ManhattanLife Assurance Company of America
10777 Northwest Freeway, Houston, Texas 77092

Application for Insurance

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.

❑ Check if replacing or changing existing coverage in this company. Effective Date: _____

PERSONS PROPOSED FOR INSURANCE

Last Name First Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
	Primary Insured					
	Spouse or Civil Union Partner					
	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 Number	Relationship to Primary Insured

Employer	Occupation

Date Employed	Hours Worked/Week	Group Number

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, Dental Vision or Hearing Insurance in this or any other company? ❑ Yes ❑ No If "Yes," complete replacement form where required.

INSURANCE PLANS

Hospital Indemnity (GAPJ15)

Coverage Applied For: ❑ Individual ❑ Individual/Children ❑ Individual/Spouse or Civil Union Partner ❑ Family

Daily Inpatient Hospital Benefit *(Choose One)*	Inpatient Hospital Admission *(Choose One)*	Doctors Office Visit	Premium
❑ $100 Per Day ❑ $200 Per Day	❑ $2,500 ❑ $5,000 ❑ $6,350	❑ $50	$_____

Optional Benefits

Outpatient Surgery	Emergency Accident	Premium
❑ $1,000 ❑ $2,000 ❑ $3,000	❑ $250	$_____

Dental, Vision & Hearing (DVH)

❑ Applicant Only ❑ Family (Family Coverage is up to 5 persons)
Policy Year Maximum ❑ $1,000 ❑ $1,500
Premium $ _____

HOSPITAL INDEMNITY COVERAGE QUESTIONS

1. Do all the members to be insured reside in the home of the applicant? ❑ YES ❑ NO If "No," which member? _____
   Explain: _____
2. Has any person proposed for coverage been declined for insurance due to health reasons? ❑ YES ❑ NO If "Yes," provide details and dates: _____
3. Has any person had surgery advised by a physician but not yet performed? ❑ YES ❑ NO If "Yes," provide details: _____

4. Has any person proposed for insurance been treated, within the last twelve months, by a physician for elevated blood pressure? ❑ YES ❑ NO If "Yes," please list the name(s) of the person(s), types of treatment including medication, date last seen by a physician, last blood pressure reading, and how long blood pressure has been under control and date diagnosed: _____

5. Are you or your Spouse or Civil Union Partner now pregnant? ❑ YES ❑ NO If "Yes," provide details: _____

6. Has any person proposed for insurance been treated (including medication) within the last 12 months by a physician? ❑ YES ❑ NO If "Yes," please list the person(s), types of treatment, including medication and date last seen by a physician.

7. Have you or anyone proposed for the coverage been diagnosed or been treated by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), "AIDS" related complex (ARC), or "AIDS" related conditions, or tested positive for Human Immunodeficiency virus (HIV) or its antibodies? ❑ YES ❑ NO If "Yes," provide details: _____

8. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had any of the following conditions? ❑ YES ❑ NO If "Yes," circle the applicable conditions shown and provide details below.

a. Addison's Disease
b. Alcoholism, Alcohol, Chemical Dependency, or Drug or Alcohol Abuse
c. Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Develpmental disorders, or Pervasive Developmental Delay
d. Cancer or Tumor
e. Cataracts uncorrected
f. Cerebral Palsy
g. Liver Disorders, excluding fully recovered Hepatitis A
h. Coronary Bypass
i. Crohn's Disease or Ulcerative Colitis
j. Currently (or within 3 months) hospitalized or confined to any health care institution
k. Emphysema, Chronic Obstructive Pulmonary Disease, Fibrotic Lung Disease, or Pulmonary Hypertension
l. Diabetes treated with insulin
m. Functionally limiting musculoskeletal disease or disorder
n. Grand Mal Epilepsy
o. Heart Attack
p. Heart Disease
q. Heart abnormality
r. Hemophilia
s. Hernia uncorrected
t. Hepatitis (other than Virus A)
u. Hodgkin's Disease
v. Kidney disorders, excluding kidney stones
w. Leukemia
x. Mental or Nervous Disorder or disease or disorder of the Central Nervous System
y. Multiple Sclerosis
z. Osteomyelitis
aa. Paralysis
bb. Peripheral Vascular Disease or Peripheral Arterial Disease
cc. Rheumatoid Arthritis (requiring 2 or more medications)
dd. Ulcerative Colitis
ee. Sickle cell anemia
f f. Stroke or Brain Aneurysm
gg. Tuberculosis

Additional Details To Health Questions Above:

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_____

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, 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 ManhattanLife Assurance Company of America ("the Company") or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history, and 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, 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, 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.