Application For Individual Life Insurance

ManhattanLife Assurance Company of America

ManhattanLife™
Standing By You. Since 1850.

Section A: Always complete this Section with Employee Information for all coverages.

Employee / Owner

Name of Employee/Owner (First Name, MI, Last Name - Please Print) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender: ❍ Male ❍ Female

Address

City State Zip Code Date of Employment (MM/DD/YYYY) / /

Employer Name and Location

Occupation (Exact duties and job title)

Gross Earnings (not including variable compensation)
$, . Per ❍ Hour ❍ Month ❍ Week ❍ Year

Benefit Group (If Applicable) ❍ 1 ❍ 2 ❍ 3 ❍ 4 ❍ 5

1. Are you currently actively at work? ❍ Yes ❍ No
2. Have you used any form of tobacco in the past 12 months? ❍ Yes ❍ No

Spouse

Spouse Name (First Name, MI, Last Name - Please Print) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender: ❍ Male ❍ Female

3. Has your spouse used any form of tobacco in the past 12 months? ❍ Yes ❍ No
   A. Is your spouse actively at work? ❍ Yes ❍ No
   B. If "No" is your spouse able to work full time? ❍ Yes ❍ No

Child One

Child Name (First Name, MI, Last Name - Please Print) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender: ❍ Male ❍ Female

Child Two

Child Name (First Name, MI, Last Name - Please Print) Suffix

Birthdate (MM/DD/YYYY) / / Social Security Number - - Gender: ❍ Male ❍ Female

M-1622 0719

Child Three

Child Name (First Name, MI, Last Name - Please Print) | Suffix

Birthdate (MM/DD/YYYY) / / | Social Security Number - - | Gender: ❍ Male ❍ Female

Section B: Complete this Section if applying for Employee Coverage.

❍ Life Paid Up at 99 - Employee Coverage

❍ Automatic Benefit Increase Rider ❍ $1/Week ❍ $2/Week
❍ Accidental Death, Dismemberment and Loss of Sight Rider
❍ Loss of Work Rider
❍ Waiver of Premium Rider
❍ Automatic Premium Loan Option

Beneficiary:
❍ 100% to my Spouse, as recorded on Page 1 of this Application
❍ Other (List Name and relationship): _____
_____

Employee Benefit Amount $, Total Modal Premium $.
❍ Level Term to Age 65 Rider - Benefit Amount: $,
❍ Family Term Rider
Spouse Benefit Amount $,
Child Benefit Amount $,

❍ Life Paid Up at 65 - Employee Coverage

❍ Automatic Benefit Increase Rider ❍ $1/Week ❍ $2/Week
❍ Accidental Death, Dismemberment and Loss of Sight Rider
❍ Loss of Work Rider
❍ Waiver of Premium Rider
❍ Automatic Premium Loan Option

Beneficiary:
❍ 100% to my Spouse, as recorded on Page 1 of this Application
❍ Other (List Name and relationship): _____
_____

Employee Benefit Amount $, Total Modal Premium $.
❍ Level Term to Age 65 Rider - Benefit Amount: $,
❍ Family Term Rider
Spouse Benefit Amount $,
Child Benefit Amount $,

Section C: Complete this Section if applying for Spouse and/or Child(ren) Stand Alone Policy.

Spouse Stand Alone Policy - Select coverage desired:

❍ **Life Paid up at 99** ❍ **Life Paid up at 65**
❍ Automatic Premium Loan Option
❍ Accidental Death, Dismemberment and Loss of Sight Rider

Beneficiary:
❍ 100% to the Employee, as recorded on Page 1 of this Application
❍ Other (List Name and relationship): _____
_____

Spouse Benefit Amount $, Total Modal Premium $.
❍ Family Term Rider (Child Coverage Only) $,
Child Benefit Amount $,

Section C: Complete this Section if applying for Spouse and/or Child(ren) Stand Alone Policy.

Life Paid up at 65 Child(ren) Stand Alone Policy - Select all coverages desired:

❍ **Coverage on Child 1** ❍ Automatic Premium Loan Option

Child 1 Benefit Amount: $ ___,___

Child 1 Total Modal Premium $ ___.__

Beneficiary:

❍ 100% to the Employee, as recorded on Page 1 of this Application

❍ Other (List Name and relationship): _____

❍ **Coverage on Child 2** ❍ Automatic Premium Loan Option

Child 2 Benefit Amount: $ ___,___

Child 2 Total Modal Premium $ ___.__

Beneficiary:

❍ 100% to the Employee, as recorded on Page 1 of this Application

❍ Other (List Name and relationship): _____

❍ **Coverage on Child 3** ❍ Automatic Premium Loan Option

Child 3 Benefit Amount: $ ___,___

Child 3 Total Modal Premium $ ___.__

Beneficiary:

❍ 100% to the Employee, as recorded on Page 1 of this Application

❍ Other (List Name and relationship): _____

Section D: Complete this Section if applying for Contingent Guarantee Issue.

Section E: Complete this Section and Section D If applying for Simplified Issue. Complete question 8 if applying for coverage on Child(ren).

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
4. 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)?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
5. In the past 12 months, has any proposed Insured been disabled, hospitalized, treated in an emergency room, and if employed, missed 5 or more consecutive days of work due to an injury or illness other than cold, flu, back problem, strained / sprained / fractured / broken limb, or maternity?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
6. 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; High Blood Pressure reading (140/90 or above); Emphysema / Lung Disease; Lupus; Blood Disorder; Epilepsy; Alcohol and / or Drug Abuse; Diabetes (Insulin Dependent)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
7. 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 3 years?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
8. Has any child proposed for coverage ever been diagnosed with or treated for Congenital Cardiac Abnormality or other abnormalities, Spina Bifida, Down's Syndrome, Cerebral Palsy, or Cystic Fibrosis?					❍	❍	❍	❍	❍	❍

Section F: Conditional Amendments to the Application

If any changes are made in the amount of coverage or in the premium amount, an endorsement will be attached to the Policy.

9. I hereby authorize ManhattanLife Assurance Company of America to issue a lesser benefit amount of coverage if I am not eligible for the dollar amount applied for . . . . . ❍ Yes ❍ No

10. If coverage is not issued as initially applied for, I hereby authorize ManhattanLife Assurance Company of America to decrease or increase the premium amount stated on this Application to cover the benefit actually issued . . . . . ❍ Yes ❍ No

NOTE: None of the above conditional amendments create any additional obligation by ManhattanLife Assurance Company of America to issue coverage to the Proposed Insured.

11. a. Do you have existing life insurance policies or annuity contracts? . . . . . ❍ Yes ❍ No
If "Yes," complete and submit replacement form.

b. Will any of the policies applied for replace any coverage currently in force? . . . . . ❍ Yes ❍ No
If "Yes," please complete the following information and submit the required replacement forms(s):

Person Covered	Type of Coverage	Company

AGREEMENTS

It is agreed that (a) the statements and answers given in this Application are representations and not warranties, (b) this Application and any Home Office Amendments attached will be the basis of any insurance issued, (c) no insurance producer has the authority to alter any contract for ManhattanLife Assurance Company of America, and (d) no insurance shall take effect until this Application is approved by ManhattanLife Assurance Company of America.

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

I have read, or had read to me, all the questions on this Application, and I represent the answers given are correct and complete to the best of my knowledge and belief. I also realize that any false statement or misrepresentation may result in loss of coverage under the Policy subject to the time limit on certain defenses or incontestability provisions of the Policy. I acknowledge, if required in my state, that I have been furnished:

❍ Life Insurance Buyer's Guide ❍ Accelerated Life Benefits Summary and Disclosure Statement

Signed at _____ City ☐☐ State

_____ Signature of Employee/Owner

☐☐ / ☐☐ / ☐☐☐☐ Date (MM/DD/YYYY)

INSURANCE PRODUCER CERTIFICATION: I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief. If checked above and required in my state, I furnished a Life Insurance Buyer's Guide to the proposed Insured, and/or the Accelerated Life Benefits Summary and Disclosure Statement.

Does the applicant have any existing life insurance policies or annuity contracts? . . . . . ❍ Yes ❍ No
Will this policy replace any life coverage currently in force? . . . . . ❍ Yes ❍ No

_____ Signature of Licensed Insurance Producer

_____ Printed Name of Licensed Insurance Producer / License ID Number

1. Insurance Producer Number ☐☐☐☐☐☐ % Credit ☐☐☐

2. Insurance Producer Number ☐☐☐☐☐☐ % Credit ☐☐☐

3. Insurance Producer Number ☐☐☐☐☐☐ % Credit ☐☐☐

4. Insurance Producer Number ☐☐☐☐☐☐ % Credit ☐☐☐

5. Insurance Producer Number ☐☐☐☐☐☐ % Credit ☐☐☐

6. Insurance Producer Number ☐☐☐☐☐☐ % Credit ☐☐☐