

Critical Illness

SUMMARY OF BENEFITS*



ManhattanLife™

Standing By You. Since 1850.

Consider coverage that helps protect your employees, their families, and their assets in the event of a critical illness. Specialized benefits supplement other health insurance when employees may be most vulnerable: during the working years. Benefit payments can assist in covering a variety of expenses associated with a critical illness: out-of-pocket medical care costs, home healthcare, travel to and from treatment facilities, rehabilitation, and other expenses.

Product Base

Group

Coverage Type

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

BENEFITS & FEATURES

Benefit Amount

Employee:

- \$10,000 or \$20,000
 - Benefits reduce by 50% at age 70.

Dependents:

- Spouse: \$5,000 or \$10,000
 - Benefits reduce by 50% at age 70.
- Child: \$5,000 for each eligible child.

Vascular Conditions

100% of benefit amount paid upon treatment period or proof of loss for Heart attack, Transplant as a result of heart failure, and Stroke. 25% of benefit amount paid at diagnosis for Coronary artery bypass surgery as a result of coronary artery disease. *Any unused benefit may be used for a future vascular condition.*

Other Critical Illnesses

100% of benefit amount paid upon proof of loss for: Major organ failure, other than heart; End-stage renal failure; Loss of sight, speech, or hearing; Coma; Severe burns; Permanent paralysis due to an accident; or Occupational HIV.

Waiver of Premium for Disability

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.

Portability

Prior to age 70 and after six month of continuous coverage, employees can take their coverage with them if they leave their employer as long as the master policy remains in effect.

Health Screening Benefit	<p>Health Screening Benefit - \$150</p> <p>Pays a cash benefit when a member has one or more of the 18 covered screening tests. This screening benefit is payable once per covered person per calendar year.</p>
Loss of Work	<p>Provides waiver of premium to employees due to authorized strike, lockout, layoff, or job elimination. 30-day elimination period. Maximum benefit period is six months per occurrence; lifetime benefit maximum of 12 months.</p>

PLAN PROVISIONS

Pre-existing Conditions	<p>If a member has a pre-existing condition that is diagnosed or symptoms occurred in the 6 months prior to policy effective date, no benefits will be paid for the first 6 months after the policy effective date.</p>
Eligibility	<ul style="list-style-type: none"> • Employee issue ages 18-69. • Full-time, benefit eligible employees, actively at work and working at least 20 hours per week. • Spouse issue ages 18-69; ineligible if employee is denied • Child issue ages 0-25; ineligible if employee is denied
Termination Age	<p>Employee - Age 70 unless actively at work, then on last day of active employment. If actively at work on or past age 70, coverage will reduce by 50% at age 70.</p> <p>Spouse - The earlier of Age 70 or when employee plan terminates.</p> <p>Child - The earlier of Age 26 or when the employee plan terminates.</p>

Benefits and riders may vary by state and may not be available in all states.

This is not a complete disclosure of plan qualifications and limitations. Please access our website to obtain a completed list for the Voluntary Benefit products at www.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.

This product is not available in CO, CT, DC, NH, NM, RI, and WA.

Please note - NJ, and NY require an individual be enrolled in a medical plan to apply for critical illness coverage.

This Summary of Benefits does not apply to CA. Please refer to CIC-SB-CA 320 for the CA version of the Critical Illness and Cancer coverage.

Policy: M-8011

Well-Being Benefit: M-1775

Insured by ManhattanLife Assurance Company of America
 NY, FL, NJ - Manhattan Life Insurance Company

Employee rates

Displaying Bi-Weekly payroll deductions including \$150 Health Screening benefit

Age	Employee - NTU	
	BENEFIT: \$10,000	\$20,000
18-29	\$3.79	\$5.22
30-39	\$4.67	\$6.98
40-49	\$6.15	\$9.93
50-55	\$8.68	\$15.01
56-59	\$8.08	\$13.81
60-64	\$10.39	\$18.42
65-69	\$11.27	\$20.18

Age	Employee - TU	
	BENEFIT: \$10,000	\$20,000
18-29	\$4.30	\$6.25
30-39	\$6.19	\$10.02
40-49	\$9.47	\$16.57
50-55	\$14.78	\$27.19
56-59	\$13.76	\$25.16
60-64	\$17.68	\$33.01
65-69	\$19.07	\$35.78

Spouse rates

Displaying Bi-Weekly payroll deductions including \$150 Health Screening benefit

Age	Spouse - NTU	
	BENEFIT: \$5,000	\$10,000
18-29	\$2.15	\$2.90
30-39	\$2.63	\$3.88
40-49	\$3.46	\$5.54
50-55	\$4.86	\$8.35
56-59	\$4.54	\$7.70
60-64	\$5.79	\$10.19
65-69	\$6.25	\$11.12

Age	Spouse - TU	
	BENEFIT: \$5,000	\$10,000
18-29	\$2.42	\$3.46
30-39	\$3.53	\$5.68
40-49	\$5.28	\$9.18
50-55	\$8.18	\$15.00
56-59	\$7.63	\$13.89
60-64	\$9.78	\$18.18
65-69	\$10.59	\$19.79

NTU: Non-tobacco user

TU: Tobacco user

Child rates

Age	Children
BENEFIT: \$5,000	
0-24	\$1.64



www.manhattanlife.com

CIC-SB 0320

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SERIES

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 Agency _____

PLEASE INDICATE: 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 _____ Date of Employment (MM/DD/YYYY) _____

S T A T E O F F L O R I D A - 8 9 8 0 6 1 _____ / _____ / _____

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

CRITICAL ILLNESS INSURANCE

Employee Spouse Child(ren)

Has any Proposed Insured used any form of tobacco in the last 12 months?.....	Employee	Spouse
	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> 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?.....	<input type="radio"/>	<input type="radio"/>								
2. Will this coverage replace a critical illness policy or certificate of insurance paid for, by, or through your employer?.....	<input type="radio"/>	<input type="radio"/>								

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

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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.

Date (MM/DD/YYYY)

		/			/				
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Signature of Licensed Insurance Agent _____

Insurance Agent Number

% Credit

Insurance Agent Number

% Credit
