
$28,251	$390	$39.00	$27.30
$29,000	$400	$40.00	$28.00
$29,725	$410	$41.00	$28.70
$30,500	$420	$42.00	$29.40
$31,226	$430	$43.00	$30.10
$32,000	$440	$44.00	$30.80
$32,727	$450	$45.00	$31.50
$33,500	$460	$46.00	$32.20
$34,228	$470	$47.00	$32.90
$35,000	$480	$48.00	$33.60
$35,729	$490	$49.00	$34.30
$36,500	$500	$50.00	$35.00
$37,230	$510	$51.00	$35.70
$38,000	$520	$52.00	$36.40
$38,731	$530	$53.00	$37.10
$39,500	$540	$54.00	$37.80
$40,231	$550	$55.00	$38.50
$41,000	$560	$56.00	$39.20
$41,732	$570	$57.00	$39.90
$42,500	$580	$58.00	$40.60
$43,233	$590	$59.00	$41.30
$44,000	$600	$60.00	$42.00
$44,733	$610	$61.00	$42.70

Annual Salary	Weekly Benefit	Monthly Cost	
		7 Day Elim	28 Day Elim
$45,500	$620	$62.00	$43.40
$46,234	$630	$63.00	$44.10
$47,000	$640	$64.00	$44.80
$47,734	$650	$65.00	$45.50
$48,500	$660	$66.00	$46.20
$49,235	$670	$67.00	$46.90
$50,000	$680	$68.00	$47.60
$50,735	$690	$69.00	$48.30
$51,500	$700	$70.00	$49.00
$52,743	$710	$71.00	$49.70
$53,486	$720	$72.00	$50.40
$54,229	$730	$73.00	$51.10
$54,971	$740	$74.00	$51.80
$55,714	$750	$75.00	$52.50
$56,457	$760	$76.00	$53.20
$57,200	$770	$77.00	$53.90
$57,943	$780	$78.00	$54.60
$58,686	$790	$79.00	$55.30
$59,429	$800	$80.00	$56.00
$60,171	$810	$81.00	$56.70
$60,914	$820	$82.00	$57.40
$61,657	$830	$83.00	$58.10
$62,400	$840	$84.00	$58.80
$63,143	$850	$85.00	$59.50
$63,886	$860	$86.00	$60.20
$64,629	$870	$87.00	$60.90
$65,371	$880	$88.00	$61.60
$66,114	$890	$89.00	$62.30
$66,857	$900	$90.00	$63.00
$67,600	$910	$91.00	$63.70

Annual Salary	Weekly Benefit	Monthly Cost	
		7 Day Elim	28 Day Elim
$68,343	$920	$92.00	$64.40
$69,086	$930	$93.00	$65.10
$69,829	$940	$94.00	$65.80
$70,571	$950	$95.00	$66.50
$71,314	$960	$96.00	$67.20
$72,057	$970	$97.00	$67.90
$72,800	$980	$98.00	$68.60
$73,543	$990	$99.00	$69.30
$74,286	$1,000	$100.00	$70.00
$75,029	$1,010	$101.00	$70.70
$75,771	$1,020	$102.00	$71.40
$76,514	$1,030	$103.00	$72.10
$77,257	$1,040	$104.00	$72.80
$78,000	$1,050	$105.00	$73.50
$78,743	$1,060	$106.00	$74.20
$79,486	$1,070	$107.00	$74.90
$80,229	$1,080	$108.00	$75.60
$80,971	$1,090	$109.00	$76.30
$81,714	$1,100	$110.00	$77.00
$82,457	$1,110	$111.00	$77.70
$83,200	$1,120	$112.00	$78.40
$83,943	$1,130	$113.00	$79.10
$84,686	$1,140	$114.00	$79.80
$85,429	$1,150	$115.00	$80.50
$86,171	$1,160	$116.00	$81.20
$86,914	$1,170	$117.00	$81.90
$87,657	$1,180	$118.00	$82.60
$88,400	$1,190	$119.00	$83.30
$89,143	$1,200	$120.00	$84.00

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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).

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

Calculate your monthly cost:

_____ x .667 ÷ 10 x _____ = _____

Weekly Salary | Rate (see chart) | Monthly Cost

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*	
	Plan 1	Plan 2
<39	$0.18	$0.27
40-49	$0.45	$0.72
50+	$1.20	$1.68

Age	Teachers Excluded*	
	Plan 1	Plan 2
<39	$0.23	$0.36
40-49	$0.55	$0.96
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:

_____ ÷ 100 x _____ = _____

Elected Monthly Benefit | Rate (see chart) | Monthly Cost

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 #	☐ Single ☐ Married	☐ Female ☐ Male
Home Address of Employee (Street, City, State, Zip)		Date of Birth	Employment Date
Job Title	Benefit Eligibility Date	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 Life Plan

Request (Please choose **one** of the following options). Note: You must be enrolled in a Basic Life Plan to enroll in the other options.

- ☐ **Plan 1:** $5,000
- ☐ **Plan 2:** $10,000
- ☐ I have Basic Life Employer-Paid Coverage Through Madison National Life Insurance Company, Inc.

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

Note: You must select one of these options to enroll in any other Options Plan Benefits.

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 and be approved for 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 and be approved for 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 - 52 Week Duration (For Those Who Don't Have Long Term Disability Coverage Through Their Employer)

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 lower.

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 (For Those Who Do Have Long-Term Disability Coverage Through Their Employer)

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 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.

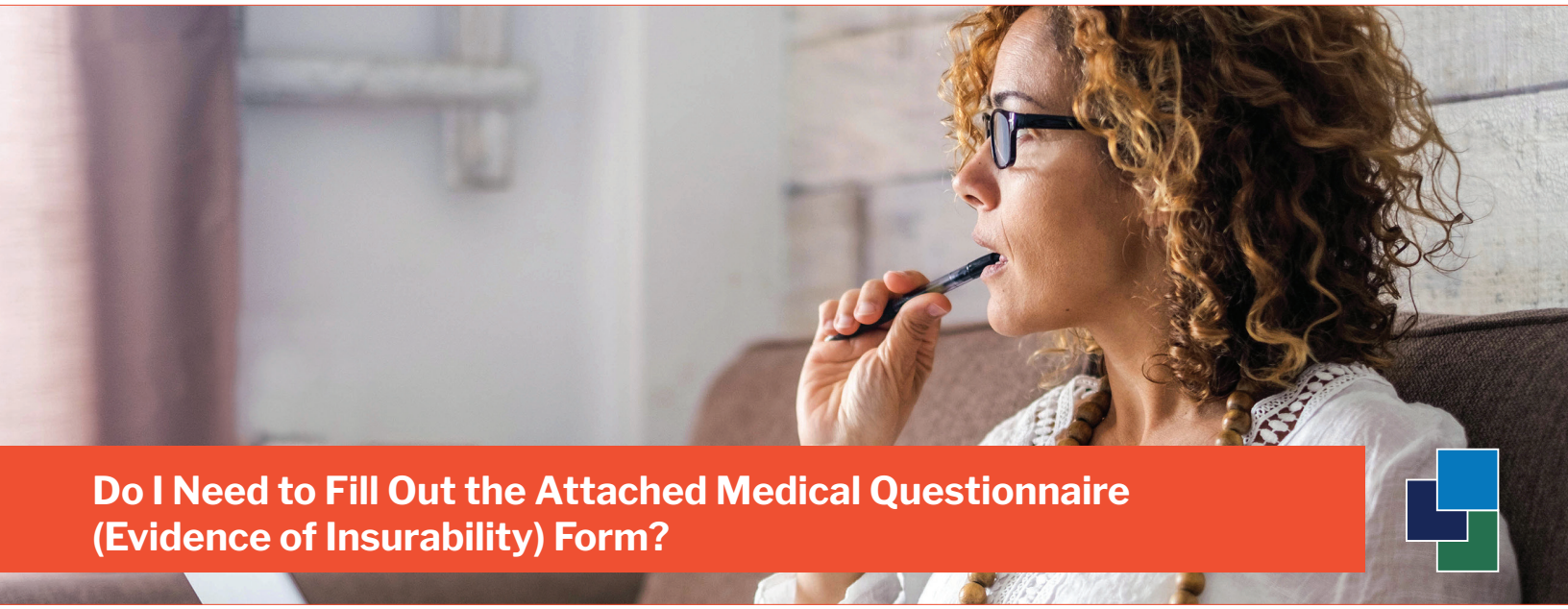
Dated this _____ day of_____, 20_____

_____

Applicant's Signature

NIS
National Insurance Services

Client Focused. Solution Driven.



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, Plan 1 and Plan 2
Dependent Life Insurance (Family Unit Plan)

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. 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.

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):		**Reason for Applying:** ☐New Hire ☐ Late Enrollee
☐Life/AD&D	☐Supp. Life:$ _____	☐ Increase in Coverage amount ☐Reinstatement
☐Long Term Disability	☐AD&D:$ _____	☐Adding Dependent(s) ☐Applying for coverage over GI
☐Short Term Disability	☐AD&D:$	☐Other:

APPLICANT INFORMATION

Applicant's Name: Last, First, MI	**Sex:** ☐M ☐F	**Age:**	**Date of Birth:** / /

Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐Yes ☐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?	☐Yes ☐No	1. Arthritis, bursitis or gout?	☐Yes ☐No
2. Chest pain, angina or shortness of breath?	☐Yes ☐No	2. Recurrent back pain or slipped disk?	☐Yes ☐No
3. Irregular heart beat or heart murmur?	☐Yes ☐No	3. Disorder of the back, neck or spine?	☐Yes ☐No
4. Rheumatic fever?	☐Yes ☐No	4. Disorder of the muscles, bones or joints?	☐Yes ☐No
5. Disease or abnormality of heart muscle, nerves or vessels?	☐Yes ☐No	5. Temporomandibular joint (TMJ) Disorder?	☐Yes ☐No
6. Stress test; electrocardiogram or echocardiogram?	☐Yes ☐No	6. Recurrent abdominal pain?	☐Yes ☐No
B. TUMORS/CYSTS		**E. OTHER**	
1. Cancer of any type?	☐Yes ☐No	1. Stroke, seizure disorder or epilepsy?	☐Yes ☐No
2. Tumors, cysts, or polyps?	☐Yes ☐No	2. Migraine or persistent headaches?	☐Yes ☐No
C. BLOOD AND URINE		3. Nervous/mental disorder, depression or anxiety?	☐Yes ☐No
1. High or low blood pressure or hypertension?	☐Yes ☐No	4. Dizziness or paralysis?	☐Yes ☐No
2. Venereal disease, syphilis, gonorrhea, genital warts or genital herpes?	☐Yes ☐No	5. Asthma, emphysema, breathing or lung disorder?	☐Yes ☐No
3. Disorder of kidneys or bladder or kidney stones?	☐Yes ☐No	6. Indigestion, ulcers or irritable bowel?	☐Yes ☐No
4. Diabetes, high or low blood sugar?	☐Yes ☐No	7. Chronic fatigue?	☐Yes ☐No
5. Protein, blood or sugar in urine?	☐Yes ☐No	8. Acquired Immune Deficiency Syndrome (AIDS)?	☐Yes ☐No
6. Night sweats, persistent swollen glands or diarrhea?	☐Yes ☐No	9. Aids Related Complex (ARC)?	☐Yes ☐No
		10. Human Immunodeficiency Virus (HIV)?	☐Yes ☐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?	☐ Yes ☐ No	D. Prostate, ovaries or uterus?	☐ Yes ☐ No
B. Eyes, ears, nose or throat?	☐ Yes ☐ No	E. Stomach, intestine, gallbladder or liver?	☐ Yes ☐ No
C. Skin or lymph nodes?	☐ Yes ☐ No	F. Thyroid, spleen or any gland?	☐ Yes ☐ No

IV. In the past 5 years, have you:

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

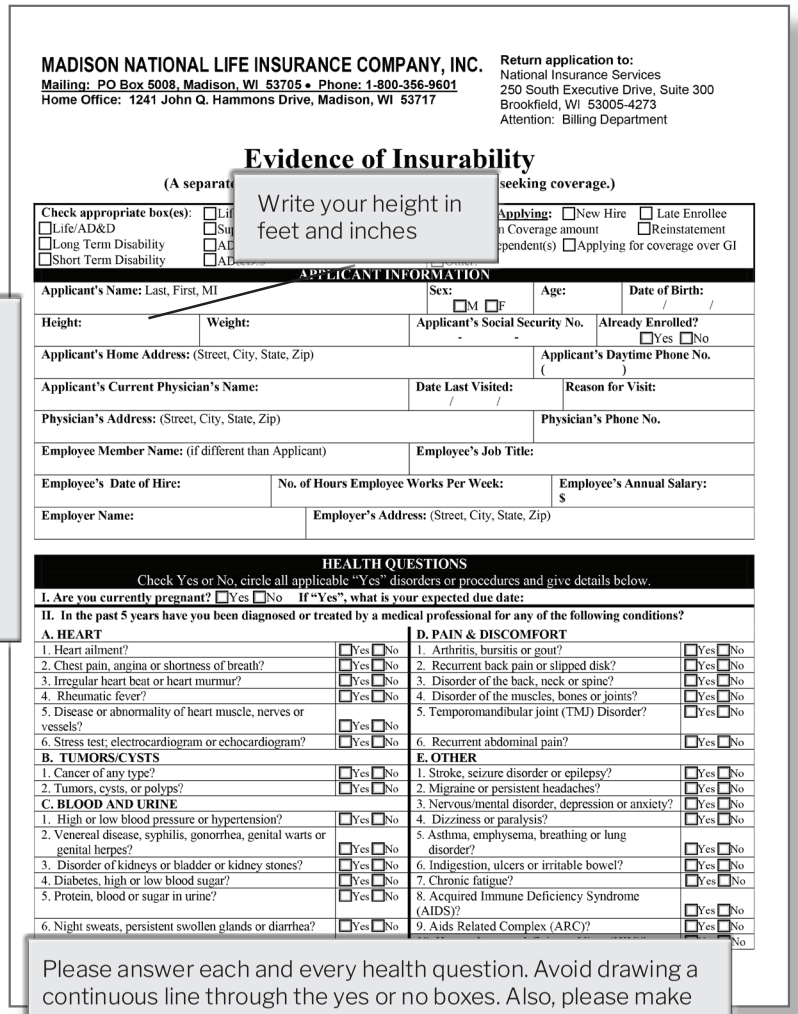
WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

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

FOR INSURER USE ONLY:	Decision: ☐ Approved ☐ Postponed ☐ Declined	Effective Date:
Underwriter's Signature:		Date:

Helpful Hints When Filling Out Your "Evidence of Insurability" Application

In order to process your request for Life and or Disability Insurance you are required to complete the following application. **Please use blue or black ink** and make sure all questions are answered completely and fully. An incomplete document with missed answers will result in the application being returned to you and a delay in the processing of your request. **If you are requesting coverage for family members, complete an additional form for each person.**



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 separat… seeking coverage.)

Check appropriate box(es): ☐Life/AD&D ☐Long Term Disability ☐Short Term Disability
Applying: ☐New Hire ☐Late Enrollee ☐Reinstatement
n Coverage amount
ependent(s) ☐Applying for coverage over GI

APPLICANT INFORMATION

Applicant's Name: Last, First, MI		**Sex:** ☐M ☐F	**Age:** / **Date of Birth:** / /
Height:	**Weight:**	**Applicant's Social Security No.** - -	**Already Enrolled?** ☐Yes ☐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:**

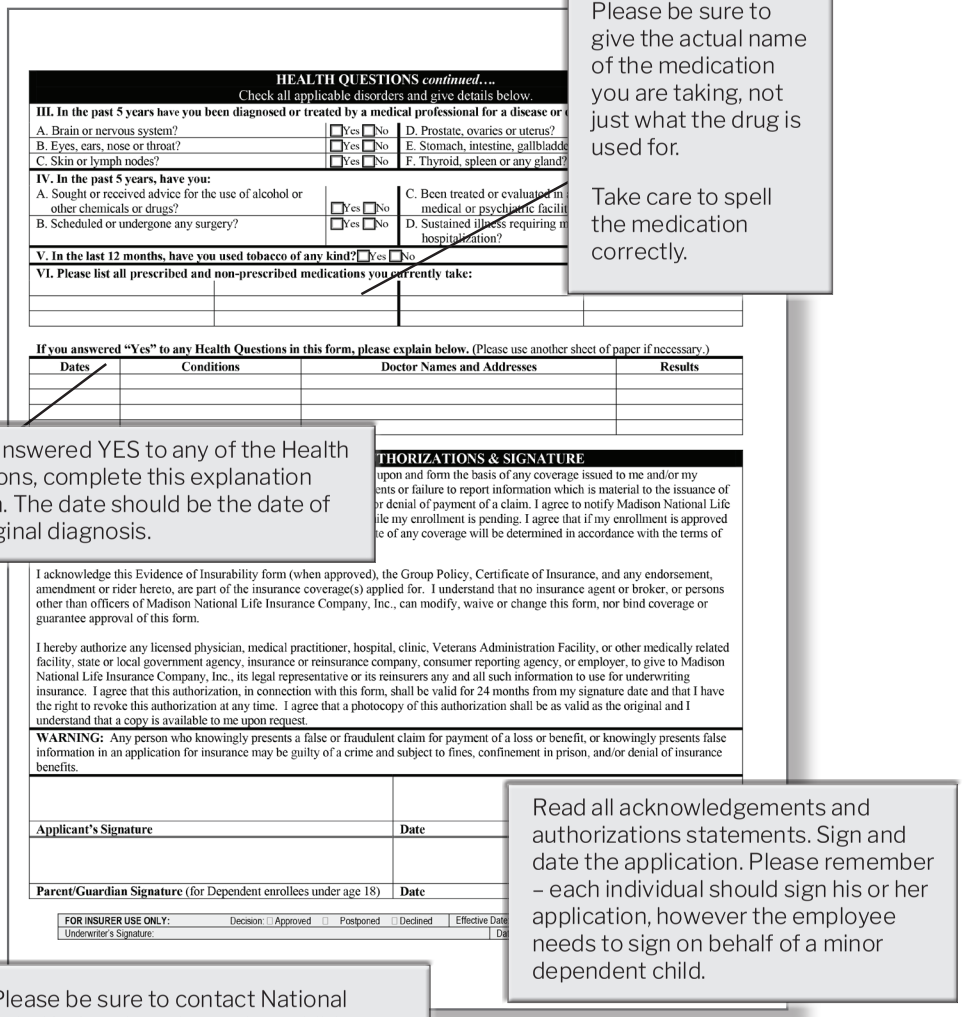
II. In the past 5 years have you been diagnosed or treated by a medical professional for any of the following conditions?

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

Write your height in feet and inches

Provide both your address and your physician's address completely, including address, city, state and zip code.

Please answer each and every health question. Avoid drawing a continuous line through the yes or no boxes. Also, please make sure your check mark clearly falls within a yes or no box.



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

A. Brain or nervous system?	☐Yes ☐No	D. Prostate, ovaries or uterus?	
B. Eyes, ears, nose or throat?	☐Yes ☐No	E. Stomach, intestine, gallbladde	
C. Skin or lymph nodes?	☐Yes ☐No	F. Thyroid, spleen or any gland?	

IV. In the past 5 years, have you:

A. Sought or received advice for the use of alcohol or other chemicals or drugs?	☐Yes ☐No	C. Been treated or evaluated in medical or psychiatric facili	
B. Scheduled or undergone any surgery?	☐Yes ☐No	D. Sustained illness requiring m hospitalization?	

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:

Please be sure to give the actual name of the medication you are taking, not just what the drug is used for.

Take care to spell the medication correctly.

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

If you answered YES to any of the Health Questions, complete this explanation section. The date should be the date of the original diagnosis.

THORIZATIONS & SIGNATURE

upon and form the basis of any coverage issued to me and/or my
ents or failure to report information which is material to the issuance of
r denial of payment of a claim. I agree to notify Madison National Life
ile my enrollment is pending. I agree that if my enrollment is approved
e of any coverage will be determined in accordance with the terms of

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: ☐Approved ☐Postponed ☐Declined Effective Date
Underwriter's Signature: Da

Read all acknowledgements and authorizations statements. Sign and date the application. Please remember – each individual should sign his or her application, however the employee needs to sign on behalf of a minor dependent child.

Please be sure to contact National behalf of a minor dependent child. Insurance Services with any changes in your health while your enrollment is pending. Failure to do so could result in the rescission of insurance and/or denial of payment of a claim.

If you have any questions when you complete this form, please feel free to contact Medical Underwriting at National Insurance Services at 800.627.3660 between the hours of 8 am and 5 pm central time, Monday through Friday.