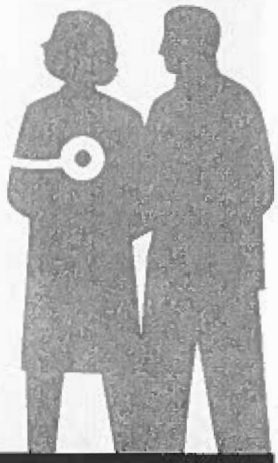


Cancer Care Plus

Cancer and Dread Disease Insurance

A Cancer and Dread Disease - Only Insurance Policy

Why Cancer Insurance?

According to the American Cancer Society:

- In the United States, men have about a 1-in-2 lifetime risk of developing cancer; for women the risk is a little more than 1-in-3.*
- It is projected that on an annual basis over 1.8 million new cancer cases will be diagnosed.*

As advances in cancer treatment continue, more and more people will survive:

- Approximately 16.9 million Americans with a history of cancer were alive in 2019.*
- The five-year relative survival rate for all cancers diagnosed between 2009 - 2015 is 69%, up from 55% in 1987-1989.*
- The National Institutes of Health estimated the overall costs for cancer in the year 2020 at $206 billion.

Although health insurance can help offset the costs of cancer treatment, you still may have to cover deductibles and copayments on your own.

Additionally, cancer treatment can cause out-of-pocket expenses that aren't covered by traditional health insurance:

- Travel
- Food
- Lodging
- Long-distance calls
- Childcare
- Household help

Meanwhile, living expenses such as car payments, mortgages or rent, and utility bills continue whether or not you are able to work. If a family member has to stop working to take care of you, the loss of income may be doubled. The Company helps provide an important safety net in fighting the financial consequences of cancer that result beyond traditional health insurance.

The Company pays benefits directly to you, unless assigned.
You use the cash however you decide.

Cancer and Specified Disease Insurance Protection with Optional Critical Care Rider Available

BENEFIT PACKAGE OPTIONS	PLAN A	PLAN B	PLAN C	PLAN D
Radiation, Chemotherapy and Immunotherapy* We will pay the actual charges for Teleradiotherapy, Radio-Active Isotopes Therapy, Chemotherapy, Chemotherapy Enhancer Drugs, and Anti-Nausea and Immunotherapy drugs, as indicated in the policy, for the treatment of cancer or a specified dread disease. Benefits are based on the maximum monthly benefit amount selected. Actual Charges means the amount(s) actually paid by or on behalf of the Covered Person and accepted by the provider as full payment for the covered services provided. This benefit is not payable if treatment is received in a government or charity hospital. **Note - Immunotherapy must be FDA approved.*	Pays actual charges, maximum $2,500 per month.	Pays actual charges, maximum $5,000 per month.	Pays actual charges, maximum $7,500 per month.	Pays actual charges, maximum $5,000 per month.
Surgical Benefit Payable for surgeries performed in or out of the hospital to treat cancer or a specified dread disease. Benefits for surgical procedures are calculated as a percentage of the per-surgery maximum benefit amount selected.	Pays maximum per surgery $2,500.	Pays maximum per surgery $3,000.	Pays maximum per surgery $4,000.	Pays maximum per surgery $4,000.
First Occurrence Benefit (Rider) Payable when a covered person is diagnosed with cancer for the first time. Payable only once for each covered person and not payable for skin cancer. Not available for ages 65 and above.	Pays $1,000.	Pays $2,500.	Pays $5,000.	Pays $10,000.
Cancer Screening Test Payable for one annual cancer screening test, including but not limited to mammography screening, pap smear (test only); CA125 (blood test for ovarian Cancer); PSA (blood test for prostate Cancer); hemocult stool specimen; flexible sigmoidoscopy; CEA (blood test for colon Cancer); colonoscopy; chest X-ray; thermography; or serum protein electrophoresis. Payment based on benefit amount selected. Not payable if received through any free-testing program or for any other cancer screening test for which a charge is not made. In PA, mammography screening is not available.	Pays $50 per calendar year. (MT only, $100 per calendar year.)	Pays your choice of $50 or $100 per calendar year. (MT only, $100 per calendar year.)	Pays $100 per calendar year. (CA and ID only, $50 per calendar year.)	Pays $100 per calendar year. (CA and ID only, $50 per calendar year.)
Daily Hospital Confinement Benefit Payable when a covered person is confined to the hospital for the treatment of cancer or a dread disease. Payment is based on the daily benefit amount selected. Payable for the first 70 days of each period of confinement.	Pays $100 per day.	Pays $150 per day.	Pays $300 per day.	Pays $150 per day.

The following defines the list of Dread Diseases covered under the Policy:

• Addison's Disease • Muscular Dystrophy • Tay-Sachs Disease • Amyotrophic Lateral Sclerosis • Myasthenia Gravis • Tetanus • Diphtheria • Niemann-Pick Disease • Toxic Epidermal Necrolysis • Encephalitis • Osteomyelitis • Toxic Shock Syndrome • Epilepsy • Poliomyelitis • Tuberculosis • Legionnaire's Disease • Reye's Syndrome • Tularemia • Lupus Erythematosus • Rheumatic Fever • Typhoid Fever • Meningitis • Rocky Mountain Spotted Fever • Whipple's Disease • Multiple Sclerosis • Sickle-Cell Anemia • Whooping Cough

HOSPITAL BENEFITS:

Ambulance We will pay for transfer of a covered person to or from a hospital for confinement as an inpatient. In CA, we will provide direct reimbursement to the medical transportation provider.	$250 per trip 3 trips per year
Physician's Attendance We will pay a Physician's Attendance benefit if the regular physician visits during a confinement in the hospital.	$50 per day
Prescribed Drugs and Medicines Actual charges for drugs and medicines prescribed while confined in a hospital. Limited to the first 70 days for each period of confinement.	Actual charges to a maximum of 20% of the Daily Hospital Confinement Benefit.
Government or Charity Hospital Pays a total benefit of $200 per day of treatment for outpatient Teleradiotherapy, Radio-Active Isotopes Therapy, Chemotherapy, Chemotherapy Enhancer Drug, Anti-Nausea, and Immunotherapy, as indicated in the policy, received in a government or charity hospital. Paid in lieu of all other benefits except for transportation and lodging benefits.	$200 per day
Extended Benefits Beginning on the 71st day of one continuous period of hospital confinement for cancer or a dread disease. Payable in lieu of all other benefits payable for the same time period.	$1,000 per day

OTHER CARE FACILITY BENEFITS:

Hospice Care For confinement in a hospice care center for care provided if a covered person has been diagnosed as terminally ill due to cancer or dread disease. Limited to a lifetime maximum of 180 days for confinement in a hospice care center, or 30 days if hospice services are provided in the covered person's home.	$100 per day
Extended Care Facility Confinement must be recommended by the attending physician and begin within 14 days of a covered hospital confinement. All days for which a Hospital Confinement benefit is paid will be included in determining the maximum of 70 days for the Extended Care Facility benefit. ID, IL and WV, pays actual charges incurred to the greater of $100 or one-fourth of the Daily Hospital Confinement Benefit.	$100 for each day of confinement to a maximum of 70 days
Private Duty Nursing Service We will pay when confined in a hospital and a private duty nursing service is retained.	$150 per day

TRANSPORTATION BENEFITS

Transportation and Lodging for Bone Marrow Donors

Paid for a donor who is either a covered person, or someone donating to a covered person. When a covered person is the donor, this benefit is payable in lieu of any other benefits payable under the policy.

- Actual charges to $2,500 for medical expenses directly relating to the services provided to the donor during the transplant.
- Actual charges for round trip coach fare on a common carrier, or a personal automobile allowance of 50 cents per mile if distance is more than 50 miles one-way. Maximum 700 miles round trip.
- Actual charges to $75 per day for lodging and meal expenses incurred by the donor.

*Transportation for Non-Local Treatment Which Requires Hospital Confinement

Actual charges for round trip coach fare, or a personal automobile allowance of 50 cents per mile if the distance is more than 50 miles one-way. Maximum 700 miles round trip.

Prescribed treatment must not be available locally and must require hospital confinement.

*Transportation and Lodging for Non-Local Treatment Which Does Not Require Hospital Confinement

- Actual charges for round trip coach fare, or a personal automobile allowance of 50 cents per mile if the distance is more than 50 miles one-way, maximum 700 miles round trip. Maximum of $1,500 per calendar year.
- Actual charges to $50 per day for lodging and meal expenses. Payable only for the days you receive treatment for cancer or dread disease for which a benefit is payable.

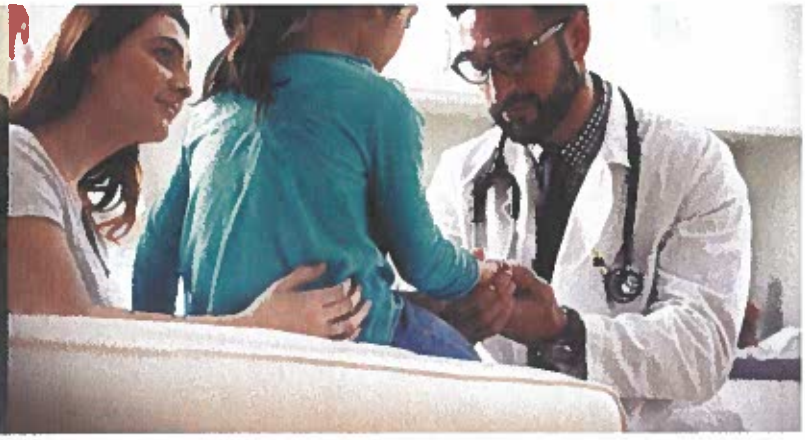
Prescribed treatment must not be available locally and must not require hospital confinement.

*Adult Companion Transportation and Lodging

Payable only for an adult companion residing and traveling within the continental United States.

- Actual charges for one adult companion to be near a covered person who is hospital confined in a non-local hospital for covered treatments. Maximum $2,500 per confinement.
- Actual charges to $50 per day for lodging and meal expenses incurred. Limited to the number of days of the covered person's hospitalization.
- Actual charges of one round trip coach fare, or a personal automobile allowance of 50 cents per mile, if the distance is more than 50 miles one-way. Maximum 700 miles round trip.

**Not payable for periodic checkups, cancer screening tests, or for treatments, services, or procedures for which a benefit is not payable under this policy*



SURGICAL BENEFITS

Bone Marrow Transplant for Cancer Actual charges incurred for bone marrow transplants or other forms of stem cell rescue and all related services and supplies. Lifetime maximum of $10,000. This benefit is in lieu of any other benefit associated with the treatment, service, or procedure underlying Bone Marrow Transplant, with the exception of the Transportation and Lodging for Bone Marrow Donors benefit. In AR, additional benefits may be available for a live donor.	Pays actual charges, lifetime maximum of $10,000.
Breast Reconstruction/Breast Prosthesis Actual Charges incurred for reconstructive surgery, and an external or internal breast prosthesis and the surgeon's fee for implantation following a mastectomy. Except in OK, lifetime maximum of $5,000. This benefit is in lieu of the surgical benefit provided in this policy.	Pays actual charges. Lifetime maximum of $5,000.
Artificial Limb and Prosthesis Pays per prosthetic device or artificial limb and the reconstructive procedure to affix or implant it. Benefits limited to only two of the same type of prosthetic device or artificial limb. Not payable if a breast reconstruction and breast prosthesis benefit is payable.	Actual charges to $1,500
Outpatient Surgery Benefit Payable for outpatient surgery in a hospital or ambulatory surgical center. Not payable for surgery in a physician's office or clinic, or for skin cancer treatment.	Pays $375 per operation for drugs, medicines and lab tests. Pays maximum of 150% of surgery shown in surgical benefits schedule.
Additional Surgical Opinions Pays for a second and third surgical opinion if the surgical opinions differ.	$200 each opinion
Anesthesia Pays for the procedure in which anesthesia is used. We will pay $50 for the administration of anesthesia for each skin cancer operation.	Pays 25% of the surgical benefit amount paid
Skin Cancer • If the diagnosis is made by a physician other than a pathologist, $150 for removal of skin cancer to a maximum of $600 per calendar year. • If the diagnosis is made by a pathologist, actual charges to the maximum amount for such surgery shown in the surgical benefits schedule.	Pays $150 per calendar year. Maximum benefit $600.

OTHER BENEFITS

Home Health Care Services Payable when services are provided by a licensed home health care agency. Benefit paid in lieu of all other policy benefits. Must be prescribed by a physician and cannot be provided by a relative. In ID, IL, and WV, pays the greater of $60 or one-fourth the Daily Hospital Confinement benefit.	Pays $60 per day at home services, 180 days max per calendar year. Pays $150 per day at home private duty nursing, 15 days max per calendar year. Pays $50 per day at home physician visits, 15 days max per calendar year.
Rental or Purchase of Durable Medical Equipment For the rental or purchase of a respirator or similar mechanical device; brace; crutches; hospital bed; or a wheel chair.	Pays actual charges, maximum $1,000 per calendar year.
Professional Mental Health Consultation For a consultation with a licensed mental health professional when receiving treatment for cancer or a dread disease. The licensed mental health professional may not be a relative.	$50 per session. Lifetime maximum of $250.
Outpatient Positive Diagnosis Test For a diagnostic test that leads to a positive diagnosis within 90 days of such test. Payable once per diagnosis.	$250 for a diagnostic test.
Experimental Treatment Treatment must be received in the United States or its territories. This benefit is in lieu of all other benefits payable for the treatment of cancer or dread disease.	Pays actual charges, to a lifetime maximum of $10,000.
Blood and Blood Plasma For blood, blood plasma and platelets inserted into a covered person. Not payable for blood which is donated or replaced.	Pays actual charges, to a maximum of $5,000 per calendar year.
Hairpiece Benefit One-time benefit for a hairpiece when hair loss is the result of cancer treatment.	Pays $100
Physical, Occupational or Speech Therapy $50 for each 60-minute session for Physical, Occupational or Speech Therapy.	$50 each session. Lifetime maximum of $1,500.
Tutor Tutor session for an insured child under age 19, when the child is receiving treatment for cancer or a dread disease.	$25 per 60-minute. Lifetime maximum of 50 sessions.
Mammography Benefit In CA, ID and MT only, pays actual charges for a mammography screening administered to a Covered Person according to the schedule listed in the policy.	Pays actual charges to a maximum of $70.
Pap Smear Benefit In CA only, pays the actual charges for one Pap Smear each year administered to each female Covered Person age 18 or older.	Pays actual charges to a maximum of $75.

OPTIONAL RIDERS (available at additional cost)

Intensive Care Unit Rider
(Form Numbers ICUR 4000, ICUR 4000 ID, ML-ICUR 4000, FL ICUR4000)
(including state variations)

Benefits Reduce to ½ at age 70.

Benefit for Intensive Care Unit. If a Covered Person is confined in an Intensive Care Unit of a Hospital, we will pay the ICU Daily Benefit Amount for each day of such confinement, not to exceed 30 days during any one period of confinement.	Pays $600 per day
Benefit for Step-Down Unit. If a Covered Person is confined in a Step-Down Unit of a Hospital, we will pay for each day of such confinement, not to exceed 30 days during any one period of confinement.	Pays $300 per day step down unit

Critical Care Benefit Rider
(Form Number CCBR 4000, CCPR 4000 ID, ML-CCBR 4000, FL CCBR 4000)
(including state variations)

Benefit for Heart Disease - A Heart Disease benefit will be paid for the actual charges incurred by a Covered Person for the following due to Heart Disease: 1. pacemaker insertion; 2. angioplasty; and 3. heart catheterization. This benefit is limited to a lifetime maximum.	Pays Actual charges to lifetime max $2,500
Benefit for Heart Attack/Stroke - A Heart Attack/Stroke benefit will be paid for the actual charges incurred by a Covered Person.	Pays Actual charges to lifetime max $5,000

Cancer First Occurrence

ManhattanLife™
Standing By You. Since 1850.

Cancer Insurance Policy
$5,000 to $50,000

How Many People Are Expected to Die of Cancer This Year?*

In 2019, it was estimated that more than 1.7 million new cases of cancer will be diagnosed and more than 600,000 will result in death.

What Percentage of People Survive Cancer?*

The 5 year relative survival rate for all cancers combined that were diagnosed during 2009 - 2015 was 67% overall.

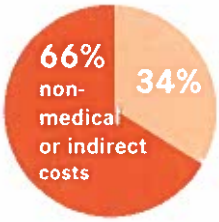
Protection Through Early Detection and Prevention*

What you eat and drink, how active you are, and other lifestyle behaviors all can affect your risk for cancer. Find out more about these risks and what you can do to reduce them thru the American Cancer Society Website, http://www.cancer.org

** Source, American Cancer Society, Cancer Facts & Figures 2020*

If You Are Diagnosed With Cancer

The cancer first occurrence benefit policy pays the amount you select from $5,000 to $50,000.



According to the American Cancer Society, your traditional medical or medicare coverage may be good, but it will only cover 34% of the costs associated with cancer.

Why Does This Policy Deserve Your Consideration?

- It is guaranteed renewable for life.
- It pays regardless of other insurance you may have.
- Payment is made directly to you.
- Benefits are paid whether you receive treatment or not.
- Benefits do not change when you reach age 65.
- You do not have to be hospitalized to receive your benefits.
- Benefit amount is the same even if treatment is provided in a government hospital, VA hospital, health maintenance organization (HMO), clinic, or any other facility.
- The Family Plan pays the same FOB benefit for each covered family member.

Choose Your Benefit Amount:

- ❑ $5,000
- ❑ $10,000
- ❑ $20,000
- ❑ $30,000
- ❑ $40,000
- ❑ $50,000

You select the insurance plan best for your needs.

This is a Supplemental Policy.
30 Day Right To Examine Policy.

You have thirty (30) days to examine the policy and have your premiums refunded.

This policy provides a one time benefit due to the initial diagnosis of cancer.

This is only a brochure which provides a brief description of the important features of your policy.

Only the policy provisions will control; therefore, it is important that you READ YOUR POLICY CAREFULLY.

OPTIONAL RIDER BENEFITS

These riders are optional and have an additional cost.

Intensive Care Unit Rider

Forms ICR97, ICR97OK and ICR02, (including state variations)
(This rider is not available in AL, AR, ID, MD, MT, NC, SC, TN, and WY)

Available from ages 18-64

Pays a daily benefit of $300 or $600 for a maximum of 45 days during any one hospitalization when confined to a Hospital Intensive Care Unit for injury or sickness.

Cancer Screening Benefit Rider

Forms CSB98 and CSB02, (including state variations)
(This rider is not available in AL, ID, MD, MT, NV and WY)

Available from ages 18-64

At your option, we can provide coverage for screening tests. Since the 5-year relative survival rate for all Cancers combined is 63% (rates varying greatly by cancer type and stage at diagnosis)*, it's important to use this benefit for annual tests. We'll pay a maximum benefit amount of $50 per calendar year for each Covered Person. That means even if you are never diagnosed with Cancer, you may collect on the screening benefit of the rider!

Covered tests include:

- CA125 Ovarian Cancer
- Serum Protein Electrophoresis
- Colonoscopy
- Flexible Sigmoidoscopy
- PSA Prostate Cancer
- Chest X-Ray
- Pap Smear (test only)
- Hemoccult Stool Specimen
- Mammography

Benefits and riders may vary by state and may not be available in all states.

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Cancer First Occurrence product at **disclosure.manhattanlife.com**. Please review this information before applying for coverage. The amounts of benefits provided depend on the plan selected. Premiums will vary according to the selection made.

The cited facts represent the U.S. population, are for information only and do not imply coverage under the policy or endorsement of the company or the policy by the American Cancer Society.

Policy Form Numbers: FOB98 (including state variations), FOB98LA, FOB98TX, and FOB02, FOB02-ID (including state variations)

Underwritten by: ManhattanLife Assurance Company of America
10777 Northwest Freeway, Houston, Texas 77092
800-669-9030

RATES FOR PLANS A - D

Premiums must be calculated on the basis of mode of payment selected.

Plan A Bankdraft	Individual	1 Parent Family	2 Parent Family
Ages 18 - 44	$23.47	$25.74	$37.45
Ages 45 - 54	$29.88	$32.15	$47.39
Ages 55 - 64	$40.83	$43.25	$64.19
Ages 65 - 69*	$44.44	$44.44	$66.66

Plan A Payroll	Individual	1 Parent Family	2 Parent Family
Ages 18 - 64	$21.30	$23.57	$34.17

Plan B Bankdraft	Individual		1 Parent Family		2 Parent Family	
	$50.00	$100.00	$50.00	$100.00	$50.00	$100.00
Ages 18 - 44	$33.71	$37.01	$37.12	$40.72	$53.91	$59.17
Ages 45 - 54	$42.92	$46.22	$46.33	$49.93	$68.54	$73.80
Ages 55 - 64	$58.95	$62.25	$62.73	$66.33	$93.52	$98.78
Ages 65 - 69*	$61.16	$67.76	$61.16	$67.76	$91.74	$101.64

Plan B Payroll	Individual		1 Parent Family		2 Parent Family	
	$50.00	$100.00	$50.00	$100.00	$50.00	$100.00
Ages 18 - 64	$30.55	$33.55	$33.96	$37.26	$49.11	$53.91

Plan C Bankdraft	Individual	1 Parent Family	2 Parent Family
Ages 18 - 44	$52.67	$58.14	$84.40
Ages 45 - 54	$66.18	$71.65	$106.25
Ages 55 - 64	$90.03	$96.25	$143.93
Ages 65 - 69*	$92.84	$92.84	$139.26

Plan C Payroll	Individual	1 Parent Family	2 Parent Family
Ages 18 - 64	$47.70	$53.17	$76.77

Plan D Bankdraft	Individual	1 Parent Family	2 Parent Family
Ages 18 - 44	$46.82	$52.44	$75.62
Ages 45 - 54	$58.78	$64.40	$96.80
Ages 55 - 64	$81.38	$88.50	$134.46
Ages 65 - 69*	$68.64	$68.64	$102.96

Plan D Payroll	Individual	1 Parent Family	2 Parent Family
Ages 18 - 64	$42.20	$47.82	$68.42

First Occurrence Benefit Rates

ManhattanLife.
Standing By You. Since 1850.

Rates are for
LA, OK, TN, TX

PAYROLL PREMIUM SCHEDULE (Ages 18-64 - Age Last Birthday)

Not available to individuals who have previously been diagnosed with cancer (other than skin cancer). Employee Age Determines Premium Unless Employee Is Not Insured. Eligibility for Coverage is Determined by Each Adult Age.

MONTHLY PAYROLL PREMIUMS

BENEFIT	ISSUE AGES	INDIVIDUAL	FAMILY 1 PARENT	FAMILY 2 PARENT
$5,000 2 Units	18-64	$6.07	$6.67	$10.08
$10,000 4 Units	18-64	$12.14	$13.35	$20.16
$20,000 8 Units	18-64	$24.28	$26.70	$40.32
$30,000 12 Units	18-64	$36.42	$40.05	$60.48
$40,000 16 Units	18-64	$48.56	$53.40	$80.64
$50,000 20 Units	18-64	$60.70	$66.75	$100.80

OPTIONAL RIDERS AND PREMIUMS

CANCER SCREENING BENEFIT (Available Ages 18-64) FORM CSB98

MONTHLY PAYROLL PREMIUMS

ISSUE AGES	INDIVIDUAL	FAMILY 1 PARENT	FAMILY 2 PARENT
18-64	$1.75	$1.75	$3.50

INTENSIVE CARE UNIT RIDER (available Ages 18-64) FORM ICR97

300/DAY MONTHLY PAYROLL PREMIUMS

ISSUE AGES	INDIVIDUAL	FAMILY 1 PARENT	FAMILY 2 PARENT
18-64	$3.30	$4.05	$6.60

600/DAY MONTHLY PAYROLL PREMIUMS

ISSUE AGES	INDIVIDUAL	FAMILY 1 PARENT	FAMILY 2 PARENT
18-64	$6.60	$8.10	$13.20

ManhattanLife.

ManhattanLife Assurance Company of America

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 ❑ Agent ❑ Insured ❑ Employer

Billing Method ❑ Monthly Bank Draft ❑ Direct Bill ❑ Listbill	Billing Mode ❑ Monthly (Bank Draft Only) ❑ Quarterly ❑ Semi-Annual ❑ Annual

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

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
CANCER (CP4000)	❑ **Cancer Plan** Plan: ❑ A ❑ B ❑ C ❑ D Plan B only - Cancer Screening Benefit: ❑ $50 ❑ $100 ❑ Individual ❑ One Parent ❑ Two Parent	$ _____
	Optional Rider(s): ❑ Critical Care Rider ❑ ICU Rider ❑ First Occurrence Rider	$ _____
FOB (FOB)	❑ **FOB Policy** Amount $ _____ ❑ Individual ❑ One Parent ❑ Two Parent	
	Optional Rider: ❑ Cancer Screening Rider	$ _____

COVERAGE 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
5. 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- 5 in the space provided below:

_____

_____

CANCER/FOB

1. Has any person to be covered under the terms of this policy now have or ever had cancer in any form including carcinoma in situ? ☐ 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 and belief, in the past 10 years has any person to be covered under the terms of this policy had cancer or treated for cancer in any form including carcinoma in situ? ☐ 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 and belief, has any person to be insured ever had a history of melanoma, 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 and belief, within the last 12 months, has any person to be insured had an elevated or rising prostate specific antigen (PSA) or carcinoembryonic antigen (CEA) tests; abnormal mammogram, pap smear radiological exam, biopsy or scope procedure; or, received treatment, including those during course of routine checkups, where the results were other than normal or still pending? ☐ Yes ☐ No
   If **YES,** then list the name(s) of the person(s) to be excluded from coverage: _____
5. I hereby represent that to the best of my knowledge, information and belief, no person to be insured under this policy is now or has ever been diagnosed or treated 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, and 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:** Has any person to be insured ever received medical care for or been diagnosed with heart disease, heart surgery, any abnormalities of the heart, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery, or been diagnosed or treated with high blood pressure unless controlled by diet and/or medication for at least one year? ☐ Yes ☐ No
   If **YES,** then list the name(s) of the person(s) to be excluded from coverage: _____
   _____

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, Inc.

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 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.

(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"? ..... ☐ Yes ☐ No
   b. Completed replacements forms, if required in your state? ..... ☐ Yes ☐ No
   c. Have you complied with state regulations on disclosure? ..... ☐ Yes ☐ 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

Printed Agent Name | Agent Phone No. | Agent #% | Agent #%

Remarks or special requests:

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.

PAYMENT OPTIONS AUTHORIZATION

☐ **Monthly Payroll Deduction (Listbill)**

Assigned list bill number, if known: _____

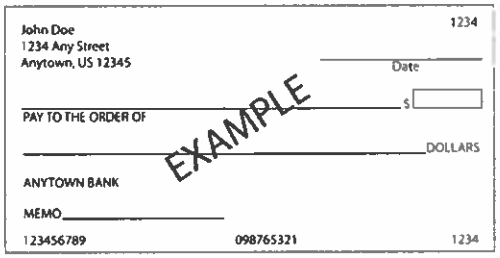
I hereby authorize _____ (Name of Employer) to deduct from my salary and pay to ManhattanLife Assurance Company of America the monthly deposits as set forth below.

Beginning with the month of _____, 20 _____

deduct $ _____ each month.

Signature of Employee _____

Date _____



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 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.

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. 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 address below. 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 below.

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. (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 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.

To obtain further information contact:
ManhattanLife Assurance Company of America, Administrative Office: 10777 Northwest Freeway, Houston, Texas 77092