Enrollment Form for Voluntary Group Disability Income Benefits
ManhattanLife Assurance Company of America

PLEASE INDICATE: ○ ENROLLMENT FOR NEW COVERAGE ○ CHANGE TO EXISTING COVERAGE

Section A: Always complete this Section with Proposed Insured's information for all coverages.

Proposed Insured (Please Print)

Proposed Insured 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 Telephone Number ( ) -

Employer Name or Group Number

Date of Employment (MM/DD/YYYY) / /

Benefit Group (If applicable) ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

○ DISABILITY INCOME COVERING ACCIDENT AND SICKNESS

Benefit Period
○ 90 Days ○6 Months ○1 Year ○2 Years ○3 Years

Elimination Period
○ 0/7 ○ 7/7 ○ 0/14 ○14/14
○ 30/30 ○ 60/60 ○ 90/90 ○180/180 ○365/365

○ DISABILITY INCOME COVERING ACCIDENT AND SICKNESS WITH WAIVER OF ELIMINATION PERIOD

Benefit Period
○ 90 Days ○6 Months ○1 Year ○2 Years ○3 Years

Elimination Period
○ 0/7 ○ 7/7 ○ 0/14 ○14/14

OPTIONAL DISABILITY INCOME BENEFITS

○ ICU/CCU Benefit ($200 per unit) ○ 1 ○ 2 ○ 3 ○ 4

○ Takeover ○ Physical Therapy Benefit ○ COBRA Rider COBRA Rider Benefit Amount $,

$, . Per ○Hour ○ Week ○ Month ○ Year

Monthly Benefit $,

Modal Premium $, .

Section B: Always Complete this Section.		Proposed Insured
1.	Are you currently actively at work?	○ Yes ○ No
2.	How many hours per week do you work?	
3.	Do you have any other disability income coverage in force or an Application/Enrollment Form for disability insurance pending with this or any other company?	○ Yes ○ No
4.	Have you used any form of tobacco in the past 12 months?	○ Yes ○ No

Section C: Complete this Section and Questions 1-4 if applying for Contingent Guarantee Issue		Proposed Insured
5.	Have you missed 5 or more consecutive days of work in the past 12 months for any injury or illness other than cold, flu or maternity?	○ Yes ○ No
6.	Have you ever been treated or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)?	○ Yes ○ No
7.	In the past 12 months, have you received medical advice, sought treatment, taken medication or been hospitalized for cancer (except basal cell skin cancer), insulin dependent diabetes or cirrhosis?	○ Yes ○ No

Section D: Complete this Section and Questions 1-7 if applying for Simplified Issue		Proposed Insured
8.	In the past 5 years have you received medical advice, sought treatment or taken medication for any of the following: heart attack, heart surgery, heart disease, high blood pressure reading of 140/90 or above, stroke, transient ischemic attack (TIA), cancer (except basal cell skin cancer), end stage renal/kidney disease, muscle, back, joint disorders, diabetes, emphysema, lung disease, liver disease, hepatitis, cirrhosis, neurological disorder, multiple sclerosis, chronic fatigue syndrome, fibromyalgia, digestive/intestinal disease, alcohol or drug usage?	○ Yes ○ No

9. Height (Ft-In) Weight

PROPOSED INSURED'S REPRESENTATION AND AGREEMENT

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.

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 | Date (MM/DD/YYYY)

____
Signature of Proposed Insured

Applicant response only:

Do you have existing life insurance policies or annuity contracts? _____YES _____NO

Agent response only:

Does the applicant have existing life insurance policies or annuity contracts? _____YES______NO

INSURANCE PRODUCER'S USE ONLY

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

Signature of Licensed Insurance Producer ________________________ Date (MM/DD/YYYY) __ __ / __ __ / __ __ __ __

(Not required)

Insurance Producer Number								

% Credit		

Insurance Producer Number								

% Credit		