ManhattanLife™
Standing By You. Since 1850.

ManhattanLife Insurance and Annuity Company
Home Office: Houston, TX
Administrative Office: 10777 Northwest Freeway, Houston, TX
(800) 669-9030

APPLICATION FOR HOME HEALTH CARE INSURANCE

❑ Reinstatement ❑ Benefit Increase Policy No._____ Group No. _____

APPLICANT A – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)	Social Security No.	
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	

APPLICANT A - INSURANCE REQUESTED		PREMIUM
Home Health Care Insurance Policy	❑ Classic - $150 ❑ Premier - $300 ❑ Deluxe - $450	$ _____
Routine Annual Examination Rider	❑	$ _____
Accidental Death & Dismemberment Rider	❑	$ _____
Home Health Equipment Rider	❑	$ _____
Accident Expense Benefit Rider	Per Accident - ❑ $1250 ❑ $2500	$ _____
Ambulance Benefit Rider	❑	$ _____
	APPLICANT A - TOTAL PREMIUM *Premium includes an annual $20 policy fee*	$ _____

APPLICANT A - HEALTH QUESTIONS		
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	❑ Yes ❑ No
2.	Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring from bed to chair?	❑ Yes ❑ No

APPLICANT A – EXISTING COVERAGE		
1.	Do you have existing health coverage (including home health care, long-term care, or similar coverage)?	❑ Yes ❑ No
2.	Are any policy(s) intended to replace any other insurance not in force? If "**Yes**," provide the company name, policy number, and type of coverage below.	❑ Yes ❑ No

APPLICANT B – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)	Social Security No.	
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	

APPLICANT B - INSURANCE REQUESTED		PREMIUM
Home Health Care Insurance Policy	❑ Classic - $150 ❑ Premier - $300 ❑ Deluxe - $450	$ _____
Routine Annual Examination Rider	❑	$ _____
Accidental Death & Dismemberment Rider	❑	$ _____
Home Health Equipment Rider	❑	$ _____
Accident Expense Benefit Rider	Per Accident - ❑ $1250 ❑ $2500	$ _____
Ambulance Benefit Rider	❑	$ _____
	APPLICANT B - TOTAL PREMIUM *Premium includes an annual $20 policy fee*	$ _____

APPLICANT B - HEALTH QUESTIONS		
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	❑ Yes ❑ No
2.	Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring from bed to chair?	❑ Yes ❑ No

APPLICANT B – EXISTING COVERAGE		
1.	Do you have existing health coverage (including home health care, long-term care, or similar coverage)?	❑ Yes ❑ No
2.	Are any policy(s) intended to replace any other insurance not in force? If "**Yes**," provide the company name, policy number, and type of coverage below.	❑ Yes ❑ No

AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, LLC (MIB), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company 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 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 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 Insurance and Annuity Company, or its reinsurers, to make a brief report of my protected health information to MIB, LLC.

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 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; 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, TX 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 as valid 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, certify that I have read, or had read to me, the completed application and that I realize that any false 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.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at _____, on _____ X_____

(City and State) (Month/Day/Year) Applicant A's signature (or their authorized representative)

Signed at _____, on _____ X_____

(City and State) (Month/Day/Year) Applicant B's signature (or their authorized representative)

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

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.

APPLICANT A - EMAIL CONSENT AUTHORIZATION

❑ I 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(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(s) 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.

APPLICANT B - EMAIL CONSENT AUTHORIZATION

❑ I 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(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(s) 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: _____

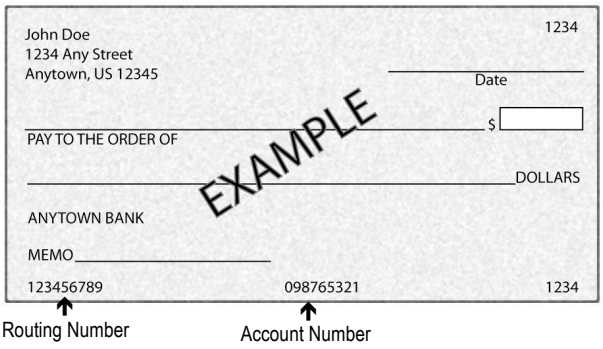
Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice 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.

APPLICANT A - PAYMENT OPTIONS AUTHORIZATION

❑ **Payroll Deduction (Listbill)**

Assigned list bill number, if known:_____

I hereby authorize my employer to deduct from my salary and pay to ManhattanLife Insurance and Annuity Company the premium.



❑ **Automatic Bank Draft (Electronic Funds Transfer)**

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Type of Account: ❑ Checking ❑ Savings

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

Bank name:_____

City:_____ State:_____

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 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.

Accountholder's Signature_____ Date_____

❑ **Direct Billing** ❑ Quarterly ❑ Semi-Annually ❑ Annually

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

Billing Address: _____

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

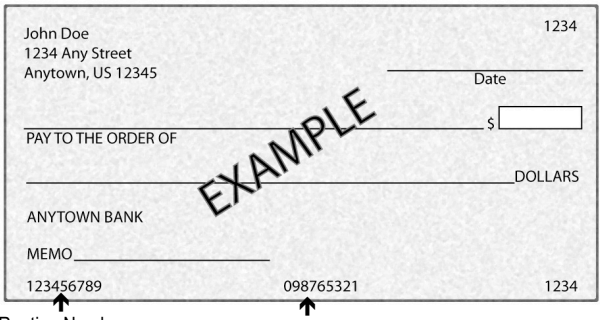
Name of person paying, if different: _____

APPLICANT B - PAYMENT OPTIONS AUTHORIZATION

❑ **Payroll Deduction (Listbill)**

Assigned list bill number, if known:_____

I hereby authorize my employer to deduct from my salary and pay to ManhattanLife Insurance and Annuity Company the premium.



❑ **Automatic Bank Draft (Electronic Funds Transfer)**

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Type of Account: ❑ Checking ❑ Savings

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

Bank name:_____

City:_____ State:_____

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 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.

Accountholder's Signature_____ Date_____

❑ **Direct Billing** ❑ Quarterly ❑ Semi-Annually ❑ Annually

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: _____

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, LLC 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 MIB, LLC (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of insurance companies that are members *of MIB Group, Inc*. 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 *or go to its website* www.mib.com. If you question the accuracy of 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, MA 02184- 8734.

ManhattanLife Insurance and Annuity Company, or its reinsurers, may also release information in 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.