○ New Application
○ Reinstatement
○ Benefit Increase

ManhattanLife Assurance Company of America

Administrative Office: 10777 Northwest Freeway, Houston, TX 77092

Requested Effective Date:_____ Group No. **WA0002565**

APPLICANT'S INFORMATION

Applicant Name (Last, First, Middle Initial)	Date of Birth	Height (Ft.)	Weight (Lbs.)	Gender (M or F)
Street Address (Street, City, State, ZIP Code)				
Telephone Numbers (Home, Work and Cell)			Email Address	
Social Security Number	Primary Employer HOOD COUNTY		Type of Business	
Current Occupation – Describe and give exact duties				
Occupation/Classification		Monthly Income		
Insured's Beneficiary/Relationship		Spouse's Beneficiary/Relationship		

DEPENDENT'S INFORMATION

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

COVERAGE APPLIED FOR

ACCIDENT EXPENSE POLICY

Type of Policy: ○ 24 Hour ○ Off the Job
Benefit Amount: ○ 1.0 Units ○ 2.0 Units

Coverage:
○ Individual ○ Individual/Spouse
○ Single Parent ○ Family

Disability Rider:

Accident Only	○ Yes	○ No
Elimination Period	○ 14 days	○ 30 days
Duration:	○ 6 mos.	○ 12 mos.
Monthly Benefit Amt.	○ $1000	○ $2000

Wellness Rider:
○ Yes
○ No

Premiums:
$ _____ Base Policy
$ _____ Disability Rider
$ _____ Wellness Rider
$ _____ Total

ACCIDENT EXPENSE QUESTIONS

1. Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, motorcycling, mountain climbing, scuba diving or intend to do so? ☐ Yes ☐ No
2. Is any person to be insured a member/participant in a semi-professional or professional sport? ☐ Yes ☐ No
3. Have you had a driver's license suspended or revoked within the past 3 years? ☐ Yes ☐ No
4. Have you had a DWI or DUI within the past 3 years? ☐ Yes ☐ No
5. Is any person to be insured currently under treatment or has any person to be insured been under treatment for drug or alcohol abuse in the past 3 years? ☐ Yes ☐ No
6. Will the insurance applied for replace or change any existing insurance? ☐ Yes ☐ No
   If "Yes," give name of company and type of insurance:_____
7. Do all members to be insured reside in the home of the applicant? If "No," provide details below ☐ Yes ☐ No
8. Are all applicants citizens of the U.S.? If "No," provide details below ☐ Yes ☐ No

Provide additional information in the space provided below:

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., 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.

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.

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.

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

_____	_____
(Signature of Proposed Insured)	(Signature of Applicant, if other than Proposed Insured)
_____	_____
Signed At (City/State)	Dated (Day/Month/Year)

AUTHORIZED REPRESENTATIVE'S STATEMENT AND CERTIFICATION

1. Does the applicant have existing health coverage? . . . . . ☐ Yes ☐ No
2. To the best of your knowledge, will the insurance applied for replace existing insurance contract or policy in any company(s)?. . . . . ☐ Yes ☐ No
3. 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
420613A			
Paul A. Crider	(817) 735-8304 Ext. 102		
Printed Agent Name	Agent Phone No.	Agent #/%	Agent #/%

REMARKS OR SPECIAL REQUESTS: _____

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 understand that I may contact the Company's Customer Service Department or login to the Company's Policyholder Center to: (i) obtain paper communications regarding my policy, (ii) update my contact information, or (iii) withdraw this consent . I understand that withdrawing such consent could delay transactions with the Company and that withdraw of my consent to receive electronic communications with the Company will be effective only after the Company has had reasonable amount of time to process my withdrawal. 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)

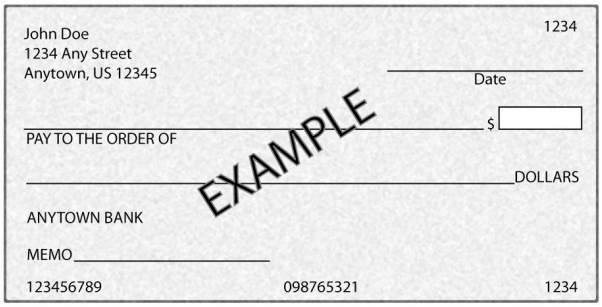
Assigned list bill number, if known:_____

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.

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: _____

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 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. However, in certain situations, we may disclose some of this information about you to third parties having a business interest in an insurance transaction involving you, or having a contract with us to perform part of our insurance function. 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. 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, Inc., 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.

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