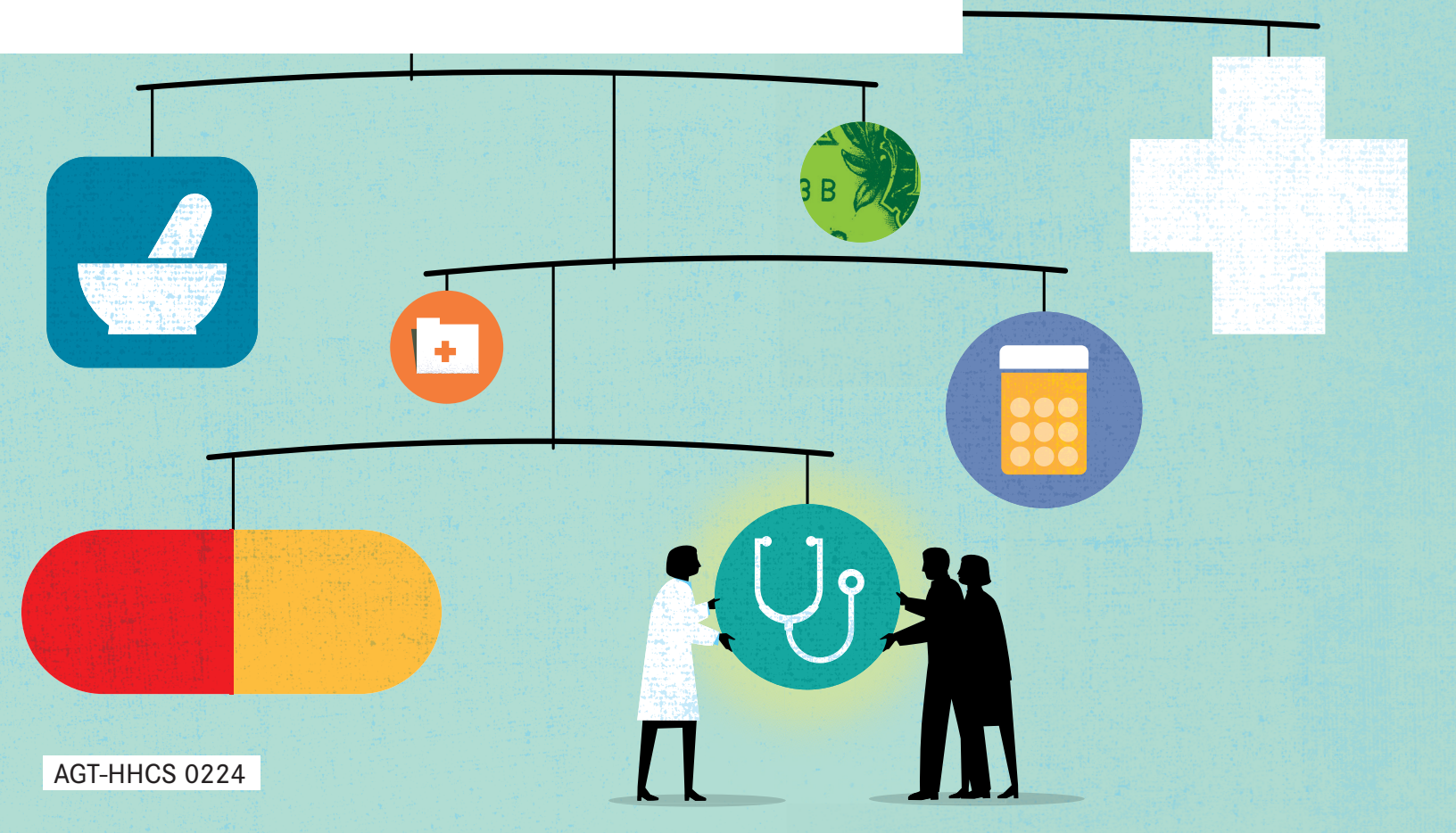
ManhattanLife™
Standing By You. Since 1850.

ManhattanLife Lighthouse Series
Home Health Care Select
Agent Guide

For Agent use only

Underwritten by: ManhattanLife Insurance and Annuity Company &
Standard Life and Casualty Insurance Company



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Thank You from ManhattanLife!

First of all, thank you for taking the time to read our Home Health Care Select Agent Guide! We realize that you have many carrier and product options to choose from and we sincerely thank you for choosing ManhattanLife!

Who We Are

Who is ManhattanLife? Since 1850, we've defined our brand with our commitment to standing by policyholders and producers with diligence and compassion. For over 170 years we've been a private and closely held company by choice. And as an independent, we have always been free to make decisions that align with our values and core mission – helping policyholders attain and sustain health, wealth and security throughout their lives.

We demonstrate this commitment by striving to honor claims and pay benefits with professionalism and care. For our producers, we are a reliable and independent partner. We stay agile and open minded about customizing products or innovating new policies to meet our policyholders' evolving needs. With a national footprint and licenses to sell in every state and U.S. territory, we are everywhere you want us to be.

The Company's longevity as staying independent in the marketplace is remarkable considering the robust merger and acquisition activity the industry has experienced in modern times. To put its staying power in context, the current average age of S&P 500 Index companies is less than 20 years old. By contrast, operating successfully for over 170 years as an independent is a testimony to ManhattanLife's enduring history and an indicator of the reliability of our future.

The Purpose

The purpose of this Agent Guide is to provide insights into the benefits available with Home Health Care Select. In addition, this agent guide should provide direction on topics such as state availability, submitting applications, underwriting process, application fees & rates, preventing processing delays and much more.

Table of Contents

Why Home Health Care Select?

Health. Value. Peace Of Mind. If possible, wouldn't your client rather recuperate from an injury or chronic illness in the comfort of their own home? A sudden illness, injury, or debilitating chronic condition can happen to any individual at any age.

ManhattanLife's Home Health Care Select Insurance is an affordable solution that provides both the flexibility and financial support insureds need to recover at home, surrounded by those they love. These plans can also minimize financial stress, allowing individuals to focus on their own personal recovery.

Plan Description & Highlights

The Home Health Care Select Insurance policy is designed for beneficiaries that would prefer to seek and receive care in the comfort of their own home versus entering a nursing home. Benefits under this policy are payable regardless of any other coverage your client may have, including Medicare.

Home Health Care Select Insurance is available with three different levels of coverage: Classic, Premier and Deluxe. Optional Riders are also available with additional coverage options. (Please see the Policy and/or Outline of Coverage for specific benefits and state-specific details.) General benefit highlights for Classic, Premier and Deluxe are listed in the chart on the next page.

- Home Health Care Benefit: Payment up to the daily maximum benefit, subject to eligibility conditions, for approved services provided in the home from an Approved Home Health Care Practitioner.
- Home Health Care Aide Benefit: Daily benefit, subject to eligibility conditions, for each day you require Home Health Care Aide services in your home. Maximum benefit period of 60 days.
- Prescription Drug Benefit: Prescription benefit for both generic and brand scripts limited to the maximum benefit amount per policy year.
- The Maximum Benefit Period for Home Health Care and Aide benefits will be restored if benefits have not been paid or required for 180 consecutive days.

Plan Description & Highlights Chart

Highlights - Home Health Care Select Insurance			
Home Health Care Benefit	**CLASSIC**	**PREMIER**	**DELUXE**
Daily Maximum Aggregate Benefit	$150	$300	$450
Maximum Benefit Period	365 days*		
Home Health Care Services	**Daily Benefit Amount**		
Nursing Care	$75	$150	$200
Physical Therapy	$75	$150	$200
Speech Pathology	$75	$150	$200
Occupational Therapy	$75	$150	$200
Chemotherapy Specialist Services	$60	$120	$200
Enterostomal Therapy	$50	$100	$200
Respiration Therapy	$50	$100	$200
Medical Social Services	$100	$200	$300
Home Health Care Aide Benefit			
Daily Benefit	$40	$80	$120
Maximum Benefit Period	60 days		
Prescription Drug Benefit			
Maximum Aggregate Benefit per Policy Year	$300	$600	$600
Per-Prescription Benefit, Generic Drugs	$10	$10	$10
Pre-Prescription Benefit, Brand-Name Drugs	$25	$25	$25

** KY, TX, and PA subject to a maximum benefit period of 364 days*

Riders

Routine Annual Physical Examination Benefit Rider[3]

- One benefit per year for a Routine Annual Physical Examination, subject to a 12-month Waiting Period.

Benefit
$150

Accidental Death & Dismemberment Benefit Rider[3]

- Benefits for accidental death or an accidental bodily injury resulting in the loss of finger, toe, hand, arm, foot, leg, or sight. To be covered, death or dismemberment must occur within 90 days of the covered accident and while this policy and rider are in force.
- Lifetime maximum is $10,000.

Accidental Death	
$10,000	
Max. Dismemberment Benefit	
Sight, both eyes	$5,000
Sight, one eye	$2,500
Hand/arm/foot/leg (multi)	$5,000
Hand/arm/foot/leg (single)	$2,500
Finger or toe (multiple)	$500
Finger or toe (single)	$250

Home Medical Equipment Benefit Rider[3]

- Benefits paid when you need Home Medical Equipment prescribed by your Physician while receiving Home Health Care Select Services and/or Home Health Care Aide benefits.
- Lifetime maximum is $500.

Benefit
$100 per piece
Home Medical Equipment Limited to
Mobility assistance
Transfer aids
Bathroom safety
Home accommodations
Personal medical equipment

Ambulance Benefit Rider[3]

- Benefits paid for transportation in an Ambulance for Emergency Care, including transportation from one medical facility to another when health care services are provided during the trip.
- Lifetime maximum is $2,500.

Benefit	
$200 per trip	
Per each one-way trip	4 trips per year

Accident Expense Benefit Rider[3]

- Benefits for dislocations, fractures, or knee ligament tears when treated by a health care practitioner in a Hospital Emergency Room, Urgent Care Facility, or Physician's office within 48 hours of the Covered Accident.

Max Amount per Accident	
Option 1	Option 2
$1,250	$2,500
Max. Dismemberment Benefit	
	Option 1 / Option 2
Fracture, hip or skull	$1,250 / $2,500
Dislocation Hip	$1,000 / $2,000
Tear, knee ligament or meniscus	$500 / $1,000
Dislocation Knee	$500 / $1,000
Fracture, all other	$250 / $500

[3]See the Rider and/or Outline of Coverage for state-specific details.

Purchasing New Policies

Applicants who were prior policyholders that either canceled their policy or allowed it to lapse are not able to purchase a new Home Health Care Select Insurance policy unless the person has had no Home Health Care Insurance coverage with ManhattanLife for 6 or more months. After this period with no coverage, the applicant would then have to submit a new application, request their desired plan option(s), and pass to underwriting.

Reinstatement

A Home Health Care Select Insurance policy can be reinstated up to 90 days after it has lapsed. Once a policy has lapsed more than 90 days, the individual must go 6 or more months without coverage with ManhattanLife. After this period with no coverage, the applicant would then have to submit a new application, request their desired plan option(s), and pass underwriting.

Conditions on Eligibility

Applicant must be between the ages of 45 - 89 as of the effective date. The applicant must be a resident of a state where the product is filed and approved.

Ineligible Persons

Ineligible persons include:

- Anyone currently living in a nursing home or assisted living facility.
- Anyone currently receiving home health care or similar-type benefits.
- Anyone physically unable to perform routine activities such as bathing, dressing, eating, toileting, or transferring to or from a bed or chair.
- Anyone who is incarcerated in a penal institution.
- Anyone currently in a psychiatric facility.

Withdrawn Applications

Applications will be withdrawn for the following reasons:

- The applicant does not recall filling out the application.
- The application was taken by an agent who was not licensed and appointed at the time of solicitation in the state of solicitation, or the state in which the applicant resides.

Benefit Changes

Request to change the Home Health Care (Classic, Premier, or Deluxe) plan will be processed as an internal replacement. An Internal replacement is processed as a new policy and will require a newly completed application with full underwriting. For internal replacements, we will use the same underwriting criteria; however, we will also use our claims database to assist in determining the risk of an applicant. The writing agent will not receive full commissions on internal replacement policies.

Request to remove benefit riders can be done at any time. All requests must be submitted to our office in writing. Once a benefit has been removed, a new application is required to re-enroll.

All benefit changes are subject to policy provisions and changes in premium amounts. For more information, please contact our Customer Service Department or your insurance agent.

Product Availability Map

Scan this QR Code to view the Product Availability Map

Click on this QR Code to view the Product Availability Map

Marketing Materials and Forms Usage

Home Health Care Select availability and forms vary by state. If there are any questions on plan availability or forms by state, contact us at 1-888-441-0770.

Obtaining Marketing Materials and Forms

Approved materials and forms are posted to the agent portal for download. To order paper copies of materials and forms, please contact your upline or call 1-888-441-0770. You can also reach out to our ACES team at *aces@manhattanlife.com*

Creation and Alteration of Advertising/Marketing Pieces

Advertising and marketing materials must be approved by each state Department of Insurance prior to use by agents. Agents are not allowed to create their own marketing materials, or modify approved ManhattanLife marketing materials. This includes, but is not limited to, letters, business cards, announcements, flyers, videos, posters, newspaper ads, etc. An agent must disclose any information relating to unauthorized use of marketing materials to ManhattanLife. *Agents who wish to modify marketing materials must first obtain approval through Sales and Marketing.*

Submitting Paper Applications

As stated above, we always suggest submitting applications through ManhattanDirect 2.0, as we have found processing times are generally quicker. We do, however, understand there may be times when this simply isn't possible. In the event a paper application has to be submitted, the agent needs to complete the application with the applicant actively engaged throughout the process. The agent can either be at the same physical location as the applicant/owner, or the application can be processed over the phone. Regardless of how the application process takes place, both the applicant/owner and the agent must physically sign the document. Therefore, if the application is completed over the phone, the agent must fax or send the application to the applicant/owner to obtain their signature before submitting it to ManhattanLife for processing. Below are options for getting paper applications to ManhattanLife for processing. Instructions provided below.

Easy Upload Feature

The Easy Upload tool can be used to upload applications rather than mailing or faxing them. Please note currently Easy Upload will only accept PDF files. Therefore, the application must be scanned and converted to a PDF to be attached. There are step-by-step instructions located in the "Help" section found to the left of the Easy Upload area within the Agent Resource Center. It should be noted that in order to submit via Easy Upload, you must be logged into our ManhattanDirect 2.0 system.

The Easy Upload feature can be found on the home page of the Agent Resource Center(ARC) and was created to enable the submission of paper applications, rather than mailing or faxing them. The Easy Upload feature can be found at the following URL:
https://producer.manhattanlife.com/life/account/login.aspx?AsAgent

Required Forms

Completed Application (pages 1-5)

Whether completing a paper application, or utilizing ManhattanDirect 2.0, please remember only current state-approved applications may be used when applying for coverage. If there is a question as to what application is available, please call our Marketing Department to confirm the correct application form number.

Sales & Marketing Hotline: 1-888-441-0770.
Email: aces@manhattanlife.com

A copy of the completed application will be attached to the policy, becoming part of the contract.

Applications & Forms

Application for Home Health Care Select Insurance	Completion instructions for the application included in this Agent Guide. Pages 1-7 must be completed in its entirety. A copy of the completed application will be made by ManhattanLife and attached to the policy to make it part of the contract.
Prescription Drug Claim Form	Often referred to as the "Prescription Drug Claim Form". Used by a policyholder to make a claim against the policy for prescription drug benefits.
HHC Standard Benefits Claim Form	Often referred to as the "Home Health Care Claim Form". Used by a policyholder to make a claim against the policy for Home Health Care and home health care aide benefits.
Physician's Home Health Certification	Often referred to as the "Physician Certification Claim Form". Used by a physician to certify that a policyholder can no longer complete Activities of Daily Living and is eligible for Home Health Care and/or Home Health Care Aide services.

Submitting New Business

Prior to submitting applications:

- Review application for completeness and accuracy.
- Verify correct premium amount.
- Collect bank draft authorization information and signature(s) as applicable.
- Any corrections must be initialed/dated by the applicant/owner. Do not use white-out.

Application Instructions

Standard Life
AND CASUALTY INSURANCE COMPANY
A ManhattanLife Company

Standard Life and Casualty Insurance Company
Home Office: Salt Lake City, UT
Administrative Office: [10777 Northwest Freeway, Houston, TX]
[(800) 669-9030]

APPLICATION FOR HOME HEALTH CARE INSURANCE

❑ Reinstatement ❑ Benefit Increase Policy No._____ Group No. _____

APPLICANT A – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)	Social Security No.	
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	

APPLICANT A - INSURANCE REQUESTED		PREMIUM
Home Health Care Insurance Policy	❑ Classic - $150 ❑ Premier - $300 ❑ Deluxe - $450	$ _____
[Routine Annual Examination Rider	❑	$ _____]
[Accidental Death & Dismemberment Rider	❑	$ _____]
[Home Health Equipment Rider	❑	$ _____]
[Accident Expense Benefit Rider	Per Accident - ❑ $1250 ❑ $2500	$ _____]
[Ambulance Benefit Rider	❑	$ _____]
	APPLICANT A - TOTAL PREMIUM	$ _____

APPLICANT A - HEALTH QUESTIONS		
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	❑ Yes ❑ No
2.	Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring from bed to chair?	❑ Yes ❑ No

APPLICANT A – EXISTING COVERAGE		
1.	Do you have existing health coverage (including home health care, long-term care, or similar coverage)?	❑ Yes ❑ No
2.	Are any policy(s) intended to replace any other insurance not in force? If "**Yes**," provide the company name, policy number, and type of coverage below.	❑ Yes ❑ No

AM7008APSC 1

Submit Completed Form to: New Business Department, [10777 Northwest Freeway, Houston, TX 77092]
Toll Free Telephone Number: [(800)669-9030] FAX: [(713) 821-6463]

Please note: *Many states have their own unique application for Home Health Care Select Insurance. Please make sure you are completing the correct state application based on the resident state of your client.*

APPLICATION INFORMATION (A)

- Application can be used for 1 or 2 applicants.
- Fill out all information fully and correctly.

ADDRESS

- Applicant's resident state must match the materials being used.
- "Mailing Address" is optional. It should only be used if the applicant wants to receive info somewhere other than their resident address.
- E-mail address is preferred but optional.

PLAN SELECTION

- Select policy choice of "Classic", "Premier" or "Deluxe".
- Use Rate Chart and conversion factors to calculate initial premium based on mode selected.

OPTIONAL RIDERS

- Use Rate Chart and conversion factors to calculate initial premium based on mode selected.

Application Instructions Continued

APPLICANT B – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)	Social Security No.	
Beneficiary Name	Requested Future Effective Date **Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	

APPLICANT B - INSURANCE REQUESTED		PREMIUM
Home Health Care Insurance Policy	❑ Classic - $150 ❑ Premier - $300 ❑ Deluxe - $450	$ _____
[Routine Annual Examination Rider	❑	$ _____]
[Accidental Death & Dismemberment Rider	❑	$ _____]
[Home Health Equipment Rider	❑	$ _____]
[Accident Expense Benefit Rider	Per Accident - ❑ $1250 ❑ $2500	$ _____]
]Ambulance Benefit Rider	❑	$ _____]
	APPLICANT B - TOTAL PREMIUM	$ _____

APPLICANT B - HEALTH QUESTIONS		
1.	Are you currently living in a nursing home or assisted living facility or currently receiving home health care or similar-type benefits?	❑ Yes ❑ No
2.	Are you physically unable to perform routine activities such as bathing, dressing, eating, toileting and transferring from bed to chair?	❑ Yes ❑ No

APPLICANT B – EXISTING COVERAGE		
1.	Do you have existing health coverage (including home health care, long-term care, or similar coverage)?	❑ Yes ❑ No
2.	Are any policy(s) intended to replace any other insurance not in force? If "**Yes**," provide the company name, policy number, and type of coverage below.	❑ Yes ❑ No

AM7008APSC 2

Submit Completed Form to: New Business Department, [10777 Northwest Freeway, Houston, TX 77092]
Toll Free Telephone Number: [(800)669-9030] FAX: [(713) 821-6463]

Please note: *Many states have their own unique application for Home Health Care Select Insurance. Please make sure you are completing the correct state application based on the resident state of your client.*

APPLICATION INFORMATION (B)

- Application can be used for 1 or 2 applicants.
- Fill out all information fully and correctly.

ADDRESS

- Applicant's resident state must match the materials being used.
- "Mailing Address" is optional. It should only be used if the applicant wants to receive info somewhere other than their resident address.
- E-mail address is preferred but optional.

PLAN SELECTION

- Select policy choice of "Classic", "Premier" or "Deluxe".
- Use Rate Chart and conversion factors to calculate initial premium based on mode selected.

OPTIONAL RIDERS

- Use Rate Chart and conversion factors to calculate initial premium based on mode selected.

Application Instructions Continued

AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, LLC (MIB), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to the Standard Life and Casualty Insurance Company (the Company) or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize Standard Life and Casualty Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB, LLC.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to the Company will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: [10777 Northwest Freeway, Houston, TX 77092]. I understand that such revocation will not have any effect on actions the Company took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits, or, for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be as valid as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete, and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, represent that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

WARNING: 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.

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant A's signature (or their authorized representative)

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant B's signature (or their authorized representative)

AGENT(S) STATEMENT: I, the undersigned agent, also represent that to the best of my knowledge, replacement ❑ is ❑ is not involved at this time.

X _____	_____	_____	_____ %	_____ %
Signature of Agent	Printed Agent's Name	Agent No.	% Credit	State ID No.
X _____	_____	_____	_____ %	_____ %
Signature of Agent	Printed Agent's Name	Agent No.	% Credit	State ID No.

NOTICE: All premium checks must be made payable to Standard Life and Casualty Insurance Company. Do not make the check payable to the agent or leave the payee blank.

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Submit Completed Form to: New Business Department, [10777 Northwest Freeway, Houston, TX 77092]
Toll Free Telephone Number: [(800)669-9030] FAX: [(713) 821-6463]

AGREEMENTS, AUTHORIZATIONS & SIGNATURES

- Read and review everything carefully in this section.

AGENT SIGNATURE(S)

- Fill out all information fully and correctly. Sign and date as appropriate.

Agent Signature(s): *Fill out all information fully and correctly. Sign and date as appropriate.*

Application Instructions Continued

APPLICANT A - EMAIL CONSENT AUTHORIZATION

❑ I give my written consent to allow Standard Life and Casualty Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(s) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

❑ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

APPLICANT B - EMAIL CONSENT AUTHORIZATION

❑ I give my written consent to allow Standard Life and Casualty Insurance Company (the Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(s) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

❑ I decline to give consent to the Company to communicate with me by email. (Do not provide email addresses below)

Primary email address:_____

Secondary email address: _____

Signature:_____ Date: _____

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

APPLICANT SIGNATURES

- Fill out all information fully and correctly. Sign and date as appropriate.
- If someone other than the applicant signs, Power of Attorney paperwork must be provided.

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Submit Completed Form to: New Business Department, [10777 Northwest Freeway, Houston, TX 77092]
Toll Free Telephone Number: [(800)669-9030] FAX: [(713) 821-6463]

Application Instructions Continued

APPLICANT A - PAYMENT OPTIONS AUTHORIZATION

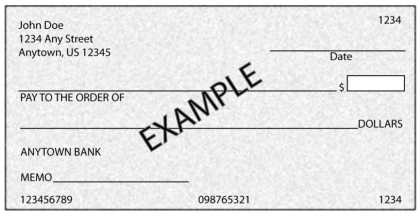
❑ **Payroll Deduction (Listbill)**
Assigned list bill number, if known:_____
I hereby authorize my employer to deduct from my salary and pay to Standard Life and Casualty Insurance Company the premium.

❑ **Automatic Bank Draft (Electronic Funds Transfer)**

❑ Monthly ❑ Quarterly ❑ Semi-Annually ❑ Annually

Type of Account: ❑ Checking ❑ Savings

Desired withdrawal date (Between the 1st and the 28th)_____
Bank name:_____
City:_____ State:_____
Routing number (9 Digits):_____
Account number:_____



Authorization for Electronic Funds Transfer (EFT)

I (we) hereby authorize Standard Life and Casualty Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder's Signature_____ Date_____

❑ **Direct Billing** ❑ Quarterly ❑ Semi-Annually ❑ Annually

If your billing address is different than your home address, please enter it below:

Billing Address: _____
(Street) (City) (State) (Zip)

Name of person paying, if different: _____

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Submit Completed Form to: New Business Department, [10777 Northwest Freeway, Houston, TX 77092]
Toll Free Telephone Number: [(800)669-9030] FAX: [(713) 821-6463]

BANK DRAFT AUTHORIZATION

- Fill out all information fully and correctly. Sign and date as appropriate.
- The Bank Routing/ ABA # is always 9 digits long.
- If two applicants apply and one bank draft form is completed, this bank account will be used for both policyholders.

Effective Dates

The policy effective date and the bank draft date must match for a policy to be issued. If the requested effective date is left blank, the bank draft date will become the policy effective date. We will honor requests for effective dates starting from the date the application was signed up to 6 months in the future. Insurance policies may not be effective on the 29th, 30th, or 31st of the month. Applications written on these days will be made effective on the 1st of the following month. Additionally, the policy effective date cannot be prior to the applicant's signature date.

Once an application is processed and accepted, the policy is scheduled to draft on the requested effective date.

Rates

Home Health Care Select rates vary by state and by age. Consult the rate schedule for each state for specific details.

- **Age Used To Determine Rates:** When a quote is prepared in the system, the rate is based on the applicant's age as of the application submission date. If the policy is then issued, this will be the rate paid by the policyholder until the next rate increase.
- **Effective Date For Rate Increases:** When a client moves from one age band to another (e.g., 65 to 69 moving to 70 to 74), the rate increase will take place on the policyholder's next policy anniversary month after moving into the higher age band.
- **Rate Increase Notification Process:** Rate increase letters are sent to policyholders when they move up to the next higher rate band and are subject to a rate increase on their next policy anniversary month. Depending on state requirements, this correspondence will be sent to the insured 30-60 days prior to the new rate's effective date.

Underwriting

The goal of ManhattanLife and group of companies is to issue insurance policies as quickly and efficiently as possible, while ensuring proper evaluation of each risk. To accomplish this goal, writing agents may be contacted via email to advise him/her of any problem(s) with an application.

Complete applications will be reviewed and processed within 48-72 hours. It is very important to ensure the entire application is filled out completely, including all health questions. This greatly helps reduce processing timeframes.

If you (agent) or insured are unsure about past medical conditions, impairments, or terminology, please provide any additional comments that could provide additional insight to our underwriters.

Telephone Interviews

There may be instances when a telephone interview is necessary to verify information within the application. In the event we are unable to complete a phone interview, additional medical records may be required.

** Any deviations from the application and information gathered during a Phone Interview could result in processing delays. Please be aware that agents and/or an agent's representative may not be present or on the line while a phone interview is being conducted.*

Premium Payments

ManhattanLife allows the following payment methods:

Direct bill*	**Bank Draft**
Annual	Annual
Semiannual	Semiannual
Quarterly	Quarterly
	*Monthly

**Monthly payments are only an option for automatic bank draft.*

The applicant may select any day for the renewal premiums to be drafted excluding the 29th, 30th, or 31st of the month.

Automatic Bank Draft Options:

Option 1: Pay initial and renewal premiums by bank draft
A completed Bank Draft Authorization form must accompany the application. The Bank Draft Authorization form must be filled out in its entirety. If the information provided is incomplete or unclear, ManhattanLife will require proof of the routing number and account number from the financial institution.

Option 2: Pay initial premium by paper check and renewal premiums by bank draft
The initial premium is due at the time the application is submitted for processing – no exceptions. A completed Bank Draft Authorization form must accompany the application. The Bank Draft Authorization form must be filled out in its entirety. If the information provided is incomplete or unclear, ManhattanLife will require proof of the routing number and account number from the financial institution.

If submitting via fax and you (the agent) have collected a premium check, please mail the check along with a copy of the first page of the application to one of the addresses provided in the "Contacting Us" section.

NOTE: If the initial EFT is returned non-sufficient funds (NSF), a second attempt will be made on the 5th business day after we are notified by the Bank. If the second attempt is unsuccessful, payment will be called due, the policy will transition to quarterly direct bill mode, and the initial premium will be required to activate the coverage. If the initial premium is drafted successfully and any renewal premiums are returned NSF, a second attempt will be made on the 5th business day after we are notified by the Bank. If the second attempt is unsuccessful, payment will be called due, and the policy will transition to quarterly direct bill mode.

Required Application Information

Whenever possible we highly recommend utilizing our ManhattanDirect 2.0 enrollment platform, as paper submissions often have undue delays. If an application is submitted with incomplete, unclear, or missing information critical to the risk evaluation process, a new application may be required, or an amendment to the application will be issued. Critical information includes, but is not limited to:

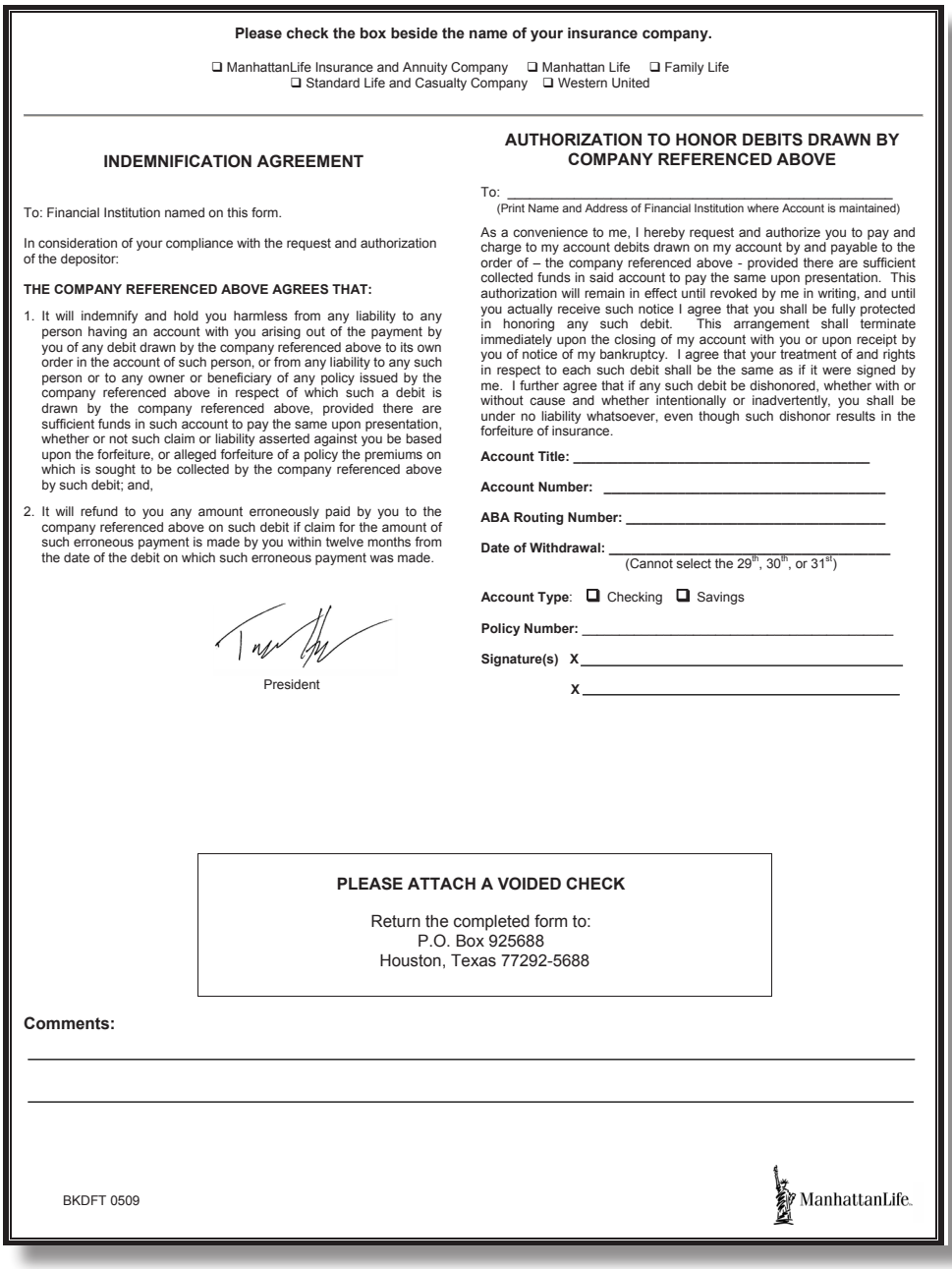
- Complete residential address
- Date of birth
- Social Security Number
- Plan selection
- Correct Premium
- Bank draft date/Policy effective date
- Eligibility questions
- Applicant's signature
- Agent's signature
- Agent Number

Top Reasons for Application Delays

- Post-dated check submitted with application (Please remember, we do not accept postdated checks).
- Temporary check submitted with application. Checks should be pre-printed from the insured's financial institution, or verification on official bank letterhead.
- The application is received at the administrative office more than 30 days from the signature date, or if the signature date is in the future.
- Pending Agent Appointment. ManhattanLife practices "Just in Time" appointments and processing of applications. What does this mean? This means that we will not run a background check and solidify appointments until your 1st piece of business is submitted. This could result in a 24-48 hr delay for this initial deal, so please keep that in mind.
- Deposit slip submitted in the place of a voided check.
- Signature stamps are not allowed on applications. Please ensure a physical signature is captured.
- Premium check from any third-party payor that has no immediate family OR business relationship to the applicant.
- If the amount quoted on the application is less than the modal premium we calculate, we will contact the agent to verify that it is acceptable to process the bank draft for the amount that we have calculated. We will amend the modal premium.
- Provide all medication information and history.
- Information listed on application does not align with Personal Health Interview (PHI).

Bank Draft Authorization Form

If client's elects to pay premiums via bank draft, please ensure the bank draft authorization form is submitted along with the application.



Please check the box beside the name of your insurance company.

❑ ManhattanLife Insurance and Annuity Company ❑ Manhattan Life ❑ Family Life
❑ Standard Life and Casualty Company ❑ Western United

INDEMNIFICATION AGREEMENT

To: Financial Institution named on this form.

In consideration of your compliance with the request and authorization of the depositor:

THE COMPANY REFERENCED ABOVE AGREES THAT:

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any debit drawn by the company referenced above to its own order in the account of such person, or from any liability to any such person or to any owner or beneficiary of any policy issued by the company referenced above in respect of which such a debit is drawn by the company referenced above, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture of a policy the premiums on which is sought to be collected by the company referenced above by such debit; and,
2. It will refund to you any amount erroneously paid by you to the company referenced above on such debit if claim for the amount of such erroneous payment is made by you within twelve months from the date of the debit on which such erroneous payment was made.

President

AUTHORIZATION TO HONOR DEBITS DRAWN BY COMPANY REFERENCED ABOVE

To: _____
(Print Name and Address of Financial Institution where Account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account debits drawn on my account by and payable to the order of – the company referenced above - provided there are sufficient collected funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of and rights in respect to each such debit shall be the same as if it were signed by me. I further agree that if any such debit 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.

Account Title: _____

Account Number: _____

ABA Routing Number: _____

Date of Withdrawal: _____
(Cannot select the 29th, 30th, or 31st)

Account Type: ❑ Checking ❑ Savings

Policy Number: _____

Signature(s) X_____

X_____

PLEASE ATTACH A VOIDED CHECK

Return the completed form to:
P.O. Box 925688
Houston, Texas 77292-5688

Comments:

_____

_____

BKDFT 0509

ManhattanLife.

PAYMENT OPTION AUTHORIZATION SIGNATURE(S)

For individuals wishing to have their monthly premiums collected via electronic ACH, please ensure correct routing and direct deposit account information is listed.

ACH information can be found on the bottom of the insureds check.

The Bank Draft authorization form can be found at:
ManhattanLIfe.com > File A Claim > Individual and Worksite > Health & Accident

*****Make sure Signature on the Bank Draft Authorization matches the signature card at the bank.*****

Policy Issue Guidelines

The policy issued is specific to the state of residence. The applicant's state of residence controls the application, forms, premium, and policy issued. If an applicant has more than one residence, the state where the federal income taxes are filed should be considered the state of residence.

Multiple Policies

An individual can only have one ManhattanLife, or Standard Life and Casualty, Home Health Care Select Insurance policy in place at any given time.

Replacements

A replacement takes place when an applicant wishes to exchange an existing ManhattanLife Home Health Care Select policy for either another MAC, Western United Life, Family Life, ManhattanLife Insurance and Annuity, or Standard Life and Casualty Home Health Care Select policy of lesser or greater value, or a policy with an external company. Internal and external replacements are processed in the same manner, and both require a newly completed application with full underwriting. An applicant that wishes to be reconsidered for the spousal discount will be handled as an internal replacement. For internal replacements, we will use the same underwriting criteria. However, we will also use our claims database to assist in determining the risk of an applicant.

Situations Requiring a New Application

A new application is required if white-out or liquid paper has been used on the application, or a change was made to the application and not initialed by the applicant.

If the incorrect state-approved application was submitted. Only the most recent state-approved application will be accepted. If the status of the available application is in question, please call Sales & Marketing to confirm the application form number.

Application Status

For your convenience, you may access *https://producer.manhattanlife.com/life/account/login.aspx?AsAgent* at any time to verify the processing status of a submitted application.

Declined Appeals

If the applicant wishes to appeal his/her declined application, a written request must be submitted by the applicant to the Underwriting Manager within 60 days of the decision. If more than 60 days have passed since the decline, the applicant will be required to submit a new application and a telephone interview will be completed. All appeals require medical records pertaining to the condition for which the applicant was declined. It is the responsibility of the applicant to obtain his/her medical records, as ManhattanLife does not make such requests. Medical records must be submitted to the Underwriting Department directly from the physician's office and will not be accepted if submitted by the applicant or agent. Please note that ManhattanLife does not reimburse any fees associated with obtaining medical records or other supporting documentation pertaining to the requested appeal. The written request and medical records may be faxed to 1-713-583-2738 and directed to the attention of the Home Health Care Select Underwriting Manager. The request and records may also be mailed to the physical address or post office box on page 37 of this Guide.

Application Status Codes

- **Data Entry:** In the process of being keyed into the computer system
- **Pending Agent Appointment:** Application processed, but pending agent appointment
- **Pending PHI:** Pending telephone interview with applicant
- **Withdrawn:** Application closed due to insufficient information or documentation
- **Declined:** Not eligible for coverage

Application Assistance

If you have any questions about the application or about how to answer any of the questions on the application, please call Standard Life and Casualty at **1-800-672-4535** or email: *aces@manhattanlife.com*

Amendments/Endorsements

An Amendment and/or Endorsement to the application will be generated for the following reasons:

- Any question left blank or answered incorrectly (as determined by a telephone interview).
- An error or unclear answer for the plan selection and/or underwriting risk classification.
- An error or unclear answer for the date of birth, sex, and/or address.
- An error or unclear answer for the modal premium.

Withdrawn Policies

Applicants who wish to withdraw an issued policy can return the insurance policy indicating they do not wish to keep the insurance policy or may be in the form of a signed letter or other signed written statement.

An applicant with a withdrawn insurance policy should be encouraged to return the insurance policy. To receive a full refund of premium, the request to not take the insurance policy must either be post- marked (if sent via mail) or received by the Company (if faxed) within the 30-day free look window. A full refund of the premium for withdrawn insurance policies will be processed 21-days after the date the check was deposited (to ensure the check has cleared the bank). If the applicant requests the refund prior to that, the applicant's financial institution will be contacted to verify the check has cleared. The refund check and a letter confirming the insurance policy was withdrawn will be mailed to the applicant. A copy of the letter will also be mailed to the writing agent.

Any commissions paid to the writing agent(s) will be reversed.

Contact Us

New business, claims, administration, and overnight mailing address:

ManhattanLife Companies
10777 Northwest Freeway
Houston, TX 77092
or
P.O. Box 925568 Houston, TX 77292

Toll-free number: 1-800-672-4535
Option 1: Direct dial extension
Option 2: Contact Information
Option 3: Commissions
Option 4: Application status
Option 5: Customer Service: Policyholder Services, Billing & Premiums.
Option 6: Marketing
Option 7: Provider benefits, eligibility, and claims status
Option 8: Personal health interviews
Option 9: Underwriting

Website: www.manhattanlife.com

ManhattanLife Marketing Department

Call 1-888-441-0770 for Marketing Support, Agent Licensing, Agent Portal Assistance or Supplies.
Marketing Support and Agent Licensing Fax: 1-713-821-6512
Marketing Support and Agent Licensing Email: *aces@manhattanlife.com*

For direct access to the Agent Resource Center portal:

https://producer.manhattanlife.com

Fax Numbers:

New Business/Customer Service/Underwriting Fax: 1-713-583-2738

When providing additional information that has been requested, please include the application number.

Claims Fax number: 1-713-583-0677

To ensure quick processing, please include the policy number on any claims inquiries.

ManhattanLife™
Standing By You. Since 1850.

Underwritten by:
ManhattanLife Insurance and Annuity Company
10777 Northwest Freeway, Houston, TX 77092

Standard Life and Casualty Insurance Company
PO Box 510690; Salt Lake City, UT 84151-0690

Thank you again for taking the time to learn about our Home Health Care Select product. Should you have any additional questions or need more clarity, please do not hesitate to reach out to Sales & Marketing directly at:
888-441-0770 or
marketingmail@manhattanlife.com

Home Health Care Select

Scan to download and view an electronic copy of this guide!

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https://www.manhattanlife.com/

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