Madison National Life

Insurance Company, Inc.
P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

ACTIVITIES OF DAILY LIVING

Notice to all persons completing this questionnaire: It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result from such an act.

Name (please print):_____ **Claim number:**_____

Address:_____

Telephone number:_____ **E-mail address:**_____

GENERAL INFORMATION

Please describe your ***current*** medical condition and any progress you believe you have made since you stopped working:_____

List ***all*** the medical problems for which you see a doctor:_____

List ***all*** medications you are ***currently*** taking along with their dosage and frequency:_____

Do you live alone? ☐No ☐Yes Are you married or have a significant other? ☐No ☐Yes
If you are married or have a significant other, does this person work? ☐No ☐Yes If yes, what is their occupation:_____
Do you have dependent children ☐No ☐Yes If you have dependent children, state their names and dates of birth:_____

What is your height? _____ What is your weight? _____ lbs/kgs

EDUCATION AND WORK EXPERIENCE

Please indicate the extent of your formal education (*circle one*)
Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School
If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*).

Job Title / Employer Name	Duties	Dates Worked
(1)		
(2)		
(3)		
(4)		

Did any of the positions listed above require additional training on your part? ☐No ☐Yes If yes, please indicate the nature and type of training (on the job, course work, etc.): _____

What do you perceive to be your current restrictions and limitations?_____

If retraining were made available to you, what occupation(s) would you be interested in?_____

PERSONAL CARE

Describe any changes in your sleeping habits since your condition began: _____

Do you need any assistance in dressing and/or grooming? ☐ No ☐ Yes If you need assistance, describe the help you require ***and*** how frequently:

Do you have problems with your memory? ☐ No ☐ Yes If you have problems with your memory, please describe the problems and how often they occur: _____

Do you prepare your own meals? ☐ No ☐ Yes If you prepare your own meals, which meals do you prepare?
☐ Breakfast ☐ Lunch ☐ Dinner If you do not prepare your own meals, who helps you? _____

Have your eating habits changed since your condition began? ☐ No ☐ Yes
Provide examples of the type(s) of changes in your eating habits: _____

HOUSEHOLD CARE

Are you responsible for the financial management of your household? ☐ No ☐ Yes If you are responsible for the financial management of your household, explain what you do (for example, write checks, pay mortgage, maintain bank records, make bank deposits, etc.): _____

If you are not responsible for the financial management of your household, who is? _____

Do you do housework? ☐ No ☐ Yes If you do housework, check the kinds of household activities you do:
☐ Laundry ☐ Dusting ☐ Vacuuming ☐ Washing dishes ☐ Household repair ☐ Car Care ☐ Garden and lawn care ☐ Trash
☐ Recycling ☐ Other *Specify:* _____

If you do not do household duties, please indicate who does the household duties for you: _____

How often do you do household activities? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly
Approximate time spent on household activities: Daily? _____ Weekly? _____ Monthly? _____
Describe any changes in your ability to care for your household and any assistance required since your disability began: _____

Do you drive? ☐ No ☐ Yes
Do you have a valid driver's license? ☐ No ☐ Yes
Do you take public transportation? ☐ No ☐ Yes Do you need assistance to travel? ☐ No ☐ Yes
If you need assistance to travel, describe why you need assistance, who assists you, and any changes in your travel since your condition began:

Do you shop? ☐ No ☐ Yes
What kinds of shopping do you do? ☐ Food ☐ Clothes ☐ Gifts ☐ Other *Specify*: _____

How often do you shop? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly
Approximate time spent on shopping? Daily? _____ Weekly? _____ Monthly? _____
Do you require assistance when you shop? ☐ No ☐ Yes If you require assistance when you shop, describe the assistance you require:

If you have childcare responsibilities, answer the following questions:
What care are you able to provide for your child/children/grandchildren:
☐ Bathe ☐ Change Clothes ☐ Change Diaper ☐ Feed ☐ Carry ☐ Play activities ☐ Lift ☐ Read
☐ Other *Specify:* _____
Approximate time spent on childcare activities: Daily? _____ Weekly? _____ Monthly? _____

Do you require assistance to perform any of these childcare activities? ☐ No ☐ Yes If you require assistance to perform childcare activities, describe the assistance you need, who provides assistance, and how frequently do you require this assistance: _____

INTERESTS AND HOBBIES

Do you read? ☐ No ☐ Yes
If you read, what do you read? ☐ Books ☐ Magazines ☐ Newspapers ☐ Other *Specify:* _____
Approximate time spent on reading: Daily? _____ Weekly? _____ Monthly? _____

Do you watch TV? ☐ No ☐ Yes If you watch TV, how many hours do you watch daily? _____

Do you use a computer? ☐ No ☐ Yes If yes, how often and for what purpose? _____
In what types of hobbies or activities do you participate?
☐ Fishing ☐ Crafts ☐ Sewing ☐ Swimming ☐ Bowling ☐ Continuing Education Courses
☐ Movies ☐ Sports ☐ Other *Specify:* _____

How often do you engage in these activities/hobbies? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Do you travel in excess of thirty miles from your home? ☐ No ☐ Yes If yes, how do you travel and how frequently do you travel: _____

_____

SOCIAL CONTACTS

Are you an active member of any club(s) or organization(s)? ☐ No ☐ Yes If you are an active member, describe your responsibilities and activities:

_____

_____

How often do you participate in these activities? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly
Do you hold any positions in your club(s) or community organization(s)? ☐ No ☐ Yes If you hold any positions, describe them: _____

_____

_____

Do you do volunteer work? ☐ No ☐ Yes If you do volunteer work, describe your volunteer activities, including the location, duties performed, hours and frequency of participation: _____

_____

Do you visit with friends or relatives? ☐ No ☐ Yes If yes, how often do you visit? ☐ Daily ☐ Weekly ☐ Weekends ☐ Monthly
Estimate how long these visits last (i.e., number of hours): _____

Has there been any change in your social contacts since your disability began? ☐ No ☐ Yes If there has been any change in your social contacts or you require assistance to maintain these social contacts, describe the change(s) and assistance you require: _____

_____

OTHER INFORMATION

Have you participated in a rehabilitation or retraining program? ☐ No ☐ Yes If you have participated in a rehabilitation or retraining program, provide the name, address and telephone number of the program: _____

_____

Do you believe that you will be able to return to work? ☐ No ☐ Yes If you do not believe that you will be able to return to work, describe the reason(s) supporting your belief: _____

List all your current sources of income and the amount received from each source: _____

_____

What is the status of your Social Security disability claim? ☐ None ☐ Pending ☐ Approved* ☐ Denied ***If your claim for Social Security benefits has been approved and we have yet to be notified, please provide a copy of your award notice with this form.**

We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	☐ Yes	☐ No	Social Security Disability or Retirement	☐ Yes	☐ No	Unemployment Benefits	☐ Yes	☐ No
Vacation/Bonus Pay	☐ Yes	☐ No	Retirement Benefits	☐ Yes	☐ No	Other Income Benefits	☐ Yes	☐ No
Automobile No-Fault	☐ Yes	☐ No	Short Term Disability	☐ Yes	☐ No	Workers' Compensation	☐ Yes	☐ No

If you have answered yes to any of the above options, please list any other income benefits that have been approved including the benefit amount and the benefit effective date (please use separate sheet if necessary): _____

Since ceasing work, have you performed work for any other employer or self employment? ☐ No ☐ Yes If Yes, please indicate the name and contact information for your employer: _____

_____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature_____Date_____

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Patient Authorization to Release Protected Medical Information

You are not required to sign the authorization, but if you do not Madison National Life Insurance may not be able to evaluate or administer your claim(s). Please complete this form in detail to assist us in providing a timely review of your claim for benefits. Please note that we are requesting that you document each of your treating providers, including any physicians, therapists, counselors, specialists, social workers, or any other representative that is providing treatment for your claimed condition(s). Facility name must be included in order to assure that this authorization form will be accepted.

Name (print): _____ **Date of birth:** _____

Telephone number: _____

I authorize the use and/or release of my protected medical and/or mental health information to Madison National Life Insurance Company for the purpose of determining insurance eligibility. I authorize the release of information from:

1) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

2) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

3) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

4) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

5) Provider / Facility Name: _____ Specialty: _____
   Address _____ Phone Number: _____
   Medical Record Department Fax Number: _____ Date Last Treated: _____

to: Madison National Life Insurance Company (address, telephone and fax number documented above)

This form serves as an authorization for Madison National Life Insurance to obtain information documenting medical treatment, including patient notes, treatment records, lab reports, physical therapy, diagnosis and prognosis from January 1, 2008 through two years from the date of the signature on this form. This form is also intended to be used to obtain psychological testing and psychological / psychiatric treatment including patient notes and treatment records from January 1, 2008 through two years from the date of the signature on this form.

Also this form provides Madison National Life Insurance the authorization to obtain information from any pharmacy, other insurance or annuity company, any consumer reporting agency, financial institution or tax preparer, any governmental agency (e.g., Social Security Administration or Public Retirement System), all former and/or current employers, educational facility/entity, vocational or rehabilitation organization, employer sponsored disability/retirement carrier, worker's compensation carrier, and or any other entity or institution that may have information needed by Madison National Life Insurance for the review of my claim for benefits. I understand this information will be used for the sole purpose of evaluating and administering my claim for benefits. I understand that I may revoke this authorization at any time by requesting the revocation in writing and submitting it to Madison National Life Insurance and to the providers listed above. I understand if I revoke this authorization, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s). This authorization will remain valid for two full years from the date of my signature.

I understand that in the course of conducting its business, Madison National Life Insurance may release / redisclose this information about me to a reinsurer, a plan administrator, or any person performing business or legal services for Madison National Life Insurance in connection with my claim(s).I understand that the information used or released as a result of this authorization may no longer be protected by federal privacy laws. I am aware my medical information may be redisclosed when necessary as part of the review process performed by Madison National Life Insurance at any point during the review of my claim or during any appeals that may take place as explained above. I understand that I have the right to receive a copy of this authorization upon request. I agree that a photocopy of this authorization is valid as the original. Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining my authorization, however I understand if I do not sign this authorization or if I alter its content in any way, Madison National Life Insurance may not be able to evaluate or administer my claim(s) and this may be the basis for denying my claim(s).

I have had full opportunity to read and consider the contents of this authorization, and I confirm that the contents are consistent with my direction to each of my health care providers. I understand that, by signing this form, I am confirming my authorization that my health care provider may disclose to Madison National Life Insurance Company the protected health information described in this form

Signature _____ ***Date*** _____

The following Fraud Warning applies to these states: **Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Iowa, Kansas, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, North Carolina, North Dakota, Oregon, South Carolina, South Dakota, Utah, Vermont, Wisconsin and Wyoming.**

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 is guilty of a crime and may be subject to fines and confinement in prison.

STATE SPECIFIC FRAUD WARNINGS

ALABAMA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

ALASKA WARNING: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS, LOUISIANA & WEST VIRGINIA 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 is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

DELAWARE & IDAHO WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

FLORIDA 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.

INDIANA WARNING: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

KENTUCKY WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

MASSACHUSETTS 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 may be subject to fines, confinement in prison and/or denial of insurance benefits.

MINNESOTA WARNING: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEW HAMPSHIRE WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO 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 is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE, VIRGINIA & WASHINGTON WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

TEXAS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss is guilty of a crime and may be subject to fines and confinement in the state prison.