ManhattanLife
Since 1850

ManhattanLife Insurance Company

PO Box 926169, Houston, TX 77092

Voluntary Benefits Coverage Change Form

Insured's Name_____ Policy Number _____
Owner's Name _____ Owner's Social Security Number _____
Owner's Address _____
City _____ State _____ ZIP+4_____
Owner's Telephone _____

Section A - C require that the health questions in Section D be completed (unless otherwise noted)

☐ **Section A: Change dividend option**
- ☐ Purchase Additional Paid-up Insurance
- ☐ Purchase One Year Term
- ☐ Left to Accumulate*
- ☐ Paid in Cash*
- ☐ Reduced Premium*

** Health questions in Section D not required*

☐ **Section B: Adding benefits and riders**
- ☐ Insured's Waiver of Premium
- ☐ Owner/Applicant's Waiver of Premium
- ☐ Accidental Death & Dismemberment
- ☐ Other Coverage _____

☐ **Section C: Remove**
- ☐ Rating
- ☐ Exclusion
- ☐ Both

For (Insured's Name) _____

The representations made in Section D apply to each person proposed for coverage.

Section D: Health and Life Insurance

The undersigned hereby represents that:

1. Within the past five years, or the period since the date of issue of the policy, whichever is shorter, has any person:	**YES**	**NO**
a. had any injury, disease or disorder?	☐	☐
b. consulted, been treated or examined by a physician or other medical practitioner?	☐	☐
c. been advised to enter, or in a hospital or health care facility for observation, diagnosis, operation or treatment?	☐	☐
d. ever had or been diagnosed as having an Immune Deficiency Disorder, AIDS or AIDS Related Complex (ARC)?	☐	☐
e. received advice or treatment for the use of alcohol or drugs?	☐	☐
f. been declined, postponed, charged an extra premium, refused reinstatement, been issued a policy with an exclusion rider, or offered a policy on a basis different from that applied for?	☐	☐
g. engaged in aviation as a pilot or crew member?	☐	☐
h. changed customary occupation?	☐	☐

2. Give full details to "Yes" answers from the above statements 1a - 1h. Always indicate the name of the person, disease, injury or disorder, dates, results of treatment, names and addresses of each physician and each hospital: _____

_____
_____
_____

3. Change in weight: (disregarding a child's normal growth). If weight has changed, give present height and weight, amount of weight lost or gained, and give reason for change: _____

_____

4. Used tobacco in any form in the last twelve months? ☐ Yes ☐ No

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MIB Disclosure Notice – Detach and Give to Proposed Insured

Information regarding your insurability will be kept confidential. ManhattanLife Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a 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], email address [www.mib.com] and telephone number [(781) 751-6000]. ManhattanLife Insurance or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

FRAUD STATEMENT

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. **(See State Specific Fraud Warning Statements below)**

AGREEMENTS

I/We have read or had read to me all the questions on this Application and I/We represent the answers and any information provided are correct and complete to the best of my knowledge and belief. I/We also realize that any false statements 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/We understand and agree that the policy will not take effect unless it is issued by ManhattanLife Insurance Company, the total modal premium must accompany the Application, and any check, bank draft or credit card payment is honored on first presentation. No agent or producer has the authority to waive any of the conditions or questions in this Application.

AUTHORIZATION

By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to ManhattanLife Insurance Company or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by ManhattanLife Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: ManhattanLife Insurance Company at [PO Box 926169, Houston, TX 77092], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that ManhattanLife Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information. **(See State Specific Authorization provisions below)**

I UNDERSTAND THE REINSTATED POLICY SHALL ONLY COVER LOSSES SUSTAINED AFTER THE DATE OF REINSTATEMENT AS SET OUT IN THE POLICY'S REINSTATEMENT PROVISION.

_____ _____/_____/_____
Signature of Licensed Insurance Producer Date

_____ _____/_____/_____
Signature of Policyowner Date

_____ _____/_____/_____
Signature of Insured if Different Than Policyowner Date

_____ _____/_____/_____
Signature of Spouse (If Insured) Date

Thank you for giving ManhattanLife the opportunity to consider your insurance needs. As part of our normal procedure for processing Applications, we may order an investigative consumer report. This includes your prescription drug history and information as to your character, general reputation, personal characteristics, and mode of living. The information obtained in such investigative consumer report will not be used to make a determination of your sexual preference. You have the right to make a written request within a reasonable period of time to receive additional, detailed information about the nature and scope of this investigation. You may request to be interviewed in connection with the preparation of this investigative consumer report and upon request you are entitled to receive a copy of the investigative consumer report. If you question the accuracy of information in the investigative consumer report, you may contact the Consumer Reporting Agency and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. We may telephone you to confirm information given in your Application or to obtain additional information needed to process your Application. All information asked for in your Application, or obtained from other sources, such as your physician, or hospitals where you have been treated, is for the sole purpose of determining your acceptability for the insurance coverage for which you have applied. All information obtained will be kept confidential. Upon your written request, we will furnish you or your physician with the nature or source of the information.

State Specific Fraud Warning Statements

Arkansas
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.

California
For your protection, California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies

District of Columbia
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Louisiana
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.

Maryland
Any person who knowingly and willfully 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.

New Jersey
Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico
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 civil fines and criminal penalties.

North Carolina
Any person with the intent to injure, defraud, or deceive an insurer or insurance claimant is guilty of a crime (Class H felony) which may subject the person to criminal and civil penalties.

Ohio
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Oklahoma
WARNING: Any person who knowingly, and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Pennsylvania
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island
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.

Tennessee, Virginia and Washington
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

State Specific Authorization Provisions

Arizona
By this form (or photocopy of it), which is valid for 30 months from the date shown below (180 days in the case of HIV related information), I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to ManhattanLife Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by ManhattanLife Insurance Company for the purpose of evaluating my Application for insurance.

I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: ManhattanLife Insurance Company at [PO Box 926169, Houston, TX 77092], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that ManhattanLife Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Florida, Kentucky, Nebraska, Oklahoma, Oregon, West Virginia and Wyoming
By this form (or photocopy of it), which is valid for 24 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to ManhattanLife Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by ManhattanLife Insurance Company for the purpose of evaluating my Application for insurance.

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Minnesota
By this form (or photocopy of it), which is valid as long as the individual is insured, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to ManhattanLife Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by ManhattanLife Insurance Company for the purpose of evaluating my Application for insurance.

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Missouri
I acknowledge that within 60 days of Home Office receipt, ManhattanLife Insurance Company will advise whether this application has been accepted or rejected. By this form (or photocopy of it), which is valid for 30 months from the date shown below, I/We authorize any licensed physician, medical practitioner, clinic, hospital, or other medical or medically related facility, pharmacy, pharmacy benefit manager or other pharmacy related services organization, insurance company, the Medical Information Bureau, or other person, organization, or institution, that has any records or knowledge of me, my spouse or my child(ren) for whom insurance Application is made, or my health, my spouse's or my child(ren)'s health, to give to ManhattanLife Insurance Company, or its reinsurers, any such information and to testify as to such information, all to the extent permitted by law. I understand that such information will be used by ManhattanLife Insurance Company for the purpose of evaluating my Application for insurance.

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Vermont
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I/We understand that I/We have the right to revoke this Authorization in writing, at any time, by providing written request for revocation to: ManhattanLife Insurance Company at [PO Box 926169, Houston, TX 77092], Attention: Underwriting Department. I/We understand that a revocation is not effective to the extent that ManhattanLife Insurance Company has relied upon information disclosed prior to the revocation. I/We understand that any information that is disclosed pursuant to this Authorization may be re-disclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

Wisconsin
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