

MPOWERMED BENEFIT SELECTION FORM

Underwritten by Madison National Life Insurance Company

CASE NUMBER _____

Applicant's Name _____ (Last) (First) (Initial)	SOCIAL SECURITY NUMBER _____
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PLAN SELECTION: Design your plan by selecting your In-Network plan options. Out-of-Network benefits differ from In-Network benefits and are based on your selections below. See the product brochure for details.

Plan Type	<input type="checkbox"/> Traditional Plan <input type="checkbox"/> PPO Plan – if selected, please specify the requested PPO Network: _____		
	M5 Plan Series	N2 Plan Series	HSA5 Plan Series
Physician Office Visit	<input type="checkbox"/> No Copay <input type="checkbox"/> \$35 Copay	<input type="checkbox"/> No Copay <input type="checkbox"/> \$35 Copay	No Copay
Calendar Year Deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000	Individual Family <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$7,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$5,650 <input type="checkbox"/> \$11,300
Coinsurance and Out-of-Pocket Maximum	<input type="checkbox"/> 100%/\$0 <input type="checkbox"/> 80%/\$4,000 <input type="checkbox"/> 50%/\$6,000	<input type="checkbox"/> 100%/\$0 <input type="checkbox"/> 80%/\$6,000 <input type="checkbox"/> 50%/\$6,000	<input type="checkbox"/> 100%/\$0 <input type="checkbox"/> 80% (Select an Out-of-Pocket Maximum) <input type="checkbox"/> \$2,000 Ind/ \$4,000 Family * <input type="checkbox"/> \$3,000 Ind/ \$6,000 Family ** <input type="checkbox"/> 50%/\$3,000 Ind/ \$6,000 Family** <small>* Not available with Individual \$5,000 or \$5,650; or Family \$10,000 or \$11,300 deductible choices</small> <small>** Not available with deductible choices above \$2,500 Ind/\$5,000 Family</small>
Prescription Medication Benefit OPTION (Must select one option) If Rx Plan not elected, Rx Discount Card (not an insurance benefit) automatically issued.	<input type="checkbox"/> Rx Plan 2 Generic-\$0 Copay Brand Formulary - \$250 Rx Deductible; \$50 Copay Brand Non-Formulary-\$500 Rx Deductible; \$75 Copay Specialty Medication-50% <input type="checkbox"/> Rx Plan 3 Generic- \$15 Copay Brand Formulary-\$50 Copay Brand Non-Formulary-\$75 Copay Specialty Medication-50% <input type="checkbox"/> Rx Plan 1 Generic-\$20 Copay Brand subject to the plan's selected calendar year deductible and coinsurance <input type="checkbox"/> None	<input type="checkbox"/> Rx Plan 5 Generic- \$15 Copay Brand Rx Deductible-\$500 Brand Formulary-\$50 Copay Brand Non-Formulary-\$75 Copay Specialty Medication-50% <input type="checkbox"/> Rx Plan 1 Generic-\$20 Copay Brand subject to the plan's selected calendar year deductible and coinsurance <input type="checkbox"/> None	<input type="checkbox"/> Rx Plan 6 Subject to the plan's selected calendar year deductible and coinsurance <input type="checkbox"/> None HSA Discount <input type="checkbox"/> IHC Freedom HSA <input type="checkbox"/> Own HSA (Submit HSA Attestation form) <input type="checkbox"/> No HSA

Optional Benefits:	
Supplemental Accident Benefit	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> None
Maternity Benefit <small>Not available on the HSA5 Series</small>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Term Life Insurance Benefit	<input type="checkbox"/> No <input type="checkbox"/> Yes, select amount <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$100,000
If Life Benefit elected, please list: Beneficiary _____ Relationship _____	

Attach this form to your Application for Insurance

For Administrative Use Only						Other:
Case Number	Enter	Date	Approved By	Date	Eff Date	PCEFD T

MADISON NATIONAL LIFE INSURANCE COMPANY, INC. CASE NUMBER: _____

APPLICATION FOR INSURANCE

Underwritten by Madison National Life Insurance Company

ATTENTION PRODUCER: Where do you want the Certificate of Coverage mailed? (Check one) Producer Insured

GENERAL INFORMATION

Applicant Information (Please print in blue or black ink)

Applicant's Name			Social Security Number			
Last	First	Initial				
Applicant's Home Address						
Street Address (P.O.Box Not Acceptable)			City	State	Zip Code	
Billing Address				E-MAIL ADDRESS		
Street			City	State	Zip Code	
Home Telephone Number	Work Telephone Number	Fax Number		Best Time and Place to Call		
				<input type="checkbox"/> Home Time: <input type="checkbox"/> Work		
Occupation (Title & Industry)		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Age	Height	Weight
		Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married			Ft In	Lbs

Dependent Information (Complete only for dependents to be covered under this plan)

Spouse's Name			Social Security Number			
Last	First	Initial				
Spouse's Occupation (Title & Industry)		Height	Weight	Birthdate	Age	
		Ft In	Lbs			
Dependent(s) Name (First and Last)	Relationship	Sex	Birthdate	Height	Weight	Full-time Student? Yes or No

Has the Applicant or Spouse (if applying for coverage) used tobacco or tobacco cessation products during the past 12 months?
 Applicant: No Yes - indicate types of tobacco/cessation products and the frequency of usage: _____
 Spouse: No Yes - indicate types of tobacco/cessation products and the frequency of usage: _____

Requested Effective Date (check one)

- I request the Company assign my effective date to be the 1st of the month following approval.
- I request an effective date of _____ (must be the 1st or 15th of the month).

If the Company is unable to approve the application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

Mode of Payment Direct Bill: Select Quarterly or Semi-annually **Submit check for first premium payment with this application.**
 Monthly Automatic Payment: Select Credit Card Bank Draft Complete the Monthly Automatic Payment Plan page.

24-hour Occupational Coverage

1. Is any person to be insured currently covered under Workers' Compensation? Applicant: Yes No Spouse: Yes No
2. Are you eligible to opt out of Workers' Compensation and are you a Sole proprietor, Partner, or Owner?
 Applicant: Yes No Spouse: Yes No

Other Health Insurance In force or Pending (must be completed for primary and dependent applicants)

Yes No If yes, please provide the following information:
 Carrier Name: _____ Policy No. _____ Efec. Date: _____ Termination Date: _____
 Is this an employer-sponsored group health plan? Yes No
 Is it your intent to be considered under HIPAA provisions? Yes No If yes, you must complete the HIPAA eligibility section of this application.

EVIDENCE OF INSURABILITY

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Excluding MO residents: Has any person to be insured ever been declined, postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain: 1. MO residents: Has any person to be insured ever been postponed, ridered, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain:
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and provide details in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Has any person to be insured received or are currently receiving disability benefits? If yes, list names and type of coverage:
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Has any person to be insured ever been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a Physician or member of the medical profession within the last 10 years? If yes, list names:
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Has anyone to be insured had breast implants, pin, plate, or other implants? If yes, list names and provide details on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Has any person to be insured had any convictions for reckless driving or driving under the influence of alcohol or drugs? If yes, list name, violation(s) and date(s) of occurrence in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. In the past 5 years, has any person to be insured engaged in, or plan to engage in, any hazardous sport including, but not limited to: scuba diving, rodeo activities, skydiving or auto, motorcycle or motor boat racing? If yes, please explain on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Is any person to be insured now pregnant, an expectant parent, or in the process of adopting a child, whether applying for coverage or not? If yes, list names and provide details in the Health History section on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Is any person to be insured currently taking or have you been prescribed medications within the past 12 months? List details/medications on the following page.
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Has any person to be insured previously applied for a policy administered by Insurers Administrative Corporation? If yes, list the policy number.
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Has any person to be insured been hospitalized within the last 7 years? If yes, list names and provide details on the following page.

12. Within the past seven years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Abnormal Test Results			Eye Disorders			Neurological Disease		
Alcoholism/Alcohol Abuse			Fractures/Dislocations			Pap Smear, Abnormal		
Allergies			Gallbladder Disorder			Paralysis		
Arthritis or Rheumatism			Headaches/Migraine			Prostate/Rectal Disorder		
Asthma/Respiratory Disorder			Heart Disorder/Murmur/Heart Attack/Coronary Artery Disease			Reproductive Organs Disorder/Endometriosis		
Back/Muscle or Joint Disorder			Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/>			Sexually Transmitted Diseases		
Bladder Disorder			Hernia			Sinus Disorder		
Blood Disorder/Hemophilia			High Blood Pressure/Hypertension			Skin Disorder		
Bone Disease/Deformity			High Cholesterol			Sleep Disorders		
Breast Disorder/Fibrocystic Breast Disease			Infertility Testing/Treatment			Spinal Disorder/Back/Neck Strain		
Cancer			Kidney Disorder			Stroke		
Colitis, Spastic Colon, Polyps			Liver Disorder			Thyroid or Goiter		
Congenital Disorder			Lupus/Systemic or Discoid			Transplants		
Cystic Fibrosis			Lymphadenopathy/Immune Disorder			Tuberculosis		
Diabetes/Pancreatic Disorders			Menstrual Disorder			Tumors/Cysts/Polyps/Growths		
Digestive Disorder/Reflux			Mental, Nervous, Emotional Disorder / Anxiety/Depression/Attention Deficit Disorder			Ulcerative Colitis/Crohn's/ Regional Ileitis		
Drug Addiction			Mental Retardation			Ulcers		
Ear/Throat Disorders			Down's Syndrome			Urinary Tract Disorder		
Eating Disorder/Anorexia/ Bulimia			Muscular Dystrophy			Vascular Disorder		
Emphysema/Lung Disorder/COPD			Cerebral Palsy			Other conditions		
Epilepsy and/or Seizure			Brain or Nerve Disorder					

If you answered "Yes" to any of the above conditions, list the condition and provide details in the Health History section on the following page.

HEALTH HISTORY

INSTRUCTIONS: Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your or any of your dependents' health history from you or your dependents' attending physician. If you need more space, please use the Health History Supplementary Form located at the end of this application.

Question #	Person's Name	Condition(s) & Treatment	Date of Onset and Last Office Visit Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals

LAST PHYSICIAN SEEN

INSTRUCTIONS: List the name of the last medical care provider you visited and the condition that was treated.

Physician's Name	Address	Condition(s) & Treatment	Phone	Dates visited

MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

INSTRUCTIONS: List all medications prescribed or taken by you or your dependents currently and in the past 12 months.

Person's Name	Medications	Frequency & Dosage	Length of time on medication	Date medication was last taken	Complete Names and Addresses of Physicians

HIPAA ELIGIBILITY: If applying for HIPAA coverage, complete this section and provide a copy of your Certificate of Creditable Coverage.

INSTRUCTIONS: This section must be completed if anyone applying for coverage is electing coverage under HIPAA provisions. If you reside in a state that offers coverage under a risk pool arrangement, please ask your producer about your risk pool coverage options.			
Who is applying for HIPAA eligibility? What will the effective date of coverage be?	<input type="checkbox"/> Applicant	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)
Has anyone applying for HIPAA coverage been continuously covered by health insurance (the last of which is a group health plan) for a minimum of eighteen months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
What was the reason the coverage terminated under the most recent health insurance plan?	Was it for non-payment of premium? <input type="checkbox"/> Yes <input type="checkbox"/> No	Was it for fraud? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was there a break in health insurance coverage in excess of 62 days during the past 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any HIPAA applicant eligible for or currently have group health insurance through an employer, spouse's employer or is a dependent on any person's plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Is any HIPAA applicant eligible for coverage under any of the following: COBRA, State Continuation, Federal Employee's Continuation, MEDICARE or MEDICAID?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the most recent coverage under COBRA or any State or Federal Continuation plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. If "yes," when did coverage begin _____ and when will coverage be exhausted under such plan _____?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Was the current coverage a conversion plan elected through a previous carrier?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

AGREEMENT & SIGNATURE

INSTRUCTIONS: Read the following information and signify your agreement with the terms of this agreement for insurance by signing and dating the application as indicated below.

Premium Payment: I agree that (1) I am responsible for making the proper monthly premium payments; (2) a grace period of 31 days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the 31-day grace period, coverage for all insured persons shall lapse as of the premium due date; (3) any negotiable premium checks received in an envelope postmarked after the 31-day grace period will be refunded less any amounts due (if any) from previous months; (4) negotiation of any check from or on behalf of the insured shall not constitute acceptance of premium as premium is only accepted when acknowledged and applied by insurer. There is a one-time, non-refundable application fee.

Pre-certification and Signature: I agree that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the master policy.

U.S. Resident: I understand that the coverage under this plan is available to United States residents only, benefits are not payable for medical expenses outside of the United States except when traveling, and if I stay outside the United States for more than 90 days I will be deemed to be residing outside of the United States and not traveling.

Application for group plan membership I understand that I am applying as an individual for membership to the Communicating for America, Inc. Association and am simultaneously applying for insurance to which I am now or may become eligible for under the provisions of the Group Master Policy issued to the Association by Madison National Life Insurance Company I understand that my application is subject to medical underwriting and approval by Madison National Life Insurance Company or its authorized administrator in accordance with the underwriting guidelines in effect. I understand that this coverage is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents is now or in the future will be paying any part of the premium either directly or through wage adjustments or otherwise and (b) to the best of my knowledge and belief my employer has not and will not maintain, endorse or represent this health plan as an employer health insurance plan for any purpose, including a tax deduction, individuals not meeting this certification above are not eligible for this plan. I further understand that acceptance of the check submitted with this application does not constitute approval or guarantee of coverage.

Updated Information: I agree to immediately notify Madison National Life Insurance Company or its authorized administrator if there is any change in my health or the health of my dependents that would require a change in the answers provided in this application prior to being notified of the approval of this coverage.

My answers are true, complete and correct: I have personally reviewed all of my answers to the questions on this application and any attachments to it and certify that all of the information I have provided is true, complete and correct, I agree that it is my responsibility to provide truthful, complete and correct information. I certify I fully understand the questions asked. I agree that any misstatements or failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents, if any. I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any question; or (c) instruct me not to disclose any particular medical condition on the application. I agree that no agent is authorized or has the authority to alter the terms of the Group Master Policy.

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

Attachments: I understand that any attachments to this application become a part of it.

Other Agreements: I have reviewed and understand the policy's benefits, limitations, and exclusions, including the pre-existing condition limitation provision. I understand that the major medical health insurance coverage for each applicant, if issued, will be subject to a pre-existing condition limitation for up to 2 years, unless the medical condition is disclosed in the Evidence of Insurability and Health History sections of this application and not specifically excluded by name from coverage under the certificate.

DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

Dated at _____ City _____ State _____ on the _____ day of _____, 20____, _____ Month _____ Year _____

Name of Applicant or parent, if applicant is under age 18 (print) _____ Name of Spouse if applying for coverage (print) _____

Signature of Applicant (or parent, if applicant is under age 18) _____ Date _____ Signature of Spouse (if applying for coverage) _____ Date _____

MONTHLY AUTOMATIC PAYMENT PLAN – Complete All Applicable Areas

To initiate the Automatic Payment Plan, the following must accompany your application:

- This fully completed and signed form.
- Credit Card information.
- OR -
- A voided check OR savings account deposit slip (business accounts not acceptable)

Coverage purchased by check is subject to clearance of the check, and coverage purchased by credit card is subject to acceptance of the credit card issuer.

A \$25 service fee will be assessed for each dishonored payment. The payor agrees to pay this fee in addition to the amount of the payment due.

Madison National Life Insurance Company (MNL), or its designated administrators, is hereby authorized to debit my bank account or credit card for the MNL insurance premiums and any applicable Communicating for America, Inc., Association membership dues for the initial amount, if applicable, and for each month thereafter until this Authorization is terminated. **I understand that the applicable initial premiums collected will be refunded to me if my health insurance certificate is not issued.** I agree that the named institution shall be fully protected in honoring any such payments. The institution's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the institution shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. This Authorization will remain in effect until the bank is notified of termination by me in writing. To terminate insurance coverage, I will also notify MNL or its administrators in writing.

Credit Card Payment Choose one: MasterCard Visa

Initial Amount collected upon receipt of application \$ _____

Name (as it appears on card) _____

Card# _____ Exp. Date _____

Signature of Cardholder _____ Date _____

Monthly Bank Account Bank Draft

Initial Amount collected upon receipt of application \$ _____

Name of Bank _____ Address _____

Routing No. _____ Account No. _____

Signature of Cardholder or Depositor _____ Date _____

Name (please print) _____

Relationship to Proposed Insured _____

PRODUCER / GENERAL AGENT INFORMATION

Producer's Name _____ Company Name _____

IHC Producer # _____ Are you licensed in the state where the application was completed? Yes No

Are you currently appointed with MNL in the state where the application was completed?

Yes No (If not, please refer to the Producers Guide for contracting rules.)

Address _____

Street _____ City _____ State _____ Zip _____

Business Phone (_____) _____ Fax (_____) _____ E-Mail Address _____

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Madison National Life Insurance Company

Producer's Signature _____ Date _____ Date Application Sent to General Agent _____

General Agent's Name: _____ General Agent's IHC # _____

General Agent's Phone (_____) _____ General Agent's Fax (_____) _____ General Agent's E-Mail _____

Date Application Received by General Agent _____ Date Application Sent to IHC _____

PRODUCER'S FINAL CHECKLIST

- ✓ Are all the questions answered and boxes checked?
- ✓ Has the applicant (and spouse, if applying) signed the Agreement & Signature section on the application?
- ✓ Has the applicant enclosed a personal check for the initial premium payable to IHC Health Solutions (not required for Monthly Bank Drafts or Credit Card payments)?

Submit to **IHC Underwriting**; 1173 W. Main St. Ste E; Whitewater, WI 53190; Fax 866-570-5234; Phone 866-472-6555

MADISON NATIONAL LIFE INSURANCE COMPANY

Ins-Special, Inc
 7505 State Hwy 37 / PO Box 218
 Purdy MO 65734
 800-789-0182
 www.insspecial.com

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

Print Name(s): (Last)	(First)	(MI)	Date of Birth (Month/Day/Year)	Social Security Number
1.				
2.				
3.				
4.				
5.				
6.				
7.				

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MLB Group), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Madison National Life Insurance Company ("MNL"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit MNL, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative:

Date:

X _____
 X _____
 X _____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: _____

Authority: _____

SUPPLEMENT TO YOUR APPLICATION FOR INSURANCE

Please read the following notice before signing your application for insurance:

Any statements on Your Application and any provision of Your Policy or Certificate that describes Our right to rescind or void the Insured/Covered Person's insurance coverage is amended to permit Us to rescind or void the insurance coverage of a Insured/Covered Person only if the individual, or You on behalf of that individual, performs an act, practice or omission that constitutes fraud; or makes an intentional misrepresentation of material fact.



Membership Application

Enrollment with endorsed insurance

Yes, I want CA working for me!

I understand benefits are offered at the sole discretion of CA and may vary by availability, vendor or state of residence of the member.

I am applying for a: Single Membership Family Membership

- I elect the following membership level and monthly cost:
- Standard** (\$8.00)
 - Premier One** (\$24.95 single/ \$41.95 family)
 - Premier Two** (\$34.95 single/ \$59.95 family)
 - Premier Three** (\$44.95 single/ \$79.95 family)
 - Premier Four** (\$54.95 single/ \$99.95 family)

Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Home phone: _____ Business phone: _____

Date of birth: _____ Social Security number: _____

E-mail address: _____

Accidental death beneficiary: _____

Relationship of beneficiary to primary member: _____

I hereby apply for membership. I understand that my membership will remain in effect as long as I qualify under membership guidelines and pay my membership dues. I understand that benefits are offered at the sole discretion of CA and may vary by availability, vendor or state of residence. Should I elect at any time not to participate in one or more of CA's sponsored benefit programs, I authorize CA to continue my membership dues and other association benefit fees at the payment mode selected by me at the time of application.

I wish to be a member of CA and I agree to the terms and conditions listed above.

Member Signature: _____

Enroller Name: _____

Enroller Number: _____

For additional information about the benefits and programs offered through Communicating for America, Inc., call 1.800.432.3276 or visit www.CommunicatingforAmerica.org.

CA—Communicating for Agriculture and the Self-Employed CA App WIns 12-10

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy MO 65734
800-789-0182
www.insspecial.com

Online Fulfillment Supplemental Form

In an effort to protect the environment and conserve resources, online fulfillment is now available with the mPowerMed Health Plans. If your application for coverage is approved, how you would like to obtain your policy documents?

- Online: Your certificate/policy documents and other correspondence will be available on a secured website. You will receive an e-mail including the Web address and your login information. Your ID cards will be sent through the U.S. Postal Service.

- U.S. Mail: Your certificate/policy documents, ID cards and other correspondence will be packaged and sent through the U.S. Postal Service.

Name of applicant or parent, if applicant is under age 18

Name of spouse if applying for coverage

Signature of applicant or parent, if applicant is under age 18

Signature of spouse if applying for coverage

Date

Ins-Special, Inc
7505 State Hwy 37 / PO Box 218
Purdy MO 65734
800-789-0182
www.insspecial.com