ManhattanLife
Standing By You Since 1850

ManhattanLife Insurance and Annuity Company

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 ❑ E ❑ F 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? .....
   If **YES,** then list the name(s) of the person(s) that will not be issued FOB coverage: _____ ❑ Yes ❑ No
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 MahattanLife 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 MahattanLife Insurance and Annuity Company, 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 MahattanLife Insurance and Annuity Company. Do not make the check payable to the agent or leave the payee blank.