

**MADISON NATIONAL LIFE INSURANCE COMPANY, INC. – P.O. Box 20593, Indianapolis, IN 46220**

**EMPLOYEE VISION INSURANCE APPLICATION**

PLEASE PRINT IN SPACE PROVIDED

<b>EMPLOYER INFORMATION</b>					
EMPLOYER NAME			LOCATION		GROUP NO.
<b>EMPLOYEE</b>					
LAST NAME		FIRST NAME			M.I.
STREET ADDRESS		CITY	STATE	ZIP	
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ( )	EMAIL ADDRESS		BIRTH DATE / /
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	
<u>Vision Insurance</u> <input type="checkbox"/> Yes <input type="checkbox"/> No			Plan Name Elected: _____		
<input type="checkbox"/> EMPLOYEE		<input type="checkbox"/> SPOUSE	<input type="checkbox"/> CHILDREN	Requested Effective Date: _____	
<b>DEPENDENT INFORMATION</b>					
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 VISION INSURANCE COVERAGE? _____					
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER: _____					
<b>REFUSAL/WAIVER – Complete Only if You Are Declining Coverage For Yourself Or Any Dependent</b>					
I DECLINE VISION COVERAGE FOR: <input type="checkbox"/> MYSELF <input type="checkbox"/> MY SPOUSE <input type="checkbox"/> MY CHILDREN					
REASON FOR REFUSAL: _____					
<b>ACKNOWLEDGMENT AND AUTHORIZATION</b>					
I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group vision 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. I declare all answers are true and complete.					
WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.					
DATE		CITY AND STATE			
SIGNATURE OF EMPLOYEE					