ManhattanLife Assurance Company of America

Home Office: Little Rock, AR
Administrative Office: [10777 Northwest Freeway, Houston, TX 77092]
[(800) 669-9030]

Enrollment Type:
- ❑ New Enrollment
- ❑ Reinstatement
- ❑ Policy Change

EMPLOYEE INDIVIDUAL ENROLLMENT FORM

Effective Date:

[Employee/Individual] Name/Owner (First, MI, Last)	S.S.N./ ID Number	Gender	Date of Birth
Street Address	City	State	Zip
Email address		Daytime Phone ( )	
Employer/Plan Sponsor	Job Class/Occupation	Date of Hire	
Location		Hours Worked/Week	
Spouse's Name (if coverage is requested)	Spouse's Gender	Spouse's Date of Birth	

	Employee	Spouse
Annual Salary $:		
Are you actively at work?	❑ **YES** ❑ **NO**	
[If applying for spouse coverage: Is your spouse actively at work? If "No," is your spouse able to work full time?		❑ **YES** ❑ **NO** ❑ **YES** ❑ **NO**]
Have you [or your spouse] used tobacco products in the last 12 months?	❑ **YES** ❑ **NO**	❑ **YES** ❑ **NO**

Eligible children for whom you are proposing coverage (from Youngest to Oldest):

Name	Gender	Date of Birth	Name	Gender	Date of Birth
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Plan Selections:

[Accident

❑ Accident Benefit Level: ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Custom

Coverage type: ❑ Employee / Individual only ❑ Employee / Individual and spouse
❑ Employee / Individual and child(ren) ❑ Family

Total Premium $_____ **]**

[Critical Illness

❑ Critical Illness

[Optional Benefit(s): ❑ Health screening ❑ Automatic Benefit Increase]

Coverage type: ❑ Employee / Individual only ❑ Employee / Individual and spouse
❑ Employee / Individual and child(ren) ❑ Family

Employee Benefit Amount: $_____ **Total Premium** $_____ **]**

[Hospital Indemnity

❑ Hospital Indemnity

Coverage type: ❑ Employee / Individual only ❑ Employee / Individual and spouse
❑ Employee / Individual and child(ren) ❑ Family

Total Premium $_____ **]**

[Group Term Life

❑ Level Term Life Base Plan: ❑ 10 Year Term ❑ 20 Year Term

Employee / Individual Benefit Amount $_____

Spouse Benefit Amount $_____

Child(ren) Benefit Amount $_____

Beneficiary: ❑ 100% to Spouse ❑ Other (Name and Relationship) _____

Total Premium $_____ **]**

[Disability Income Plus

❑ Disability Income

Base Benefit Period: ❑ 3 Month ❑ 6 Month ❑ 1 Year ❑ 2 Year ❑ 3 Year

Base Elimination Period: ❑ 0/7 ❑ 7/7 ❑ 0/14 ❑ 14/14 ❑ 30/30 ❑ 60/60 ❑ 90/90 ❑ 180/180 ❑ 365/365

Monthly Benefit Amount $_____

Total Premium $_____]

Contingent Guarantee Issue Underwriting Questions				
		Employee	**Spouse**	**Children**
1. [All except accident	Has any proposed insured ever been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?	❑ **YES** ❑ **NO**	❑ **YES** ❑ **NO**	❑ **YES** ❑ **NO**]
2. [All except accident	In the past 12 months, have you missed 5 or more consecutive days of work or been unable to perform your normal activities due to an injury or illness other than as a result of a cold, the flu, back problems, strained/sprained/fractured/broken limb, or as a result of pregnancy?	❑ **YES** ❑ **NO**	❑ **YES** ❑ **NO**	❑ **YES** ❑ **NO**]
3. [All except accident	[Height/Weight]	Height (ft./in.)	Weight	
Simplified Issue Underwriting: Answer all questions including for Employee, Spouse, and child(ren)				
4. [All except accident	Has any proposed insured been advised by a member of the medical profession to have any diagnostic test, hospitalization, or surgery that has not been completed within the past 5 years?	❑**YES** ❑**NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]
5. [Critical Illness	In the past 5 years has any proposed insured been diagnosed, sought treatment, taken medication or been hospitalized for any of the following: heart disease, including angina; heart attack; congestive heart failure; heart bypass; cerebrovascular disease, including transient ischemic attack (TIA); stroke (blockages or hemorrhage); diabetes, blood pressure readings above the normal range which have not been controlled with medication, drug abuse, or alcohol abuse; disease of the liver, kidney, or digestive system; disease or disorder of the lung; diseases of the nervous system, including Parkinson's Disease, multiple sclerosis, and cerebral palsy; or any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?	❑ **YES** ❑ **NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]
6. [Critical Illness	In the past 5 years has any proposed Insured been diagnosed, sought treatment, taken medication or been hospitalized for any of the following: Cancer, including melanoma; leukemia; and, malignant tumors?	❑ **YES** ❑ **NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]

7. [Critical Illness	To the best of your knowledge and belief, have any 2 natural parents or natural siblings (sisters or brothers) been diagnosed with the same disease before age 60 based on the following list: heart attack, heart disease or stroke, cancer, kidney disease or diabetes?	❑ **YES** ❑ **NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]
8. [Group Term Life & Hospital Indemnity	In the past 5 years has any proposed Insured been diagnosed with, sought treatment, taken medication or been hospitalized for any of the following: heart attack/heart surgery/heart disease; stroke/transient ischemic attack (TIA); cancer (except basal skin cancer); liver disease/hepatitis/cirrhosis; end stage renal/kidney disease; neurological disorder/multiple sclerosis; now taking 3 or more medications for high blood pressure; emphysema/lung disease; lupus; blood disorder; epilepsy; alcohol and/or drug abuse; diabetes (insulin dependent)?	❑ **YES** ❑ **NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]
9. [Group Term Life & Hospital Indemnity	If your employer or group has elected tier 3 critical illness benefit, does anyone on this application have a parent, brother, or sister with a history of heart attack, heart disease, stroke, or cancer diagnosis prior to age 60?	❑ **YES** ❑ **NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]
10. [Hospital Indemnity	If your employer or group has elected tier 2 critical illness benefit, can you perform your activities of daily living (ADL's) without need of assistance? ADL's include: bathing, transferring, feeding, dressing and bowel/bladder/toileting?	❑ **YES** ❑ **NO**	❑**YES** ❑**NO**	❑**YES** ❑**NO**]
11. [Disability	In the past 5 years have you received medical advice, sought treatment or taken medication for any of the following: heart attack, heart surgery, heart disease now taking 3 or more medications for high blood pressure, stroke, transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, muscle, back, joint disorders, diabetes, emphysema, lung disease, liver disease, hepatitis, cirrhosis, neurological disorder, multiple sclerosis, chronic fatigue syndrome, fibromyalgia, digestive/intestinal disease, alcohol or drug usage, diabetes or cirrhosis?	❑**YES** ❑**NO**]		
If you answered, "Yes" to any question for Child Coverage, indicate name(s) of Child/Children:				

Waiver (refusal of coverage)

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer / group. I proclaim that I was not pressured or forced by my employer / group, the writing agent, or ManhattanLife Assurance Company of America into waiving (declining) coverage. If I have waived any coverage offered to me or my dependents, my signature below is evidence of this action.

I hereby waive coverage for (check all that apply):
Waive Coverage for Workplace Voluntary Benefits:

[Accident ❑ No ❑ Yes] [Level Term Life ❑ No ❑ Yes]
[Critical Illness ❑ No ❑ Yes] [Disability Income ❑ No ❑ Yes]
[Hospital Indemnity ❑ No ❑ Yes]

True and complete acknowledgment

I understand, agree, and represent:

- I have read the Employee Individual Enrollment Form or it has been read to me and answers provided are true and complete to the best of my knowledge and belief.
- Neither my employer / group nor the agent can waive any question, determine coverage or insurability, alter any contract or waive any of ManhattanLife Assurance Company of America's other rights and requirements.
- If the Employee Individual Enrollment Form for coverage is accepted, coverage will be effective on the date specified by ManhattanLife Assurance Company of America on the policy or certificate.
- If I have a new dependent as a result of a qualifying event, I may in the future be able to enroll myself or my

dependents provided I request enrollment within 31 days after the qualifying event.
- If any deductions are required for this coverage, I authorize those deductions from my earnings.
- If I am applying for coverage for my dependents (including my spouse), I attest by my signature below, I have gathered the necessary health information from my dependents in order to fully and truthfully complete the Employee Individual Enrollment Form.
- -I hereby authorize ManhattanLife Assurance Company of America to decrease or increase the premium or rate amount stated on the Employee Individual Enrollment Form to cover the benefit actually issued.
- Intentional fraud or intentional misrepresentation of a material fact may void, reduce or increase past premium, or terminate an individual's coverage or group's coverage.
- 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.
- Rates or premium quoted and the effective date requested are not guaranteed. The final rate or premium and effective date will be determined upon underwriting review and approval of the Employee Individual Enrollment Form by ManhattanLife Assurance Company of America.

If you decide not to sign this agreement, we will decline to enroll you in an insurance product or to give you insurance benefits.

Authorization

My dependents and I understand and agree:
- The information obtained by use of this authorization may be used by ManhattanLife Assurance Company of America to make claims determinations, determine eligibility for coverage, or eligibility for benefits under an existing policy and plan administration.
- Any information obtained will not be released by ManhattanLife Assurance Company of America to any person or organization except to reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing health care operations or business or legal services in connection with the Employee Individual Enrollment Form, claim or as may be otherwise lawfully required, or as I (we) may further authorize.
- This authorization shall be valid for twenty-four (24) months from the date shown below and I have the right to revoke this authorization at any time by writing to ManhattanLife Assurance Company of America Administrative Office.

The Employee Individual Enrollment Form, together with any supplemental forms, will make up part of any contract and be the basis for or certificate.

Signature - Please sign below if enrolling or waiving any group coverage

Employee / Individual or legal representative signature _____

Date ___/___/_____

Agent / Producer Information

This section to be completed by Agent or Producer.

1. Agent / Agency of Record:	**2. Agent / Agency of Record:**
Name (print)	Name (print)
ManhattanLife Assurance Company of America Agent #	ManhattanLife Assurance Company of America Agent #
Commission split:	Commission split:
1. Writing Agent / Producer:	**2. Writing Agent / Producer:**
Name (print)	Name (print)
ManhattanLife Assurance Company of America Agent #	ManhattanLife Assurance Company of America Agent #
Commission split:	Commission split:

Will the coverage selected replace or change any existing life or disability insurance policy(s) and/or annuity(s)?

❑ **Yes** ❑ **No**

As the Writing Agent / Producer, I acknowledge that I am responsible to meet with the primary applicant submitting the Employee Individual Enrollment Form in order to fully and accurately represent the terms and conditions of the plans and services of the offering or insuring entity, or one of its subsidiaries. These provisions are available to me and the primary applicant in the benefit summary document or other plan literature.

Signed at _____ _____
City State

Writing Agent's Signature_____ Date___/___/_____