

**ManhattanLife Insurance and Annuity Company**  
Administrative Office: 10777 Northwest Freeway, Houston, TX 77092 800-669-9030  
**Cancer/FOB Application**

☐ New Application   ☐ Reinstatement   ☐ Benefit Increase   ☐ Additional Dependent   Group # \_\_\_\_\_

**APPLICANT'S INFORMATION**

Name: (Last, First, Middle Initial)		Date of Birth	Height (ft./in.)	Weight (Lbs.)	Gender (M or F)
Address: (Street, City, State, ZIP Code)					
Telephone Numbers: (Home, Work, and Cell)		Email Address		Social Security Number	
Beneficiary Name			Beneficiary Relationship		
Requested Effective Date			Mail Policy To <input type="checkbox"/> Agent <input type="checkbox"/> Insured <input type="checkbox"/> Employer		
Billing Method <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/> Listbill		Billing Mode <input type="checkbox"/> Monthly (Bank Draft Only) <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual			
Primary Physician's Name		Primary Physician's Address		Primary Physician's Telephone Number	

Do all proposed insureds have comprehensive health benefits, HMO plan, or employer health benefit plan providing for essential benefits? ☐ Yes ☐ No If NO, persons without such comprehensive coverage are not eligible to apply for neither the Cancer or First Occurrence (FOB) policies.

**DEPENDENT(S) INFORMATION**

Name (Print Full Name)	Social Security Number	Gender (M or F)	Date of Birth	Height (ft./in.)	Weight (Lbs.)

**COVERAGE APPLIED FOR**

		Monthly Premium
<b>CANCER</b> (CP4000)	<input type="checkbox"/> <b>Cancer Plan</b> Plan: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> E <input type="checkbox"/> F Plan B only - Cancer Screening Benefit: <input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> Individual <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent	\$ _____
	<b>Optional Rider(s):</b> <input type="checkbox"/> Critical Care Rider <input type="checkbox"/> ICU Rider <input type="checkbox"/> First Occurrence Rider	\$ _____
<b>FOB</b> (FOB)	<input type="checkbox"/> <b>FOB Policy</b> Amount \$ _____ <input type="checkbox"/> Individual <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent	
	<b>Optional Rider:</b> <input type="checkbox"/> Mammography Rider	\$ _____

**COVERAGE QUESTIONS**

- Do all members to be insured reside in the home of the applicant? If **NO**, provide details below . . . . . ☐ Yes   ☐ No
- Has any applicant been declined for insurance due to health reasons? If **YES**, provide details below . . . . . ☐ Yes   ☐ No
- To the best of your knowledge are you or your spouse now pregnant? If **YES**, provide details below . . . . . ☐ Yes   ☐ No
- Is the policy intended to replace any other insurance now in force? If **YES**, provide company name, policy number, and type of coverage below . . . . . ☐ Yes   ☐ No

Provide additional information requested for questions 1- 4 in the space provided below:

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**COVERAGE QUESTIONS (continued)**

5. Have you or anyone proposed for coverage ever been treated for or been told by a member of the medical profession that he/she had Acquired Immune Deficiency Syndrome (AIDS)? ..... ☐ Yes ☐ No

**IMPORTANT NOTE:** California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

**CANCER/FOB**

1. To the best of your knowledge, has any person to be covered under the terms of this policy ever been diagnosed or treated by a medical professional for cancer in any form including carcinoma in situ, or melanoma? ..... ☐ Yes ☐ No  
If **YES**, then list the name(s) of the person(s) that will not be issued FOB coverage: \_\_\_\_\_
2. To the best of your knowledge, in the past 10 years has any person to be covered under the terms of this policy been diagnosed or treated by a medical professional for cancer in any form including carcinoma in situ, or melanoma? ..... ☐ Yes ☐ No  
If **YES**, then list the name(s) of the person(s) to be excluded from coverage: \_\_\_\_\_
3. To the best of your knowledge, in the past 10 years, has any person to be insured ever been diagnosed or treated by a medical professional for Hodgkin's disease, or leukemia? ..... ☐ Yes ☐ No  
If **YES**, then list the name(s) of the person(s) to be excluded from coverage: \_\_\_\_\_
4. To the best of your knowledge, within the last 12 months, has any person to be insured had a a mammogram, pap smear, prostate specific antigen (PSA) test, carcinoembryonic antigen (CEA) test, chest x-ray, colonoscopy, biopsy or scope procedure? ..... ☐ Yes ☐ No  
If **YES**, then list the name(s) of the person(s) to be excluded from coverage: \_\_\_\_\_
5. To the best of my knowledge, within the last 10 years, has any person to be insured under this policy been diagnosed or treated by a medical professional for Addison's disease, amyotrophic lateral sclerosis, diphtheria, encephalitis, epilepsy, Legionnaires' disease, lupus erythematosus, meningitis, multiple sclerosis, muscular dystrophy, myasthenia gravis, Niemann Pick disease, osteomyelitis, poliomyelitis, Reye's syndrome, rheumatic fever, Rocky Mountain spotted fever, sickle cell anemia, Tay-Sachs disease, tetanus, toxic epidermal necrolysis, toxic shock syndrome, tuberculosis, tularemia, typhoid fever, Whipple's disease, or whooping cough? ..... ☐ Yes ☐ No  
If **YES**, please circle the disease(s) and list the name(s) of the person(s) to be excluded from dread disease coverage: \_\_\_\_\_
6. **Critical Care/Intensive Care Rider:** 1. To the best of your knowledge, within the last 10 years, has any person to be insured been diagnosed or treated by a medical professional with heart disease, any abnormalities of the heart, chest pain, heart attack, or stroke; had, heart surgery, a pacemaker implanted, or blood vessel surgery? . ☐ Yes ☐ No  
If **YES**, then list the name(s) of the person(s) to be excluded from coverage: \_\_\_\_\_
7. To the best of your knowledge, has any person to be insured been diagnosed by a medical professional with high blood pressure that has not been controllable for at least one year? . . . . . ☐ Yes ☐ No

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 ("DMV"), the Veterans Administration or other medical or medically-related facility, or other organization, institution or person, that has any insurance, health, or DMV records of me to give to the ManhattanLife Insurance and Annuity Company ("the Company") or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed ((excluding disclosures of information relating to human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDS), and AIDS related complex (ARC)) 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 authorize ManhattanLife Insurance and Annuity Company, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my DMV and insurance 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 evaluation and underwriting of my application for the Policy for which I have applied, to determine eligibility for insurance, risk rating or policy issue determinations, obtain reinsurance, administer claims, and determine or fulfill responsibility for coverage and provision of benefits; 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 am, or a person authorized to act on my behalf is, entitled to receive a copy of this authorization.

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 photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete, and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, c I have read, or had read to me, the completed application and that I realize that any statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

**FRAUD: The falsity of any statement in this application for any covered Policy shall not bar the right to recovery under this Policy unless such false statement was made with the actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.**

\_\_\_\_\_  
(Signature of Proposed Insured)

\_\_\_\_\_  
(Signature of Applicant, if other than Proposed Insured)

\_\_\_\_\_  
Signed At (City/State)

\_\_\_\_\_  
Dated (Day/Month/Year)

#### AGENT'S STATEMENT AND CERTIFICATION

1. If a replacement(s), and if state regulations require it, have you:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| a. Given "Notice to Applicant Regarding Replacement of Accident and Sickness Insurance"? ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| b. Completed replacements forms, if required in your state? .....                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| c. Have you complied with state regulations on disclosure? .....                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

All information recorded by me on this application is true and accurate to the best of my knowledge.

Agent No. _____	Soliciting Agent Signature _____	Date _____
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Printed Agent Name _____	Agent Phone No. _____	Agent #% _____	Agent #% _____
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Remarks or special requests: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**NOTICE:** All premium checks must be made payable to ManhattanLife Insurance and Annuity Company. Do not make the check payable to the agent or leave the payee blank.

### OPT IN TO RECEIVE RECORDS BY ELECTRONIC TRANSMISSION

I voluntarily opt in and therefore give my written consent to allow ManhattanLife Insurance and Annuity Company (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(s) that I provide below. I acknowledge that, should I desire to opt out of receiving records by electronic transmission, change or correct the email address(s) below, that I will inform the Company, in writing at their Administrative Address, 10777 Northwest Freeway, Houston, Texas 77092, of such revocation, change or correction.

**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 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.

Primary email address: \_\_\_\_\_ Secondary email address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### PAYMENT OPTIONS AUTHORIZATION

#### ☐ Monthly Payroll Deduction (Listbill)

Assigned list bill number, if known: \_\_\_\_\_

I hereby authorize \_\_\_\_\_ (Name of Employer)  
to deduct from my salary and pay to ManhattanLife Insurance and Annuity  
Company the monthly deposits as set forth below.

Beginning with the month of \_\_\_\_\_, 20\_\_\_\_

deduct \$ \_\_\_\_\_ each month.

Signature of Employee \_\_\_\_\_

Date \_\_\_\_\_

John Doe 1234 Any Street Anytown, US 12345		1234
Date _____		
PAY TO THE ORDER OF _____ \$ _____		
_____ DOLLARS		
ANYTOWN BANK		
MEMO _____		
123456789	098765321	1234

↑  
Routing Number

↑  
Account Number

#### ☐ 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: \_\_\_\_\_

#### Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize ManhattanLife Insurance and Annuity Company, hereinafter called COMPANY, to initiate debit entries to my account and to debit the same to such account. This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY a reasonable opportunity to act on it.

Account holder's signature: \_\_\_\_\_ 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: \_\_\_\_\_

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

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. You may request to be interviewed in connection with the preparation of this investigation report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living. 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 address below. You are entitled 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 ((excluding disclosures of information relating to human immunodeficiency virus (HIV), acquired immunodeficiency syndrome (AIDs), and AIDs related complex (ARC)), 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 below.

**MIB, Inc. Pre-Notice**

Information regarding your insurability will be treated as confidential. ManhattanLife Insurance and Annuity Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc. (MIB), 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 Insurance and Annuity Company, 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](http://www.mib.com).

**To obtain further information contact:**

**ManhattanLife Insurance and Annuity Company, Administrative Office: 10777 Northwest Freeway, Houston, Texas 77092**