Application for Group Insurance
WORKPLACE VOLUNTARY BENEFITS

The offering company(s) listed below, severally or collectively, as the content may require, are referred to in this Application for Group Insurance as "ManhattanLife," "We," or "Our."

Workplace Voluntary Benefits, insurance coverage is provided or administered by ManhattanLife Assurance Company of America at their Administrative Office, [10777 Northwest Freeway, Houston, Texas 77092] [(800) 669-9030]

GROUP INFORMATION: Please type or print clearly

For existing group, please provide current Group number: 898061

Group name: State of Florida/Capital Insurance				Requested effective date of policy 04/01/2019
Corporate/Situs location street address: PO Box 15949	City: Tallahassee	State: FL	ZIP code: 32317	County:

ELIGIBILITY REQUIREMENTS

Number of eligible employees/members: 25,416	Payroll Deduction Frequency Number of hours worked per week to be eligible (selection between 20 and 40 hours): 20
❑ Benefits are provided in conjunction with a HSA Plan ❑ Benefits are offered in conjunction with an IRS qualified pre-tax plan	❑Weekly ☒Bi-Weekly ❑Semi-monthly ☒Monthly ❑Other, please indicate:

PLAN SELECTION - Please review the Regulatory Pre-enrollment Disclosure Guide with your agent, broker or producer. Sold quote number: _____

Accident	❑Electing	**Supplemental Health**	❑Electing	**Term Life**	❑ Electing
Critical Illness	☒Electing	**Disability Income**	❑Electing	**Whole Life**	❑ Electing
Hospital Indemnity	❑Electing	**Cancer Benefits**	❑Electing		

GROUP AGREEMENT AND SIGNATURE

If We approve this Application for Group Insurance, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. 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.

Dated on:_____(month, day, year) at_____(city and state)

By: _____ _____ _____

Group Authorized Representative (Print name) (Signature) (Title)

AGENT INFORMATION

As the Agent, I acknowledge that I am responsible to meet with the group submitting this Application for Group Insurance 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 group in the Regulatory Pre-enrollment Disclosure Guide or other plan literature.

Writing Agent 1

Name (print or type)	Date
ManhattanLife Agent/Tax ID Number	Signature
Agent/Agency of Record (AOR)	ManhattanLife Agent/Tax ID Number
Is there a case split? ❑No ❑Yes If yes, Agent 1_____%	Agent 2_____%

Writing Agent 2

Name (print or type)	Date
ManhattanLife Agent/Tax ID Number	Signature
Agent/Agency of Record (AOR)	ManhattanLife Agent/Tax ID Number