ManhattanLife Critical Illness

Florida

State Of Florida

ManhattanLife Critical Illness offers benefits for vascular coverage (heart attack, stroke, coronary artery bypass surgery) and other critical illnesses (end-stage renal failure, coma, transplant other than heart). All benefit payments are made directly to you, and are payable in addition to any other coverage you have. During your recovery, you and your loved ones can rest a little easier knowing you won't have to rely solely on your savings accounts or take on additional debt to cover day-to-day living expenses.

Coverage type

Voluntary Critical Illness insurance is a group policy form that includes coverage for heart/stroke and other critical illnesses.

Benefit amount

Benefit amounts are available at various levels. You can choose:

- $10,000 to $20,000 for employees

You can also add coverage for your dependents:

- Spouse: $5,000 to $10,000. Spouse coverage benefit is equal to exactly half of the employee's coverage
- Child: $5,000 for each eligible child. Child coverage benefit is equal to exactly half of the employee's coverage to a maximum of $5,000.

Coverage for vascular conditions

Percent of benefit amount paid at initial diagnosis:

• Heart attack	100%
• Transplant as a result of heart failure	100%
• Stroke	100%
• Coronary artery bypass surgery as a result of coronary artery disease	25%

Coverage for other critical illnesses

Percent of benefit amount paid at initial diagnosis:

• Transplant, other than heart	100%
• End-stage renal failure	100%
• Loss of sight, speech, or hearing	100%
• Coma	100%
• Severe burns	100%
• Permanent paralysis due to an accident	100%
• Occupational HIV	100%

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Workplace Voluntary Benefit products at **Disclosure.ManhattanLife.com**. Please review this information before applying for coverage. The amount of benefits provided depends on the plan selected. Premiums will vary according to the selection made. THIS POLICY PROVIDES LIMITED BENEFITS.

Policy: 8011
Underwritten by ManhattanLife Assurance Company of America.

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Additional included benefits

Waiver of premium for disability: This waives an employee's premium if he or she becomes totally disabled for at least 180 days after the effective date of coverage. For employees ages 18-55.

☐ **Health screening:** Benefit pays per calendar year for covered health screenings. There are 18 covered tests including mammograms, colonoscopies, and stress tests.

- Indemnity based and payable once per calendar year per insured
- Employer selects this optional benefit and the benefit amount; Employee may decline the benefit if he/she chooses
- Coverage is same for all insureds on the certificate
  - ☐ $150

☐ **Loss of work:** We'll waive an employee's premium in the event of authorized strike, lockout, layoff, or job elimination (maximum six-month benefit per occurrence, with a lifetime maximum of 12 months' waiver). Available through age 55 at time of original certificate issue only. Elimination period is 30 days for benefit qualification.

Portability

Portable after six months of continuous coverage if group master policy remains in force and the insured is less than age 70. Participants may continue coverage by paying premiums on a direct billing method.

- All ported certificates will be subject to any rate increases on the Employer's Master Policy.

Pre-existing provision

6/6

Additional plan information

Spouse includes domestic partners where allowed by state and employer.

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ManhattanLife Critical Illness Rates

State of Florida

Florida

Employee rates

Displaying Monthly payroll deductions based on monthly premium calculation including Loss of Work, and $150 Health Screening Benefit

Age	Employee - NTU		Employee - TU	
BENEFIT:	$10,000	$20,000	$10,000	$20,000
18-29	$8.23	$11.33	$9.33	$13.54
30-39	$10.13	$15.14	$13.42	$21.72
40-49	$13.33	$21.53	$20.53	$35.93
50-55	$18.83	$32.53	$32.03	$58.93
56-59	$17.53	$29.93	$29.82	$54.53
60-64	$22.52	$39.92	$38.32	$71.53
65-69	$24.43	$43.73	$41.33	$77.53

Spouse Rates

Displaying Monthly payroll deductions based on monthly premium calculation including Loss of Work, and $150 Health Screening Benefit

Age	Spouse - NTU		Spouse - TU	
BENEFIT:	$5,000	$10,000	$5,000	$10,000
18-29	$4.65	$6.30	$5.25	$7.50
30-39	$5.70	$8.40	$7.65	$12.30
40-49	$7.50	$12.00	$11.45	$19.90
50-55	$10.55	$18.10	$17.75	$32.49
56-59	$9.85	$16.70	$16.55	$30.10
60-64	$12.55	$22.10	$21.20	$39.40
65-69	$13.55	$24.10	$22.95	$42.90

NTU: Non-tobacco user; TU: Tobacco user

Children Rates

Displaying Monthly payroll deductions based on monthly premium calculation including and $150 Health Screening Benefit

Age	Children
BENEFIT:	$5,000
0-24	$3.55

The proposed rates are for an effective date no later than 02/01/2016

Policy: 8011
Underwritten by ManhattanLife Assurance Company of America.

Manhattan Life Insurance Company
10777 Northwest Freeway, Houston TX 77092
1-855-448-6982

ManhattanLife™
Standing By You. Since 1850.

Enrollment Form for Voluntary Group Critical Illness

☐ Bi-weekly ☐ Monthly Deduction code - 206

PLEASE INDICATE: (x) ENROLLMENT FOR NEW COVERAGE ( ) CHANGE TO EXISTING COVERAGE

Proposed Insured (Please Print)

Person Proposed for Coverage (First Name, MI, Last Name) Suffix

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

Address (Street or R.R.)

City State ZIP Code Home Telephone ( ) -

Employer Name or Group Number: STATE OF FLORIDA-898061 Date of Employment (MM/DD/YYYY) / /

How many hours per week do you work? Employee Class (If Applicable) ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5

Spouse

Spouse Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

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

Child One

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

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

Child Two

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

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

Child Three

Child Name (First Name, MI, Last Name) (If proposed for coverage) Suffix

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

10777 Northwest Fwy, Houston TX 77092
1-855-448-6982
Home Office: Great Neck, NY

CRITICAL ILLNESS INSURANCE ☒ Employee ☐ Spouse ☐ Child(ren)

Has any Proposed Insured used any form of tobacco in the last 12 months?.....	Employee	Spouse
	☐ Yes ☐ No	☐ Yes ☐ No

Base Plan ☒ Vascular ☐ ☒ Other Critical Illnesses

Base Benefit Benefit Amount $ ___,___ Total Modal Premium $ ___.___

Optional Benefits ☒ Health Screening

	Employee		Spouse		Child 1		Child 2		Child 3	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
1. Are you Actively at work?.....	☐	☐								
2. Will this coverage replace a critical illness policy or certificate of insurance paid for, by, or through your employer?.....	☐	☐								

Evidence of Insurability: Complete Only if Proposed Insured is a Late Enrollee

EMPLOYEE'S REPRESENTATION AND AGREEMENT

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.

The above statements are true and complete to the best of my knowledge and belief. I understand and agree that the above statements are representations and not warranties.

Signed At _____ (City) ☐☐ (State)

_____ (Signature of Proposed Insured/Owner) ☐☐ / ☐☐ / ☐☐☐☐ (Date (MM/DD/YYYY))

INSURANCE AGENT'S USE ONLY

I certify any information recorded by me on this Application is true and accurate to the best of my knowledge and belief.

Signature of Licensed Insurance Agent _____

Date (MM/DD/YYYY) / /

Insurance Agent Number	% Credit	Insurance Agent Number	% Credit