ManhattanLife Assurance Company of America **Application for Insurance**
10777 Northwest Freeway, Houston, Texas 77092

FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

❑ New Application ❑ Reinstatement ❑ Benefit Increase **Policy Number:** **Group Number:**

PERSONS PROPOSED FOR INSURANCE

Last Name First Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
	Primary Insured	/ /				
	Spouse	/ /				
	Child	/ /				
	Child	/ /				
	Child	/ /				

Address	City	State	Zip	Home Telephone ( )
Secondary Address	City	State	Zip	Home Telephone ( )

Payor or Owner if other than Primary Insured	❑ Payor ❑ Owner	Social Security No. - -	Relationship to Primary Insured

Employer	Date Employed	Occupation	Hours Worked/Week

Beneficiary (Estate of Primary Insured unless beneficiary named)	Age	Relationship

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities and been actively at work full time at their regular occupation? ❑ Yes ❑ No If "No," explain: _____

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Health Insurance in this or any other company? ❑ Yes ❑ No
If "Yes," complete replacement form where required.

IS ANY PROPOSED INSURED currently covered or eligible for Medicare? ❑ Yes ❑ No If "Yes," a "Guide to Health Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.

INSURANCE PLANS

HOSPITAL	Base Policy	AD & D Rider	Emergency Acc. Rider	Hospital Injury Rider	ICU Rider	Lump Sum Rider	**Monthly Premium**
❑ Primary Ins.	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
❑ Spouse	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
❑ Children	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	

	Private Nurse Rider	Surgical Rider	Surgical + Rider	1st Hospital Conf. Rider	Outpatient Sick.Rider	Outpatient DX Proc. Rider	
❑ Primary Ins.	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
❑ Spouse	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	
❑ Children	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____	$ _____

HEALTH QUESTIONS

1. **HAS ANY PROPOSED INSURED:** Ever been treated for or been told by a member of the medical profession that he/she had Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for Human Immunodeficiency Virus (HIV)? ❑ Yes ❑ No

2. **HAS ANY PROPOSED INSURED:** Consulted a Physician, received medical treatment of any kind, or been hospitalized or confined during the past 4 years? ❑ Yes ❑ No

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HEALTH QUESTIONS (CONTINUED)

3. Have you or any person proposed for insurance within the past 5 years been diagnosed (or treated) as having or been told by a doctor that they had any of the following conditions? ❑Yes ❑ No
   a) fibrotic lung disease, or cystic fibrosis
   b) heart disorder, heart attack, coronary bypass (excluding mitral valve prolapse or surgically corrected or closed atrial septal defect/ventricular septal defect)
   c) kidney disorders, excluding kidney stone

   If you answered "Yes," to this question, list the names of the person(s) to be excluded from coverage:
   _____

4. Have you or any person proposed for insurance within the past 5 years been diagnosed (or treated) as having or been told by a doctor that they had any of the following conditions? ❑Yes ❑ No If "Yes," circle the applicable condition(s) and provide details below.
   a) cancer or tumor
   b) peripheral vascular disease or peripheral arterial disease
   c) autism spectrum disorders, autism, Asperser's disorder. Rett's syndrome, pervasive developmental disorders or pervasive developmental delay
   d) Hodgkin's disease
   e) lupus
   f) paralysis
   g) sickle cell anemia
   h) basal cell carcinoma
   i) emphysema, chronic obstructive pulmonary disease (COPD), or primary pulmonary hypertension

Details of "Yes" answers in 1- 4 above. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury/Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Authorization to Obtain and Release Information: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc. ("MIB"), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to the ManhattanLife Assurance Company of America ("the Company") or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize ManhattanLife Assurance Company of America, or its reinsurers, to make a brief report of my protected health information to MIB.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for the evaluation and the underwriting of my application for the policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; to obtain reinsurance; to administer claims and determine or fulfill responsibility for coverage and provision of benefits; and, to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to the Company will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: 10777 Northwest Freeway, Houston, Texas 77092. I understand that such revocation will not have any effect on actions the Company took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits, or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photographic copy of this authorization shall be as valid as the original.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of ManhattanLife Assurance Company of America's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Mail policy to: ❑ Insured ❑ Agent

Signed at _____ this _____ day of _____ 20 _____
City, State

X _____ X _____ X _____
Signature of Primary Insured (Parent if person to be insured is less than 15 years old) | Payor/Owner (if other than Proposed Insured) | Spouse

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ❑ is ❑ is not involved at this time.

X _____ _____ _____ _____ % _____
Signature of Agent | Printed Agent's Name | Agent No. | % Credit | State ID No.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO MANHATTANLIFE ASSURANCE COMPANY OF AMERICA. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

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EMAIL CONSENT AUTHORIZATION

❒ I give my written consent to allow ManhattanLife Assurance Company of America (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

❒ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below).

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

PAYMENT OPTIONS AUTHORIZATION

❑ Payroll Deduction (Listbill)

You are hereby authorized to deduct $ _____ from my pay according to the mode indicated below, until further notice from me, and remit to ManhattanLIfe Assurance Company of America, 10777 Northwest Freeway, Houston, TX 77092. Premiums will be deducted:

❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Bi-Monthly ❑ Other _____

Signature of Employee_____ Date_____

Agent's Signature_____ Date_____

❑ Monthly Automatic Bank Draft (Electronic Funds Transfer)

Desired withdrawal date (Between the 1st and the 28th)_____

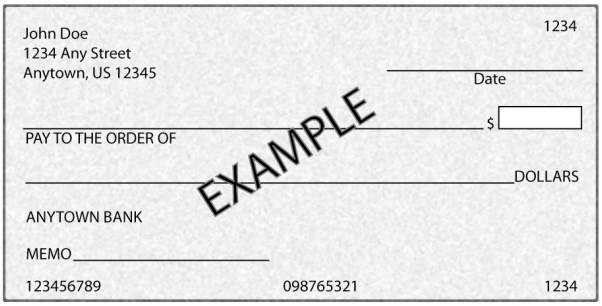
Bank name:_____

City:_____ State:_____

❑ Checking ❑ Savings

If checking account, routing number (9 Digits):_____

Account number:_____



↑ Routing Number ↑ Account Number

AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER (EFT): I (we) hereby authorize ManhattanLife Assurance Company of America (Company), to initiate debit entries to the account and depository, hereinafter called Depository, to debit the same to such account. This authority is to remain in full force and effect until Company and Depository have received written notification from me (or either of us) of its termination in such time and in such manner as to afford company and depository a reasonable opportunity to act on it.

_____ _____

Bank Accountholder's Signature Exactly as it appears on Bank Records Date

❑ Bill Me Directly: ❑ Quarterly ❑ Semi-Annual ❑ Annual

If your billing address is different than your home address, please enter it below:

Billing Address: _____

(Street) (City) (State) (Zip)

Name of person paying, if different: _____

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Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

To obtain further information, contact
ManhattanLife Assurance Company of America
10777 Northwest Freeway, Houston, TX 77092

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Administrative Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Administrative Office at the address on the front of this Notice.

MIB, Inc. Pre-Notice

Information regarding your insurability will be treated as confidential. ManhattanLife Assurance Company of America or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

ManhattanLife Assurance Company of America, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.