

Madison National Life

Insurance Company, Inc.

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ACTIVITIES OF DAILY LIVING

Notice to all persons completing this questionnaire: It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result from such an act.

Name (please print): _____ Claim number: _____

Address: _____

Telephone number: _____ E-mail address: _____

GENERAL INFORMATION

Please describe your **current** medical condition and any progress you believe you have made since you stopped working: _____

List **all** the medical problems for which you see a doctor: _____

List **all** medications you are **currently** taking along with their dosage and frequency: _____

Do you live alone? ☐ No ☐ Yes Are you married or have a significant other? ☐ No ☐ Yes

If you are married or have a significant other, does this person work? ☐ No ☐ Yes If yes, what is their occupation: _____

Do you have dependent children ☐ No ☐ Yes If you have dependent children, state their names and dates of birth: _____

What is your height? _____ What is your weight? _____ lbs/kgs

EDUCATION AND WORK EXPERIENCE

Please indicate the extent of your formal education (*circle one*)

Grade: 1 2 3 4 5 6 7 8 9 10 11 12 College: 1 2 3 4 Masters Ph.D. Trade School

If your education exceeds 12th grade, please indicate your major: _____

Briefly describe your past work experience for the last 20 years (*begin with your most recent job*).

Job Title / Employer Name	Duties	Dates Worked
(1)		
(2)		
(3)		
(4)		

Did any of the positions listed above require additional training on your part? ☐ No ☐ Yes If yes, please indicate the nature and type of training (on the job, course work, etc.): _____

What do you perceive to be your current restrictions and limitations? _____

If retraining were made available to you, what occupation(s) would you be interested in? _____

PERSONAL CARE

Describe any changes in your sleeping habits since your condition began: _____

Do you need any assistance in dressing and/or grooming? ☐ No ☐ Yes If you need assistance, describe the help you require **and** how frequently: _____

Do you have problems with your memory? ☐ No ☐ Yes If you have problems with your memory, please describe the problems and how often they occur: _____

Do you prepare your own meals? ☐ No ☐ Yes If you prepare your own meals, which meals do you prepare?

☐ Breakfast ☐ Lunch ☐ Dinner If you do not prepare your own meals, who helps you? _____

Have your eating habits changed since your condition began? ☐ No ☐ Yes

Provide examples of the type(s) of changes in your eating habits: _____

HOUSEHOLD CARE

Are you responsible for the financial management of your household? ☐ No ☐ Yes If you are responsible for the financial management of your household, explain what you do (for example, write checks, pay mortgage, maintain bank records, make bank deposits, etc.): _____

If you are not responsible for the financial management of your household, who is? _____

Do you do housework? ☐ No ☐ Yes If you do housework, check the kinds of household activities you do:

☐ Laundry ☐ Dusting ☐ Vacuuming ☐ Washing dishes ☐ Household repair ☐ Car Care ☐ Garden and lawn care ☐ Trash
☐ Recycling ☐ Other *Specify:* _____

If you do not do household duties, please indicate who does the household duties for you: _____

How often do you do household activities? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Approximate time spent on household activities: Daily? _____ Weekly? _____ Monthly? _____

Describe any changes in your ability to care for your household and any assistance required since your disability began: _____

Do you drive? ☐ No ☐ Yes

Do you have a valid driver's license? ☐ No ☐ Yes

Do you take public transportation? ☐ No ☐ Yes Do you need assistance to travel? ☐ No ☐ Yes

If you need assistance to travel, describe why you need assistance, who assists you, and any changes in your travel since your condition began: _____

Do you shop? ☐ No ☐ Yes

What kinds of shopping do you do? ☐ Food ☐ Clothes ☐ Gifts ☐ Other *Specify:* _____

How often do you shop? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Approximate time spent on shopping? Daily? _____ Weekly? _____ Monthly? _____

Do you require assistance when you shop? ☐ No ☐ Yes If you require assistance when you shop, describe the assistance you require: _____

If you have childcare responsibilities, answer the following questions:

What care are you able to provide for your child/children/grandchildren:

☐ Bathe ☐ Change Clothes ☐ Change Diaper ☐ Feed ☐ Carry ☐ Play activities ☐ Lift ☐ Read

☐ Other *Specify:* _____

Approximate time spent on childcare activities: Daily? _____ Weekly? _____ Monthly? _____

Do you require assistance to perform any of these childcare activities? ☐ No ☐ Yes If you require assistance to perform childcare activities, describe the assistance you need, who provides assistance, and how frequently do you require this assistance: _____

INTERESTS AND HOBBIES

Do you read? ☐ No ☐ Yes

If you read, what do you read? ☐ Books ☐ Magazines ☐ Newspapers ☐ Other Specify: _____

Approximate time spent on reading: Daily? _____ Weekly? _____ Monthly? _____

Do you watch TV? ☐ No ☐ Yes If you watch TV, how many hours do you watch daily? _____

Do you use a computer? ☐ No ☐ Yes If yes, how often and for what purpose? _____

In what types of hobbies or activities do you participate?

☐ Fishing ☐ Crafts ☐ Sewing ☐ Swimming ☐ Bowling ☐ Continuing Education Courses

☐ Movies ☐ Sports ☐ Other Specify: _____

How often do you engage in these activities/hobbies? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Do you travel in excess of thirty miles from your home? ☐ No ☐ Yes If yes, how do you travel and how frequently do you travel: _____

SOCIAL CONTACTS

Are you an active member of any club(s) or organization(s)? ☐ No ☐ Yes If you are an active member, describe your responsibilities and activities: _____

How often do you participate in these activities? ☐ Daily ☐ Twice a week ☐ Weekly ☐ Monthly

Do you hold any positions in your club(s) or community organization(s)? ☐ No ☐ Yes If you hold any positions, describe them: _____

Do you do volunteer work? ☐ No ☐ Yes If you do volunteer work, describe your volunteer activities, including the location, duties performed, hours and frequency of participation: _____

Do you visit with friends or relatives? ☐ No ☐ Yes If yes, how often do you visit? ☐ Daily ☐ Weekly ☐ Weekends ☐ Monthly

Estimate how long these visits last (i.e., number of hours): _____

Has there been any change in your social contacts since your disability began? ☐ No ☐ Yes If there has been any change in your social contacts or you require assistance to maintain these social contacts, describe the change(s) and assistance you require: _____

OTHER INFORMATION

Have you participated in a rehabilitation or retraining program? ☐ No ☐ Yes If you have participated in a rehabilitation or retraining program, provide the name, address and telephone number of the program: _____

Do you believe that you will be able to return to work? ☐ No ☐ Yes If you do not believe that you will be able to return to work, describe the reason(s) supporting your belief: _____

List all your current sources of income and the amount received from each source: _____

What is the status of your Social Security disability claim? ☐ None ☐ Pending ☐ Approved* ☐ Denied *If your claim for Social Security benefits has been approved and we have yet to be notified, please provide a copy of your award notice with this form.

We ask that you indicate yes below if you have applied for any of the following. If you are receiving benefits, please provide documentation showing your gross benefit amount and benefit effective date. Failure to provide documentation of your other income benefits may result in a delay in benefit payment from our company.

Salary Continuation/Commission	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Disability or Retirement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Unemployment Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vacation/Bonus Pay	<input type="checkbox"/> Yes <input type="checkbox"/> No	Retirement Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Income Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No
Automobile No-Fault	<input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No	Workers' Compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have answered yes to any of the above options, please list any other income benefits that have been approved including the benefit amount and the benefit effective date (please use separate sheet if necessary): _____

Since ceasing work, have you performed work for any other employer or self employment? ☐ No ☐ Yes If Yes, please indicate the name and contact information for your employer: _____

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Signature _____ Date _____