Telephone claim submission for Short-Term Disability

If you are out of work...

If you are out of work due to an injury, illness or pregnancy, or if you are planning a disability absence (such as surgery or childbirth) up to 2 weeks in advance, please follow the procedures outlined below:

1 **Notify** your supervisor

2 **Fill out** the attached authorization form and provide a copy to your physician. This authorizes your physician to share your information with the insurance company.

3 **Gather** important information: your social security number, physician's name and telephone number, brief description of your medical condition, last day worked, first day out of work due to your condition and the date you expect to return to work.

4 **Call** Madison National Life Insurance Company, Inc. 800-356-9601, ext. 2410. A claim representative will take your claim information over the telephone.

Claim and payment status...

You can call customer service at 800.356.9601, ext. 2410 Monday - Friday, 8 AM to 5 PM (CST). Or view your claim status online 24 hours a day at www.madisonlife.com/myclaims/myclaims.aspx.

Keep this sheet with your coverage. By submitting your claim by telephone, you acknowledge that you have read the following fraud warning: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

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Underwritten by:

Madison National Life Insurance Company
A Member of The IHC Group

PO Box 2865 Clinton IA 52733

Madison National Life Insurance Company, Inc. is a Wisconsin insurance company and a Member of the IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop loss insurance solutions for over 30 years. For information on the IHC Group, visit www.ihcgroup.com.

Madison National Life

Insurance Company, Inc.
P.O. BOX 5008, MADISON, WI 53705
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

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.

Name (print): _____

Date of birth: _____ Telephone: _____

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 _____through two years from the date of 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 _____ through two years from the date of 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 (example: 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 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_____