
PART D

In the spaces below, give details to all conditions circled in Part C by indicating dates, condition number(s), diagnosis, treatment results, duration and outcomes. If necessary, use a separate sheet of paper, dated and signed by the proposed insured. Please use the first line to list the name of the physician who is most likely to have your complete medical records.

Physician's Name and Address	Dates	Condition Number(s)	Diagnosis	Treatment Results
1. _____				
2. _____				
3. _____				
4. _____				
5. _____				
6. _____				
7. _____				

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

I hereby AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, insurance or reinsuring company, the Medical Information Bureau, Inc., (MIB) consumer reporting agency or employer having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family to give to ManhattanLife Assurance Company of America, its reinsurers or its legal representative, any and all such information as permitted by law and the rules of MIB, Inc. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by ManhattanLife Assurance Company of America to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that the application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I AGREE that no insurance will take effect unless and until the policy is issued and delivered to the proposed insured(s), the first premium has been paid to and accepted by ManhattanLife Assurance and there has been no change in the insurability of the Proposed Insured since the date of this application.

If this application is declined, any premiums received by ManhattanLife Assurance will be refunded.

No Agent or Broker is authorized to make or modify any policy or waive any of ManhattanLife Assurance's rights or requirements or waive the answer to any question in the Application.

Signed at _____
City State Month-Day-Year

X

Signature of Proposed Insured

Date

Agent's Signature

Agent No.

BENEFITS UNLIMITED, INC.

01THE11
415-459-5019

Print Agent's Name

Telephone Number

ELECTION FORM
Postal (Manhattan Life)

Name: _____
 Address: _____

On the accompanying benefit applications and this enrollment form, I have applied for certain benefits offered through the above group. It is my decision to receive the following through allotment/payroll deduction.

DISABILITY PLAN - OCC3 - 1 YEAR		
INITIAL ELECTION	BENEFIT AMOUNT PER MONTH	BI-WEEKLY DEDUCTION
	\$600	\$22.13
	\$700	\$25.81
	\$800	\$29.50
	\$900	\$33.19
	\$1,000	\$36.88
	\$1,100	\$40.56
	\$1,200	\$44.25
	\$1,300	\$47.94
	\$1,400	\$51.63
	\$1,500	\$55.32
	\$1,600	\$59.00
	\$1,700	\$62.69
	\$1,800	\$66.38
	\$1,900	\$70.07
	\$2,000	\$73.75

Total Bi-Weekly: \$ _____ Add \$2.00 Fee = Total Allotment: \$ _____
 (includes any Rider Costs)

EMPLOYEE ID # POSTAL EASE PIN#

SSP Password: _____

Authorized Signature: _____ Date: _____

