ManhattanLife Assurance Company of America

10777 Northwest Freeway, Houston, TX 77092

Hospital Indemnity Application

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.

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

APPLICANT'S INFORMATION

Name (Last, First, Middle Initial)	Date of Birth	Height (Ft.)	Weight (Lbs.)	Gender (M or F)

Address (Street, City, State, ZIP Code)	
Telephone Numbers (Home, Work, and Cell)	Email Address
Social Security Number / Primary Employer Name and Address	
Current Occupation – Describe and give exact duties	
Beneficiary Name	Beneficiary Relationship
Requested Effective Date	Mail Policy To ❒ Agent ❒ Insured ❒ Employer

Primary Physician's Name	Primary Physician's Address	Primary Physician's Telephone Number

Is the policy intended to replace any other Insurance now in force? ❑ Yes ❑ No
If "**YES**," provide company name, policy number, and type of coverage: _____

DEPENDENT'S INFORMATION

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

COVERAGE APPLIED FOR

	Plan:	Coverage Applied For:	Premiums:
HOSPITAL INDEMNITY POLICY (C-AFF)	❒ Elite ❒ Classic	❑ Individual ❑ Individual/Children ❑ Individual/Spouse ❑ Family	$ _____

HEALTH QUESTIONS

1.	Do all members to be insured reside in the home of the applicant? If "**NO**," provide details below.	❑ Yes ❑ No
2.	Has any applicant been declined for insurance due to health reasons? If "**YES**," provide details below.	❑ Yes ❑ No
3.	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? If "**YES**," provide details below.	❑ Yes ❑ No
4.	Are you or your spouse now pregnant? If "**YES**," provide details below	❑ Yes ❑ No

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

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: 1-800-669-9030 FAX: 713-821-6463

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HEALTH QUESTIONS (cont.)

5. Has any person proposed for insurance had surgery within the last 5 years? ❑ Yes ❑ No If "**YES**," provide details (date, reasons, results).

_____

Has any person had surgery advised but not yet performed? ❑ 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 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) shown below and provide details in the Comment Section below.

a. Alcoholism, Alcohol, Chemical Dependency or Drug or Alcohol Abuse
b. Autism Spectrum Disorders, Autism, Asperser's Disorder. Rett's Syndrome, Pervasive Developmental disorders or Pervasive Developmental Delay
c. Basal Cell Carcinoma with recommended surgery that has not been completed
d. Cancer or Tumor
e. Crohn's Disease or Ulcerative Colitis
f. Diabetes (Type I or Insulin controlled)
g. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Fibrotic Lung Disease or Primary Pulmonary Hypertension
h. Heart Disorder, Heart Attack, Coronary Bypass (excluding Mitral Valve Prolapse or surgically corrected or closed Atrial Septal Defect/ Ventricular Septal Defect)
i. Hernia Uncorrected
j. Hodgkin's Disease
k. Kidney disorders, excluding Kidney Stone
l. Liver disorders, excluding fully recovered Hepatitis A
m. Lupus
n. Osteomyelitis
o. Paralysis
p. Peripheral Vascular Disease or Peripheral Arterial Disease
q. Rheumatoid Arthritis
r. Sickle cell anemia
s. Stroke or Brain Aneurysm
t. Tuberculosis (TB)

Provide details for any "**YES**" answers to question 7: _____

_____

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INSURED'S 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, 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 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 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, 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.

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

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.

_____ _____
(Signature of Proposed Insured) (Signature of Applicant, if other than Proposed Insured)

_____ _____
Signed At (City/State) Dated (Day/Month/Year)

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.

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.

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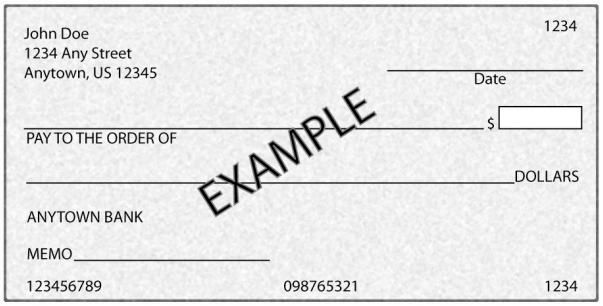
PAYMENT OPTIONS AUTHORIZATION

❑ 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 Assurance Company of America the monthly deposits as set forth below.
Beginning with the month of _____, 20_____
deduct $_____ each month.
Signature of Employee_____ Date_____

❑ Monthly Automatic Bank Draft (Electronic Funds Transfer)

Desired withdrawal date (Between the 1st and the 28th)_____
Bank name:_____
City:_____ State:_____
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, 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_____

❑ 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 home 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 home office at the address on the front of this Notice.

MIB, Inc. 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. (MIB), 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.

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