"Diversified Insurance and Financial Services Since 1978"

CUL FirstChoice
APPLICATION CHECKLIST
For MICHIGAN

:: PLEASE NOTE ::
An appointment with Family Life Insurance Company is required for Michigan sales. Please contact your up line BEFORE completing this application to ensure you have completed this appointment.

Please complete this page and the application in its entirety and fax/mail/email to BMC Agency.

AGENT ____ DATE ___________________

PROPOSED INSURED____

PLAN SELECTED____________________________ MONTHLY PREMIUM_______________

EFFECTIVE DATE_____________________ AGENT PHONE____________________________

BMC FAX : 843.763.1602 ATTN Hillary Hatcher

BMC EMAIL : hillaryh@bmcagency.com

BMC Agency Inc.
ATTN Hillary Hatcher
1529 Sam Rittenberg Blvd. Ste. 200
Charleston, SC 29407

FAMILYLIFE INSURANCE COMPANY **Application for Insurance**

[10700 Northwest Freeway, Houston, Texas 77092]

FRAUD: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

☐ Check if replacing or changing existing coverage in this company. **Policy Number** ______________________

PERSONS PROPOSED FOR INSURANCE									
Last Name	First	Middle	Relationship	Birthdate	Sex	Height	Weight	Social Security Number
			Primary Insured	/ /				
			Spouse	/ /				
			Child	/ /				
			Child	/ /				
			Child	/ /				

Address	City	State	Zip	Home Telephone ( )
Secondary Address	City	State	Zip	Home Telephone ( )

Payor or Owner if other than Primary Insured	☐ Payor ☐ Owner	Social Security No. - -	Relationship to Primary Insured
Employer	Date Employed	Occupation	

Hours Worked/Week	Monthly Income $	Group Number	Employee/Payroll Number
Beneficiary (Estate of Primary Insured unless beneficiary named)		Age	Relationship

FOR THE PAST 30 DAYS: Have all proposed Insureds been performing normal activities and been actively at work full time at their regular occupation? ______ Yes _______ No. If "No", explain: ______________________________

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? ______ Yes ______ No.
If "Yes", complete replacement form where required.

INSURANCE PLANS									Monthly Premium
HOSPITAL		Base Policy	AD & D Rider	Emergency Acc. Rider	Hospital Injury Rider	ICU Rider	Lump Sum Rider	Outpatient Sick.Rider	
☐ 0/0	180 Primary Ins.	$ ________	$ ________	$ ________	$ ________	$ ________	$ ________	$ ________	
☐ 0/0	365 Spouse	$ ________	$ ________	$ ________	$ ________	$ ________	$ ________	$ ________	
☐ 0/3	365 Children	$ ________	$ ________	$ ________	$ ________	$ ________	$ ________	$ ________	
		Private Nurse Rider	Surgical Rider	Surgical + Rider	Spec. Injury Rider	1st Hospital Conf. Rider	________	________	
Primary Insured		$ ________	$ ________	$ ________	☐	☐	$ ________	$ ________	
Spouse		$ ________	$ ________	$ ________	☐	☐	$ ________	$ ________	
Children		$ ________	$ ________	$ ________	☐	☐	$ ________	$ ________	$ _______

If Guaranteed Issues requirements are met, medical underwriting will be waived.

1. **HAS ANY PROPOSED INSURED:** Ever been treated for or been told by a member of the medical profession that he/she had Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? _____ Yes _____No
2. **HAS ANY PROPOSED INSURED:** Consulted a Physician, received medical treatment of any kind, or been hospitalized or confined during the past 4 years? _____ Yes _____ No
3. **IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? _____ Yes _____ No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.

Details of "Yes" answers in 1 or 2 above. Attach additional sheet if necessary.

Question No.	Name	Date	Type of Injury/Illness	Doctor/Hospital & Address	Fully Recovered?	Medication Taken

Authorization to Obtain and Release Information: I hereby AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Family Life Insurance Company, its reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of Family Life's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

AGENT'S STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ☐ is ☐ is not involved at this time.

Signed at ______________________ this ____________ day of ____________ 20 ________
City, State

X ______________________ X ______________________ X ______________________

Signature of Primary Insured (Parent if person to be insured is less than 15 years old) | Payor/Owner (if other than Proposed Insured) | Spouse

X ____________ ____________ ____________ ________ % ____________

Signature of Agent | Agent's Name (printed) | Agent No. | % Credit | State ID No.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO FAMILY LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

FL-HPHI-APP-2010

PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct $ ______________________ from my pay according to the deduction mode indicated below, until further notice from me, and remit to Family Life Insurance Company [10700 Northwest Freeway, Houston, Texas 77092].

Premiums will be deducted ☐ Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other Specify ____________

Name ______________________ Date ______________________

Employee's Signature ______________________ Agent's Signature ______________________

BANK DRAFT AUTHORIZATION TO HONOR CHECKS DRAWN BY FAMILY LIFE INSURANCE COMPANY

To ______________________

Your Bank's Address ______________________

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of Family Life Insurance Company of [Houston, Texas] provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Date ______________________ X ______________________

Your signature Exactly as it appears on Bank Records Account No.

To obtain further information, contact
Family Life Insurance Company
[10700 Northwest Freeway, Houston, TX 77092]

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 Home Office at the above address. 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 indicant 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 Home Office at the address on the front of this Notice..

MIB, Inc. Notice

While the information regarding your insurability is treated as confidential, Family Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (781) 751-6000. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

CENTRAL UNITED LIFE
INSURANCE COMPANY

Underwriting Authorization

Name(s) of Proposed Insureds

Applicant's Social Security Number: ____

Applicant: ___________________________________* Spouse: ___________________________________

Dependant: ___________________________________ Dependent: ___________________________________

Dependant: ___________________________________ Dependent: ___________________________________

*If you are requesting coverage as a representative for any minor individual on this application and are not the parent or legal guardian, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Central United Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Central United Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Central United Life Insurance Company, including, but not limited to MIB, Inc. and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Central United Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Central United Life Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Central United Life Insurance Company may refuse to consider my application for enrollment.

SIGNATURES

______________________________	______________________________
Applicant	Spouse
______________________________	______________________________
Dependent	Dependent
______________________________	______________________________
Dependent	Dependent

10700 Northwest Freeway
Houston, TX 77092
Customer Service Department 1-800-669-9030

MANHATTAN
INSURANCE GROUP

PLEASE RETAIN A COPY FOR YOUR RECORDS

THE MANHATTAN LIFE
INSURANCE COMPANY

Underwriting Authorization

Name(s) of Proposed Insureds

Applicant's Social Security Number: ____

Applicant: _____________________________________* Spouse: ____________________________________

Dependant: ___________________________________ Dependent: ____________________________________

Dependant: ___________________________________ Dependent: ____________________________________

*If you are requesting coverage as a representative for any minor individual on this application and are not the parent or legal guardian, you must attach documentary evidence of your authority to act as the individual's representative for this authorization to be valid.

I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Manhattan Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Manhattan Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Manhattan Life Insurance Company, including, but not limited to MIB, Inc. and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Manhattan Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Manhattan Life Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to me and/or my minor children. If I refuse to sign or revoke this authorization, Manhattan Life Insurance Company may refuse to consider my application for enrollment.

SIGNATURES

______________________________	______________________________
Applicant	Spouse
______________________________	______________________________
Dependent	Dependent
______________________________	______________________________
Dependent	Dependent

10700 Northwest Freeway
Houston, TX 77092
Customer Service Department 1-800-669-9030

PLEASE RETAIN A COPY FOR YOUR RECORDS

BMC Consumer Understanding Section

Applicant's Name ______________________________

Applicant's Signature___________________________ **Agent's Name** _________________________

1) The above referenced agent visited with me in reference to making an application for insurance with your company. The soliciting agent explained to me the provisions showing benefits, waiting periods, limitations, and exclusions. I have received an outline of coverage for the policy(s) for which I applied. I understand that I must be working an average of 30 hours per week in order to qualify for **Guaranteed Issue** consideration with any **First*Choice*** plan design.

Applicant's Initials __________

2) I understand that CUL Hospital Indemnity policies are limited benefit policies policies, and the policy(s) I am purchasing have limited outpatient coverage and doctor benefits. I know that this policy(s) will not cover everything, and that I will be responsible for some costs.

Applicant's Initials __________

3) I understand that I will not have insurance coverage with CUL until my application(s) has been approved and the Company has notified me that I have been accepted for coverage with a particular effective date.

Applicant's Initials __________

4) I understand that even though I may be accepted for coverage I may have exclusionary riders for particular pre-existing medical conditions, and that conditions for which I have sought or received treatment or manifest symptoms in the 12 months prior to my application date will not be covered until 12 months after my policy effective date if fully disclosed, and that I should not let any other coverage lapse until I have received and reviewed the FirstChoice individual policy(s) in my name and found them to be suitable for my needs.

Applicant's Initials __________

5) I understand that the **CUL CP4000 Cancer Plan is NOT Guaranteed Issue,** and must be applied for and be underwritten separately from the CUL Hospital Indemnity policy.

Applicant's Initials __________

6) I understand that the **CUL THE PROTECTOR ACCIDENT POLICY Form #AC02-A is NOT Guaranteed Issue,** and must be applied for and be underwritten separately from the CUL Hospital Indemnity policy.

Applicant's Initials __________

7) I represent that I have answered all questions on the application(s) and on this form truthfully and completely, to the best of my knowledge and belief. I have, to the best of my recollection, fully disclosed all health history on myself or any other family members listed on the application(s), and I understand that this agent has no authority to waive or modify any answer to any health question(s).

Applicant's Initials __________

Premium Calculation Worksheet for First*Choice*

Supplemental Health Insurance With **OPTIONAL** Cancer and Accident Coverage

Send PAPER APPLICATIONS to:

Michigan

BMC Agency, Inc., 1529 Sam Rittenberg Blvd. Suite 200, Charleston, SC 29407
PHONE: 800-357-2342 **FAX:** 843-763-1602 **TOLL FREE:** 800-357-2342

I wish to apply for: ☐ Myself ☐ Myself & Spouse ☐ Myself & Children ☐ Family

Plan	Employee	Employee/Sp	Employee/Ch	Family
Platinum	$217.63	$433.51	$353.41	$569.29
Gold	$156.71	$311.67	$255.92	$410.88
Traditional Supp	$72.19	$142.63	$113.93	$184.37
Super Supp	$42.68	$83.61	$66.46	$107.39
+Optional Accident	$13.38	$23.66	$16.62	$23.66
* Optional CANCER	Include the premium from below	Include the premium from below	Include the premium from below	Include the premium from below
TOTAL				

CIRCLE the MONTHLY PREMIUM for the coverage desired and TOTAL below.

Monthly Rates for the CP4000 Cancer and Dread Disease Policy, Plan "A"

Add the selected premium to the *Optional Cancer column above

* CP4000 "A"	Employee	Employee/Spouse	Employee/Children	Family
Age 18-44	$23.47	$37.45	$25.74	$37.45
Age 45-54	$29.88	$47.39	$32.15	$47.39
Age 55-64	$40.83	$64.19	$43.25	$64.19

Subject to Underwriting and a separate application for each, a proposed insured may apply for an additional Cancer Plan and/or Accident Plan. IF APPROVED, the Cancer and/or Accident plan will be issued as a separate policy.
+The Accident rates shown are for the AC02-A THE PROTECTOR Accident Policy. (*based upon the oldest adult age*)
The Cancer rates shown are for the CP4000 "A" Cancer Policy. Please ask to see an outline of coverage for each.

ONLY ONE of the HI plans may be purchased, with or without the optional Cancer or Accident Coverage.

Please attach a check for the first modal premium here. If requesting that the first premium be drafted, please indicate here and on the BANK DRAFT AUTHORIZATION section of the application.

☐ Please draft the initial premium for the application(s) ☐ The initial premium for the applications is attached.

❑ New Application ❑ Change/Policy No. ______________ ❑ Conversion/Policy No. ______________

FAMILY LIFE INSURANCE COMPANY

10700 NORTHWEST FREEWAY, HOUSTON, TEXAS 77092

❑ Group No. ______________

CANCER APPLICATION

Name of Applicant: ______________ (Last) ______________ (First) ______________ (MI) Date of Birth: ______________ Sex: ____

Address of Applicant: ______________ Phone #: (______) ______________

City: ______________ State: ________ Zip: ________ Soc. Sec. # ______________

Height: ________ Weight: ________

Name of Covered Spouse or Dependent	Ht	Wt	DOB	Name of Covered Spouse or Dependent	Ht	Wt	DOB
1.				4.			
2.				5.			
3.				6.			

COVERAGE DESIRED: [❑ FL4000] ❑ ______________

PREMIUM $ ________

OPTIONAL COVERAGE:

❑ Critical Care Rider ________

❑ First Occurrence Benefit Rider $ ________ ________

❑ Intensive Care Rider $ ________ ________

❑ ______________ ________

TOTAL $ ________

PAYMENT METHOD: ❑ Payroll ❑ Non-Payroll

CHECK ONE: ❑ Individual ❑ One Parent Family ❑ Two Parent Family

MODE OF PAYMENT:

❑ Monthly Bankdraft ❑ Annual

❑ 9 - Pay ❑ 24 - Pay ❑ 26 - Pay ❑ 52 - Pay

❑ ______________

Requested Policy Effective Date: ______________

Premium Collected $ ________ Date ______________

Agent's Name

Is the premium under this policy pre-taxed through a Cafeteria Plan?
❑ Yes ❑ No

APPLICANT'S STATEMENTS AND AGREEMENTS:

1. **All Policies:** I am employed by ______________
2. **Cancer Policy:** To the best of my knowledge and belief, no person to be covered under the terms of this policy has now or during the past ten years has had cancer in any form including carcinoma in situ, except ❑ NONE ❑ ______________ ______________ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX.
3. **Cancer Policy:** I have not, nor has any proposed insured, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), except ❑ NONE ❑ ______________ ______________ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX.
4. **Cancer Policy:** 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, except ❑ NONE ❑ (Circle condition and state name) ______________ ______________ who is (are) to be excluded from the dread disease condition circled. CHECK ONE BOX.
5. **Cancer Policy:** I hereby represent that to the best of my knowledge, information and belief, within the last 6 months no person to be insured, has (1) undergone a biopsy, (2) had an elevated PSA (Prostate Specific Antigen) or (3) received medical advice or consultation or had medical tests advised or performed, including those during the course of routine check ups where the results were other than normal or still pending for cancer, except ❑ NONE ❑ ______________ ______________ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX.
6. **Critical 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, list the name(s) of persons: ________ ______________ Those persons will not be issued coverage under this Policy/Rider.

(Please continue on reverse side)

ANSWER QUESTION 7 ONLY IF APPLYING FOR NON PAYROLL COVERAGE:

7. **Critical Care Rider:** Has any parent age 50 or less of any person to be insured died of heart attack or stroke? ❑ Yes ❑ No If Yes, list the name(s) of persons: ____ Those persons will not be issued coverage under this Policy/Rider.

8. **Cancer Policy:** Do you have another cancer, accident and/or intensive care plan you intend on keeping? ❑ Yes ❑ No If Yes, please state the name of the company for the other plan and the type of policy ______________________

9. **Cancer Policy:** Is this insurance intended to replace any other health insurance now in force? ❑ Yes ❑ No If Yes, give name of Company and Policy Number: ______________________

10. **Cancer Policy:** Beneficiary Designation ______________________

11. **Cancer Policy:** Mail policy to: ❑ agent ❑ insured ❑ ______________________

12. **Cancer Policy:** The "effective date" of the policy/riders will be the date recorded on the Policy Schedule by the Home Office. It is not the date the application is signed. When all underwriting requirements have been satisfied, coverage will begin as stated in your policy including any riders and/or endorsements.

13. **Cancer Policy:** I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; and (d) no change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. I represent that no person to be covered under the terms of the policy being applied for is also covered by any Medicaid or similar program. I have read, or had read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief.

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

Signed at City: ______________________ State: ____________ Date: ______________

Applicant's Signature: ______________________ Agent's Signature: ______________________

Agent Number: ______________________

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Family Life Insurance Company of Houston, Texas. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy; or the new policy may also provide for a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on: ______________________ ______________________

Date (Applicant's Signature)

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO FAMILY LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

BANK DRAFT AUTHORIZATION
AUTHORIZATION TO HONOR CHECKS DRAWN BY FAMILY LIFE INSURANCE COMPANY

To: ______________________________

Your Bank's Address: ______________________________

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of Family Life Insurance Company of Houston, Texas, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

______________________ X ______________________________

Date — Your signature Exactly as it appears on Bank Records — Account No.

FL-CEP09

PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct $ ______________ from my pay according to the deduction mode indicated below, until further notice from me, and remit to Family Life Insurance Company, 10700 Northwest Freeway, Houston, TX 77092.

Premiums will be deducted: ❑ Weekly ❑ Bi-Weekly ❑ Monthly ❑ Semi-Monthly ❑ Other Specify______________________

Name ______________________________ Date ______________

Employee's Signature ______________________ Agent's Signature ______________________

FL-CEP09

❑ New Application ❑ Change/Policy No. __________ ❑ Conversion/Policy No. __________

THE MANHATTAN LIFE INSURANCE COMPANY

ADMINISTRATIVE OFFICE: 5 WATERSIDE CROSSING, THIRD FLOOR, WINDSOR, CONNECTICUT 06095

ACCIDENT APPLICATION

❑ Group No. __________

Name of Applicant __________ (Last) (First) (MI) Date of Birth __________ Sex _____

Address of Applicant __________ Phone #: ( ) Area Code __________

City: __________ State: _____ Zip: _____ Soc. Sec. # __________

Height __________ Weight __________ Average Monthly Income __________

Name of Covered Spouse or Dependent	Ht	Wt	DOB	Name of Covered Spouse or Dependent	Ht	Wt	DOB
1.				4.			
2.				5.			
3.				6.			

COVERAGE DESIRED: ❑ ML-AC03-A ❑ ML-AC03-B ❑ __________

PREMIUM $__________

OPTIONAL COVERAGE:

❑ Package __________ $__________ __________

❑ __________ __________

❑ The Disability Income Rider $__________ __________

❑ML-DI90-AC ❑ML-DI180-AC

❑ML-DI90-ACS ❑ML-DI180-ACS TOTAL $ __________

Sickness Elim. Pd. ❑ 7 ❑ 14 ❑ 30

IS THE PREMIUM UNDER THIS POLICY BEING SHELTERED BY A CAFETERIA PLAN? ❑ Yes ❑ No

PAYMENT METHOD: ❑ PAYROLL ❑ NONPAYROLL

CHECK ONE: ❑ Individual ❑ One Parent Family ❑ Two Parent Family

MODE OF PAYMENT:

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

❑ 9-Pay ❑ 10-Pay ❑ 11-Pay ❑ 24-Pay ❑ 26-Pay ❑ 52-Pay

❑ __________

Requested Policy Effective Date __________

Premium Collected $__________ Date __________

Agent's Name __________

APPLICANT'S STATEMENTS AND AGREEMENTS:

1. I am employed by __________
2. Are all applicants citizens of the U.S.? ❑ Yes ❑ No If no, give details. __________
3. I have not, nor has any proposed insured, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed with or received treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), except __________ (if none, so state), who is to be excluded.
4. Has any person proposed for insurance been declined for insurance due to health reasons? ❑ Yes ❑ No __________
5. Are you or anyone to be insured pregnant? ❑ Yes ❑ No __________
6. Has any person proposed for insurance had a driver's license suspended or revoked within the past 3 years? ❑ Yes ❑ No If Yes, please list the name and drivers license number of the proposed insured. __________
7. Has any person proposed for insurance had a DUI or DWI within the past 3 years? ❑ Yes ❑ No If Yes, please list the name and drivers license number of the proposed insured. __________
8. **If applying for Non Payroll Coverage:** Is any person proposed for insurance blind, bedridden, confined to a wheelchair, unable to walk without a cane or crutch or in the past five years, has any person proposed for insurance had an epileptic seizure, stroke, Parkinson's disease, or Alzheimer's disease? ❑ Yes ❑ No __________
9. **Disablity Income Riders:** To the best of my knowledge and belief, no person to be covered under the terms of this policy has now or has ever had cancer in any form including carcinoma in situ, except__________(if none, so state), who is to be excluded. Any disease or illness listed will require further underwriting review by the Administrative Office.
10. **Disablity Income Riders:** I hereby represent that to the best of my knowledge, information and belief, within the last year no person to be insured, has (1) undergone a biopsy, (2) had an elevated PSA (Prostate Specific Antigen), (3) been hospitalized or (4) received medical advice or consultation or had medical tests advised or performed, including those during the course of routine check ups where the results were other than normal or still pending, except ❑ NONE ❑ __________ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX.

(Please continue on reverse side)

11. **Disablity Income Riders:** Has any person proposed for insurance been diagnosed by or received treatment from a member of the medical profession for heart or vascular disease, chronic obstructive pulmonary disease, renal disease, rheumatoid arthritis, liver disease, sickle cell anemia, asthma requiring steroid therapy, ulcerative colitis, insulin dependent diabetes, Parkinson's disease, seizures, mental and/or nervous disorder, musculoskeletal, knee or back disorder, or any disease or disorder of the immune system? ❑ Yes ❑ No
____

12. Does any person proposed for insurance have another accident plan he/she intends on keeping? ❑Yes ❑No If so, please state the name of the proposed insured, the name of the company for the other plan and the type of policy. ____________________
____

13. Is this insurance intended to replace any other health insurance now in force? ❑Yes ❑No If yes, give name of Company and Policy Number: ____

14. Beneficiary Designation____

15. Mail policy to: ❑ agent ❑ insured ❑ ____________________________________

16. The "effective date" of the policy/riders will be the date recorded on the Policy Schedule by the Administrative Office. It is not the date the application is signed. When all underwriting requirements have been satisfied, coverage will begin as stated in your policy including any riders and/or endorsements.

17. I understand that: (a) the policy of insurance I am now applying for will be issued solely upon the written answers to questions and information asked for in this application; (b) the agent cannot change the provisions of the policy or waive any of its provisions either orally or in writing; (c) the policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance; (d) no change to the policy will be valid until approved by an officer of the Company which must be noted on or attached to the policy; and (e) I have read, or had read to me, the completed application and realize policy issuance is based upon statements and answers provided herein and they are complete and true to the best of my knowledge and belief.

Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

Signed at City:____ State:__________ Date:__________________________

Applicant's Signature:____________________________________ Agent's Signature: __________________________________

Agent Number: ____________________________________

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Manhattan Life Insurance Company of Great Neck, New York. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1.) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy; or the new policy may also provide for a waiting period for certain specified conditions. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2.) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

(3.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

____
Date

____
(Applicant's Signature)

NOTICE :
ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE MANHATTAN LIFE INSURANCE COMPANY. DO NOT MAKE THE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

BANK DRAFT AUTHORIZATION
AUTHORIZATION TO HONOR CHECKS DRAWN BY THE MANHATTAN LIFE INSURANCE COMPANY

To: ____

Your Bank’s Address: ____

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of The Manhattan Life Insurance Company of Great Neck, New York, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

____________________ X ____
Date Your signature EXACTLY as it appears on Bank Records Account No.

ML-ACC03-MI

PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER ______________________________

You are hereby authorized to deduct ____________ from my pay each month, until further notice from me, and remit to The Manhattan Life Insurance Company, 5 Waterside Crossing, Third Floor, Windsor, Connecticut 06095.

Agent ______________________________ Date ______________________________

Employee’s Signature __________________________ Print Name __________________________

ML-ACC03-PD-MI