CAM BENEFIT PROGRAM

APPLICATION FOR GROUP INSURANCE - PART I

MNL MADISON NATIONAL LIFE MEMBER OF THE IHC GROUP NYSE: IHC

MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

Please print in black or blue ink

APPLYING FOR:

☐ MEDICAL ☐ VISION (insured by Vision Service Plan)
☐ TERM LIFE AD&D ☐ DISABILITY (insured by American United Life)
☐ DENTAL

☐ APPLICANT ONLY
☐ DEPENDENT ADDITION
☐ APPLICANT AND DEPENDENTS

Employee's Last Name	First Name	Middle Initial	Address	City	State	Zip	Phone #

Name of Employer	Group Number	Location Number

Spouse's Employer	Address of spouse's employer (City & State)

Height (Ft. | In.)	Wt.	Age	Birth Date (Mo. | Day | Yr.)	Sex		Marital Status	Social Security No. / Occupation / Date Employed Full-Time
						Single ☐ Married ☐ Widowed ☐ Divorced ☐	Social Security No. Occupation Date Employed Full-Time

Dependents to be enrolled (Include last name if different)	Relationship	Sex	Birth Date (Mo. | Day | Yr.)	Ht.	Wt.
1)	Spouse				
2)					
3)					
4)					
5)					

TERM LIFE ☐ **SELF** ☐ **DEP.**
VISION ☐ **SELF** ☐ **DEP.**
MEDICAL ☐ **SELF** ☐ **DEP.**
DENTAL ☐ **SELF** ☐ **DEP.**
DISABILITY ☐ **SELF**

CONFIRMATION____________________/___/___

DO NOT COMPLETE SHADED AREAS

Children 19 to 25 must be attending an accredited educational institution full-time and be claimed as a dependent on the employee's income tax return to be eligible for coverage. **You must include a current course schedule or letter from school verifying current full-time student status (12 or more credits).**

- Have you or any of your dependents ever been covered by the CAM Benefit Program (the "Program")? ☐ Yes ☐ No
  If Yes, employer: ____________________
- Do you or any of your dependents have medical, dental or vision benefits other than through your current employer? ☐ Yes ☐ No
  If Yes, indicate name of cardholder: ____________________
  Plan name(s): ____________________
- Is there a stipulation in a divorce decree (or other court order) regarding insurance coverage for any of the dependents? ☐ Yes ☐ No If yes, submit copy of court order.

THE FOLLOWING QUESTIONS APPLY TO YOU AND EACH DEPENDENT APPLYING FOR COVERAGE.
CHECK THE APPROPRIATE BOX, CIRCLE ALL THAT APPLY AND PROVIDE DETAILS TO "YES" ANSWERS BELOW.

1. Has any applicant in the last 5 years, had, been medically advised of having, been treated for, or been referred for treatment (including medication), advice or hospitalization for any of the following?

a) Any disorder/disease of the heart, lungs, liver, pancreas, colon, back, bones, muscles, joints or arthritis?……………… ☐ Yes ☐ No
b) Any disorder/disease of the eyes, ears, digestive system, urinary tract, kidneys, reproductive system/infertility? …….. ☐ Yes ☐ No
c) Stroke, paralysis, leukemia, cancer, tumors, neurological or seizure disorder, or birth defect? …………………………… ☐ Yes ☐ No
d) Any mental, nervous, or behavioral disorder, chemical imbalance, alcoholism or drug abuse or addiction?…………….. ☐ Yes ☐ No
e) Diabetes? If YES, last blood sugar reading & date: ____________________ ☐ Yes ☐ No
f) High blood pressure? If YES, last 3 blood pressure readings & dates: ____________________ ☐ Yes ☐ No
g) AIDS, AIDS-related complex (ARC), human immunodeficiency virus (HIV) or any immune system disorder?………… ☐ Yes ☐ No

2. Is any applicant currently ill or taking medication or have been advised of the need for any future surgery? ..………… ☐ Yes ☐ No

3. Is employee or any dependent pregnant (whether applying for coverage or not) or does any person have reason to believe that he/she is expecting to become a parent? ………………………………………………………………………………………….. ☐ Yes ☐ No
Anticipated due date: ___________ History of complications, premature birth, C-section?……………………………… ☐ Yes ☐ No

For any YES answers above, please provide complete details below. Attach separate paper if necessary and be sure to sign and date it.
Additional information may be requested when necessary.

(Name of person)	(Illness/Diagnosis)	(Nature of Treatment)	(Dates of Treatment)	(Medications)	(Results/Recovery)

Details and/or additional comments: ____________________

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1. **VERBAL STATEMENTS ARE OF NO EFFECT.** I have not disclosed to any agent any information not disclosed on this application. I understand that no agent can waive or change my obligation to fully and accurately complete this application, and that verbal statements by me or any agent are of no effect.
2. **COVERAGE COULD BE LIMITED.** I understand and agree that coverage will not go into effect until this application is accepted by the CAM Benefit Program and the insurers. I understand that no insurance exists until and unless my employer receives an approval notice from CAM Administrative Services, Inc., accepting coverage for me and my dependents and indicating the effective date of coverage, and satisfaction of any probationary period.
3. **PRE-EXISTING CONDITION LIMITATION.** I understand that coverage may be limited for pre-existing conditions (see Notice of Pre-Existing Condition Limitation and HIPAA Rights). I understand that this pre-existing condition limitation period may be reduced by the amount of continuous coverage I may have had under previous health insurance. **(You and your dependents have the right to prove you had previous health coverage. If you had prior health coverage, you should have received a certificate of creditable coverage as evidence of that coverage and you should submit the certificate along with this application.** If you did not get a certificate, you should request one from the previous administrator or insurer (or fully complete the Prior Creditable Coverage section below.)
4. **HELP COMPLETING APPLICATION.** Has any person helped you in completing this application? _________ If yes: the name of the person who helped you complete this application is: ____________________

BENEFICIARY DESIGNATION. I hereby appoint the following person(s) as my beneficiary for any life and AD&D insurance coverages and revoke all previous designations.
Name of Beneficiary ____Relationship to Employee/Applicant_________________

PRIOR CREDITABLE COVERAGE

☐ Prior medical coverage information is **the same for all family members** (including coverage start/end dates). Complete prior coverage information once for that plan/policy, or attach Certificate of Creditable Coverage.

☐ Prior medical coverage was provided by more than one health plan/carrier or coverage start/end dates were **NOT the same for all family members.** Please photocopy this section or include a separate sheet. Indicate the prior medical coverage information separately for each distinct plan/policy and the family members covered under them and sign and date each page, or attach each insured's certificate of creditable coverage.

Who was covered under this policy?	Name of Prior Carrier/HMO:	Prior Policy Number	Prior Carrier/HMO's Telephone No.: ( )

Check type of plan:	Was it Employer Sponsored?	Reason for Termination of prior coverage?
☐Group ☐Individual ☐COBRA ☐Other	☐ Yes ☐ No	☐Left Employment ☐Employer Cancelled Policy ☐Non-Payment of Premium ☐Non-Renewal ☐Divorce ☐Death of A Spouse ☐Other, Please Specify: ____________

Prior Medical Coverage Started	Prior Medical Coverage Ended	Waiting Period Start Date Prior Medical Plan
Mth/Day/Yr ____________	Mth/Day/Yr ____________	Mth/Day/Yr ____________

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact your employer plan administrator or CAM Administrative Services, Inc., at (800) 732-8906.

WAIVER OF COVERAGE

WAIVER OF COVERAGE (complete this section only if you are **NOT** enrolling in any or all of the following benefits)

I certify I was given the opportunity for group benefits offered by my employer through the CAM Benefit Program and I do not accept the offer. I have read this entire Waiver of Coverage section and understand the enrollment requirements if I make a request for such coverage at a later date.

I WAIVE: ☐ Medical ☐ Vision ☐ Dental ☐ Life—AD&D ☐ Long Term Disability

Reason: ☐ Covered under my spouse's insurance ☐ Covered under an employer sponsored HMO. Name of HMO: ____________
☐ Other: Explain ____

Employee's Signature ______________________________________ Date ______________________

ACKNOWLEDGMENT/FRAUD WARNING

I acknowledge by my signature that my answers to the questions contained in this application are accurate, correct, and true and that no material information has been withheld or omitted. I understand that it may be illegal, and may be a felony, for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or submit an application containing false, incomplete or misleading information. I understand that this will not be considered as a complete application unless all pages are attached and completed. I understand that information on this application is valid for a maximum of 60 days from the date of signature.

Applicant (Employee) Signature **X**____ Date________________
(If for child only, signature must e the child's parent or legal guardian if the child is not of legal age.)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant.

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Spouse **X**______________________________________ Date______________________
(If spouse is covered)
Dependent(s) (age 18 or older) **X**____ Date________________

AUTHORIZATION TO RELEASE MEDICAL INFORMATION FOR UNDERWRITING
SIGNATURE REQUIRED

I hereby authorize those physicians, medical practitioners, dentists, hospitals, clinics, veterans administration facilities, medical information services, urgent care facilities, and other medical or medically related entities, insurance or reinsurance companies, service plans, unions, trusts, funds, providers, networks, schools, employers, and consumer reporting agencies that have information available as to the present or former physical health condition, including drug and alcohol abuse, and/or treatment of me or my dependents to release any and all such information, including, but not limited to, medical records, health-care provider notes, pharmacy data, laboratory tests and results, diagnoses, treatment, and prognoses, to CAM Administrative Services, Inc. ("CAMADS") and Madison National Life Insurance Company, Inc. ("MNL") and their authorized representatives. I understand that the information obtained by use of this authorization may be used to determine eligibility for issuance of insurance coverage and eligibility for benefits for my dependents and me. This authorization is not applicable to psychotherapy notes.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by CAMADS and MNL and may no longer be protected by state or federal law.

I agree that a photographic copy of this authorization shall be as valid as the original and that this authorization shall expire 15 months from the latest signature date below. I understand that I may request a copy of this authorization. I understand that I may revoke this authorization at any time in writing unless action has been taken in reliance on my authorization. Because this authorization is given as a condition of obtaining coverage, my revocation will not prevent CAMADS or MNL from the right to contest a claim under the policy if another law so allows. Should my dependents or I refuse to sign this authorization, I understand that it may affect my enrollment in the benefit plan. I understand that all pages must be attached and complete, including this authorization, for this application to be considered complete and that incomplete applications may be rejected.

Applicant (Employee) Signature **x** ____ Date________________

Social Security Number__________________________
(If for child only, signature must be the child's parent or legal guardian if the child is not of legal age.)

If signed by a representative of Applicant, please indicate the representative's authority to act on behalf of Applicant.

____

Spouse **x**______________________________________ Date______________________
(If spouse is covered)

Signature of each covered dependent age 18 and over:

X__________________________ Date__________ **X**__________________________ Date______________

X__________________________ Date__________ **X**__________________________ Date______________