The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We" or "ManhattanLife"

Life, Specified Disease/Critical Illness, Hospital Indemnity, and Accident Insurance products insured by ManhattanLife Assurance Company of America, ManhattanLife Insurance Company.

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 on pages 2-3) The below Statements are true to the best of my knowledge and belief. Signature of Subscriber Member Information: Is the claim for the:

Subscriber

Dependent Subscriber's Name ______Policy No._____ Scocial Security No._____ Mailling Address_____ City_____ State____ ZIP Code_____ Date of Birth / / Daytime Phone No. () Type of critical illness/condition for which the claim is being made: Heart Attack **Heart Transplant** Coronary Artery Bypass Stroke Malignant Melanoma Carcinoma In Situ **End State Renal Disease** Invasive Cancer Severe Burns Coma Majory Organ Transplant Permanent Paralysis Loss of Vision, Hearing or Speech



Occupational HIV

Mail to the Manhat following address: Claims

ManhattanLife Claims P.O. Box 926169 Houston, TX 77092 Customer Service: 1-855-448-6982 Fax to: 1-502-405-7107 Email to:

State Specific Fraud Warning Statements

ManhattanLife:

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

Alabama:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, 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.

Arizona:

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California:

For your protection California law requires the following statement 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, 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.



Mail to the following address:

ManhattanLife Claims P.O. Box 926169

Houston, TX 77092

Customer Service: 1-855-448-6982 Fax to: 1-502-405-7107

Email to:

State Specific Fraud Warning Statements

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York:

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 fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Virginia:

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.



Physician information: Attending (Treating) physician/facility:

Physician's Name/Facility	Address	F	Phone Number		
Has the claimant ever been If yes, Please provider the p	reated for the same or a similar condition in the past?	No			
Physician's Name/Facility	Address	F	Phone Number		
	Hospitalized for this condition? ☐ Yes ☐				
no il yes, Please provider tr	e prior physician information:				
Hospital Name	Address	F	Phone Number		
If the claim is being filed fo the physician and medicat	r services within the first 2 years following the policy effectiven information below:	e date, c	omplete		
Physician information: List	all physicians that treated the patient in the five years prior to the	policy eff	ective date:		
Physician's Name/Facility	Address Phone	Number	Reason for Visit		
Medication information: Lis	t all medication being taken by the patient:		1		
Medication	Prescribing Physician	[Date Prescribed		



Authorization to release information - For the Use and Disclosure of Protected Health Information

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

- 1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
- 2. I authorize all health care professionals to disclose my protected health information to ManhattanLife Insurance Company,
- 3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
- 4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
- 5. I authorize only designated staff of ManhattanLife Insurance Company to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
- 6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
- 7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to Manhattan Life Attn: Claims Department PO Box 926169 Houston, TX 77092. This revocation shall become effective on the date it is received by ManhattanLife Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim. A photocopy or facsimile of this authorization shall be valid as the original.

Nameto m e and/or disclosure (Authorized Represe	of protected heal		
and/or disclosure	of protected heal		
.,	ntative thereor.	/	/
nship to Applicant	Date	'	······································
	n ManhattanLife.	, ,,	,



Mail to the following address:

ManhattanLife Claims P.O. Box 926169 Houston, TX 77092

Customer Service: 1-855-448-6982 Fax to: 1-502-405-7107

Email to:

Critical Illness Claim Form – Attending (Treating) Physician Statement

Patient Information:				
Name			Policy No	
Street Address				
City				
Treatment Information:				
Please check appropriate box for information listed under the Me	or each condition	on below for which you o station Requirements se	ire treating this patient, an ction.	d enclose the
Illness/Condition	Medical Doc	cumentation Requireme	ents	
Vascular	'			
□ Heart Attack	EKG report(s)Cardiac enzImaging sto	zymes levels udies	room and cardiologist	
☐ Heart Transplant	Proof that of Organ Share	ords from the transplant to covered person is registere ing or its recognized succe		of the United Network for eplacement of the whole
Stroke	Medical recNeuroimagi	ords from the neurologist	after stroke	
☐ Coronary Artery Bypass Surgery		f coronary heart disease n ded treatment plan includ	nade by angiography test(s) ir	
Cancer	,			
☐ Invasive Cancer				
☐ Malignant Melanoma	 Pathologist 	s report		
☐ Carcinoma In Situ				
Other				
☐ Major Organ Transplant		covered person is registere	d with and on the waiting list uman to human replacement	
☐ End Stage Renal Failure	Medical recProof of ren	ords from the nephrologis nal dialysis	t	
□ Loss of Vision	Proof must the condition	document that the blindn	t; including refractions, visual ess was due to Accidental Inji nterruption for a period of at	ury or Sickness; and that least six (6) consecutive
□ Loss of Speech	 Clinically-pr 	ords from a neurologist roven that the loss of abilit t least six (6) consecutive n	y to speak has continued with nonths	nout interruption for a
☐ Loss of Hearing	Medical rec	ords from an audiologist		



Mail to the following address:

ManhattanLife Claims P.O. Box 926169 Houston, TX 77092

of at least six (6) consecutive months after diagnosis

Customer Service: 1-855-448-6982 Fax to: 1-502-405-7107 Email to:

• Proof of irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of Illness or Injury that has continued without interruption for a period

Critical Illness Claim Form – Attending (Treating) Physician Statement

Treatment Information:

Other continued								
□ Coma	 Medical records from neurologist Proof of complete and continuous unconsciousness state not less than 24-96 hours induration which exhibits an inability to be aroused or to respond to external stimuli aside from primitive avoidance reflexes 							
□ Severe Burns	Medical records from plastic surgeon Proof that covered person has sustained third degree burns covering at least 20% of the surface area of their body						20% of the	
Permanent Paralysis due to Accident	 Medical records Proof that loss is expected to be permanent; been present continuously for at least 180 days; caused by injury sustained in an accident; evidenced by the total and irreversible loss of use of two or more limbs; marked by loss of muscle function in two arms, two legs, or one arm and one leg 							
□ Occupational HIV	 Medical records Proof that the cause of HIV must be from an Accidental needle stick/sharp injury or by mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the 12 months preceding diagnosis; accident occurred while covered person was following the normal occupational duties and reported in accordance with the established occupational procedure for such accidents; the covered person must have undergone a blood test within 5 days of the accident which indicate the absence of HIB or antibodies to such a virus; within 12 months of the accident, the covered person must undergo a follow up blood test indicating the presence of HIV or antibodies to such a virus 							
Diagnosis (including any complic	ations)				_ ICD-9/ICD-1	10 Code		
Date the symptoms first app	eared:	/	/		Date of the	first visit:	/	
Date of the definitive diagno								/
Has the patient been treated for If yes, list the date(s) of prior								
Was this patient referred to you? If yes, please provide the referrin Referring Physician Name Referring Physician Address_	Yes Nong physician	o informa	ition:		_Phone No. ()		
Any Person, who with the intent Application or files a claim conta insurance fraud. (See State Speci	iining a false ific Fraud Wo	e or dece arning St	eptive state tatements	ement m on page	ay be subject 1)	to prosecut	ion and pi	
The above Statements are true								
Printed Name of Physician			•		-)		
Street Address								
City								
Signature of Attending Physician						Date		



Mail to the following address:

ManhattanLife Claims P.O. Box 926169 Houston, TX 77092

Customer Service: 1-855-448-6982 Fax to: 1-502-405-7107

Email to: