

MIDWEST SECURITY LIFE INSURANCE COMPANY
IMPORTANT: PLEASE READ PRIOR TO ENROLLMENT

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 30 days after your 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 30 days after the marriage, birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact us at:

Midwest Security Life Insurance Company
2700 Midwest Drive, Onalaska, WI 54650
800-542-6642

GENERAL NOTICE OF PRE-EXISTING CONDITION LIMITATION

This plan excludes coverage for conditions that existed prior to your enrollment date. The exclusion applies only to conditions that you received medical advice, diagnosis, care or treatment for during the six-month period prior to your enrollment date in this plan. This exclusion complies with state and federal laws and will not exceed a period of 12 months (9 months for INDIANA 2-50 size groups) from your enrollment date or 18 months (15 months for INDIANA 2-50 size groups) from your enrollment date if you are a late enrollee. Your enrollment date is the first day of your eligibility period. If you are not subject to an eligibility period, your enrollment date is your effective date under the plan. If you are a late enrollee, your enrollment date is your effective date under the plan. This exclusion complies with federal law.

The exclusion does not apply to claims for pregnancy. The exclusion will not be applied to a child that is enrolled under the plan within 30 days of the child's birth, adoption or placement for adoption.

You have the right under federal law to have the pre-existing condition limit reduced. Credit is based on the number of days of creditable coverage you can show. Creditable coverage is a period of continuous coverage, without a lapse of more than 63 days (not including waiting periods), under any of the following:

- A group health plan
- Health insurance coverage (group, individual or other)
- Part A or B of Medicare
- Medicaid
- The Active Military Health Program or TRICARE
- A medical care program of the Indian Health Services or of a tribal organization
- A State sponsored health benefits risk sharing pool
- The Federal Employees Health Plan
- The Peace Corp. Health Program
- A State Children's Health Insurance Program
- A public health plan that provides health coverage to enrolled individuals and is sponsored by the U.S. government, a State, a foreign country, or any political subdivision thereof.

Credit may be obtained by providing the plan with a Certificate of Creditable Coverage from your prior health plan or coverage. If you do not have a certificate from the prior plan or coverage, federal law requires them to provide you with one in most cases. If you are unable to obtain a certificate after requesting one in writing, you should contact this plan. This plan will assist you in obtaining the certificate or in demonstrating proof of prior coverage in other ways.

For more information regarding the plan's pre-existing condition exclusion or on obtaining credit for prior health coverage, contact us at:

Midwest Security Life Insurance Company
2700 Midwest Drive, Onalaska, WI 54650
800-542-6642

MIDWEST SECURITY LIFE INSURANCE COMPANY
Enrollment Form
For 26 + medical lives

| | | | | | | | | | | | | | | |
|----------|-----------------------|--|--|---------------------------------|----------------|---|----------------------|---|--|---|--|---|---------------|-------------------|
| A | Last Name | | | First Name | | | M.I. | | | Home Phone Number | | | | |
| | Street Address | | | | City | | | State | | Zip Code | | Sex | Date of Birth | |
| | Marital Status | | | <input type="checkbox"/> Single | | <input type="checkbox"/> Married Date _____ | | <input type="checkbox"/> Separated Date _____ | | <input type="checkbox"/> Divorced Date _____ | | <input type="checkbox"/> Widowed Date _____ | | Social Security # |
| | Hours Worked Per Week | | | Date Employed Full Time | | | Gross Monthly Salary | | | Occupation | | | | |
| | Employer Name | | | | Street Address | | | | | FOR HOME USE ONLY Individual Number _____ | | | | |
| | City | | | State | | Zip Code | | | | | | | | |

| | | | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|--|--|--|--|
| B | Coverage Selected: <input type="checkbox"/> Select Coverage <input type="checkbox"/> Select Coverage 2000 | | | | | | | | | | | |
| | Deductible: _____ | | | Coinsurance: _____ | | | Coinsurance Maximum: _____ | | | | | |
| | Network: _____ | | | | | | | | | | | |
| | Group Health: | | | <input type="checkbox"/> self only | | | <input type="checkbox"/> self and spouse | | | <input type="checkbox"/> self and dependent children | | |
| | | | | <input type="checkbox"/> self, spouse, and dependent children | | | | | | | | |
| | Group Life and AD&D: | | | \$ _____ | | | | | | | | |
| Dependent Life | | | <input type="checkbox"/> yes <input type="checkbox"/> no | | | | | | | | | |
| Short Term Disability Income: | | | \$ _____ | | | | | | | | | |
| Dental: | | | <input type="checkbox"/> self only | | | <input type="checkbox"/> self and spouse | | | <input type="checkbox"/> self and dependent children | | | |
| | | | <input type="checkbox"/> self, spouse, and dependent children | | | | | | | | | |
| Complete the Waiver of Coverage section (G) only if eligible benefits are Being waived for either the employee, spouse, or dependent children. | | | | | | | | | | | | |

| | Sex | Dependent's Name(s) | | | Date of Birth (Mo/Dy/Yr) | Social Security # | Full-time Student (Y or N) |
|------------------------|--------|---------------------|---------|--------|-----------------------------|-------------------|-------------------------------|
| | | (Last) | (First) | (M.I.) | | | |
| C | Spouse | | | | | | |
| | Child | | | | | | |
| | Child | | | | | | |
| | Child | | | | | | |
| | Child | | | | | | |
| | Child | | | | | | |
| Primary Beneficiary | | _____ | | | Relationship | | _____ |
| Contingent Beneficiary | | _____ | | | Relationship | | _____ |

| | | | | | | | | | | | |
|---|---|--|--|--|--|--|--|--|--|--|--|
| D | Medicare Information | | | | | | | | | | |
| | If you need to complete this section for more than one person, please use a separate sheet of paper and attach it to this application (please sign and date the additional sheet). | | | | | | | | | | |
| | Are you, your spouse or your child(ren) covered by Medicare Part A? [] Yes [] No Medicare Part B? [] Yes [] No | | | | | | | | | | |
| | Name of person covered by Medicare: _____ | | | | | | | | | | |
| | If "Yes", reason for Medicare: [] Over Age 65 [] Disability [] End-Stage Renal Disease (ESRD) [] Disability and ESRD | | | | | | | | | | |
| Medicare Part A Effective Date: _____ Medicare Part B Effective Date: _____ | | | | | | | | | | | |
| Medicare Part C (Medicare + Choice) Effective Date: _____ | | | | | | | | | | | |

E Portability Information: Complete to determine appropriate reduction of this plan's pre-existing condition limitation. Attach certification of creditable coverage from your prior plan if you are a new enrollee under the above employer's plan.

Prior Coverage Start Date: _____ End Date: _____

Covered Individuals: _____

Prior plan or carrier name: _____

Reason for ending prior coverage: _____

F

1. Are you or your dependents participating in other group coverage (not being replaced by this plan) or Medicare benefits? Yes No
If yes, name individuals and coverage/company. _____

2. Are you or any dependent currently disabled, pregnant, or anticipating surgery? Yes No
If pregnant, when due? _____
If disabled or anticipating surgery, list person's name, type of disability or surgery, and date of disability or anticipated surgery. _____

3. Have you or any dependent received treatment, had surgery, been hospitalized, or taken medication for any condition in the last 5 years? Yes No If yes, list the person's name, the condition, date of treatment, reason for treatment, medication taken, and degree of recovery. _____

G I have decided not to apply for coverage offered for (check those that apply):

Medical: self spouse dependent children

Dental: self spouse dependent children

Other: _____

Reason for waiving coverage: _____

H To the best of my knowledge, all statements and answers in this application are complete and true.

I authorize any physician, medical practitioner, hospital, clinic or medical related facility, insurance or reinsuring company, having information available as to diagnosis treatment and prognosis with respect to any physical or mental condition and/or treatment of me, my spouse, or my minor children and any other non-medical information of me, my spouse, or my minor children to give Midwest Security or their legal representative, any and all such information.

Any information obtained will not be released by Midwest Security to any person or organization except to reinsuring companies, the Plan Administrator, the Plan Sponsor, Plan consultants, insurance intermediaries, or other persons or organizations performing business or legal service in connection with my application, claim, Plan renewal or as may be otherwise lawfully required or as I may further authorize.

I hereby enroll for benefits for which I am presently eligible or for which I may become eligible under my employer's group contract(s). I authorize deductions for this coverage from my earnings if any such deductions are required. I reserve the right to revoke this deduction authorization at any time upon written notice.

I acknowledge that I have received a copy of the Authorization to Obtain Medical Information. I agree this Authorization shall be valid for two and one half years from the date shown below and that a copy of this Authorization shall be as valid as the original.

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

Date: _____ EMPLOYEE'S SIGNATURE **X** _____