

Please list names of the facilities at which the deceased received treatment within the last five years preceding death:

NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ATTENDANCE
NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ATTENDANCE
NAME	ADDRESS	TELEPHONE NUMBER	DATES OF ATTENDANCE

BENEFICIARY 1

Name: _____
 Date of birth: _____ Relationship: _____
 Social security number: _____
 Telephone number : _____
 Complete address: _____

Signature: _____ **Date:** _____

BENEFICIARY 2

Name: _____
 Date of birth: _____ Relationship: _____
 Social security number: _____
 Telephone number : _____
 Complete address: _____

Signature: _____ **Date:** _____

BENEFICIARY 3

Name: _____
 Date of birth: _____ Relationship: _____
 Social security number: _____
 Telephone number : _____
 Complete address: _____

Signature: _____ **Date:** _____

BENEFICIARY 4

Name: _____
 Date of birth: _____ Relationship: _____
 Social security number: _____
 Telephone number : _____
 Complete address: _____

Signature: _____ **Date:** _____

Authorization

I agree that the written statements of all physicians who attended or treated the deceased and all other papers called for by Madison National Life Insurance Company, hereafter called the Company, shall constitute, and they are hereby made a part, of these proofs of death and further agree that all provisions of law forbidding any physician or other person who attended deceased from disclosing any knowledge or information acquired by him are hereby waived.

I hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically-related health care facility or health care provider, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer, having information available concerning the diagnosis, treatment or prognosis of any physical or mental condition of the deceased, to give to the Company, or its legal representative any and all such information.

I understand the information obtained by use of this Authorization will be used by the Company to determine eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application or claim or as may be otherwise lawfully required or as I may further authorize.

I understand that I may receive a copy of this authorization upon request, agree that a photographic copy of this Authorization shall be as valid as the original and agree that this Authorization shall be valid for two years from the date shown below.

I have received and read the fraud warning statements provided with this form

_____ Signature of Beneficiary 1	_____ Date
_____ Signature of Beneficiary 2	_____ Date
_____ Signature of Beneficiary 3	_____ Date
_____ Signature of Beneficiary 4	_____ Date

Fraud Warnings

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. This warning applies to the following states and the District of Columbia: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

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.

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.

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.

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.

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 YORK 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 shall also be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA 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.

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.

Signature: _____

Date: _____