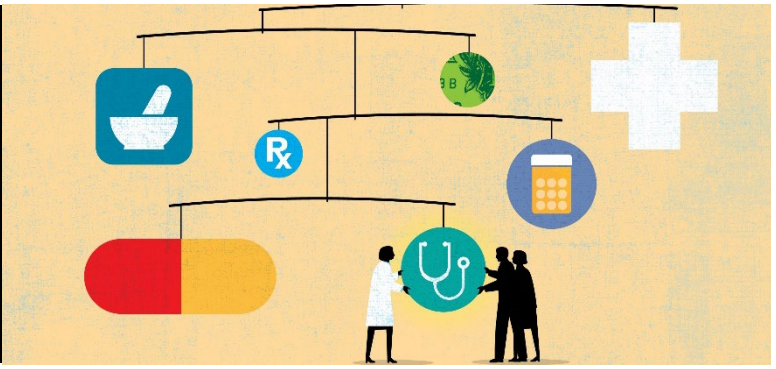
ManhattanLife™

Wellness Screening Benefit



Wellness Screening – Covered Tests

- Bone Marrow Testing
- CA-125 (blood test for ovarian cancer)
- CA 15-3 (blood test for breast cancer)
- CEA (blood test for colon cancer)
- Colonoscopy
- Mammography (inc. breast ultrasound)
- PSA
- Pap smear (including ThinPrep Pap)
- Serum Protein Electrophoresis (test for myeloma)
- Oral cancer screening as part of a comprehensive dental exam
- Biopsy for skin cancer
- Flexible Sigmoidoscopy
- Chest X-ray
- Electrocardiogram (EKG)
- Stress EKS
- Stress test (bike or treadmill)
- Lipid panel (total cholesterol count)
- Blood test for triglycerides
- 3 Blood Pressure Checks in 14 days
- Skin Caliper
- Water Displacement
- A1C Blood Test

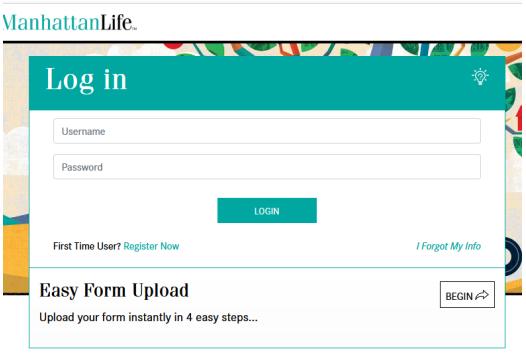
Filing a Claim

Please call Customer Service to submit a telephonic claim or submit completed claim form via fax, email, US mail, online via our website or via our Mobile App.

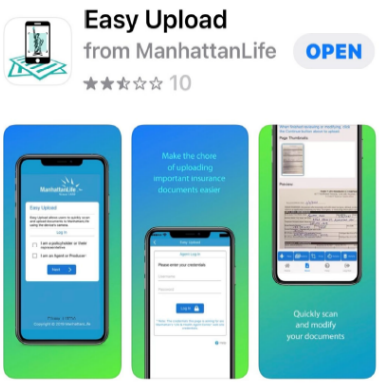
Mailing Address: ManhattanLife VB Claims
P.O. Box 926169 Houston, TX 77292

Customer Service (telephonic): 1-855-448-6982
Fax to: 1-502-405-7107
Email to: vbclaimssubmissions@manhattanlife.com

Employee portal website:
https://clients.manhattanlife.com/#/



Download our Mobile Application



Voluntary Benefits
Accident, Critical Illness and Hospital Indemnity
Wellness Screening Benefit Claim Form

ManhattanLife™

This claim form can be used to request reimbursement for your Health Screening Benefits under your Critical Illness, Accident or Supplemental Health plan. Benefit may not be available for all plans. Please refer to your Policy Certificate for specific benefits. Any Person, who with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on page 3)

Service Information:

Claim is for: ☐ **Policyholder** ☐ **Dependent**

Date services were rendered: _____

- ☐ Bone Marrow Testing
- ☐ Chest X-ray
- ☐ Flexible Sigmoidoscopy
- ☐ Pap Smear
- ☐ Biopsy for Skin Cancer
- ☐ Lipid Panel
- ☐ CEA (Colon Cancer)
- ☐ PSA(Prostate Cancer)
- ☐ Stress Test (Bike or Treadmill)
- ☐ Blood Test for Triglycerides
- ☐ CA 15-3 (for Breast Cancer)
- ☐ CA-125 (Ovarian Cancer)
- ☐ Colonoscopy
- ☐ Mammography
- ☐ Electrocardiogram (EKG)/Stress EKG
- ☐ Serum Protein Electrophoresis
- ☐ Oral Cancer Screening, as part of a comprehensive dental exam
- ☐ Biometric Screening - **Critical Illness and Hospital Indemnity Plans only**
- ☐ Hemoccult Stool Analysis- **Critical Illness and Hospital Indemnity Plans only**
- ☐ 3 Blood pressure readings in 14 days with Health Care Practitioner attestation
- ☐ Blood Glucose Test A1C1 Test (Diabetes)
- ☐ Water Displacement Test (Obesity)
- ☐ Skin Caliper Test (Obesity)
- ☐ **Critical Illness State of California Only:** Human papillomavirus screening test or any other cervical cancer screening test approved by the U.S. Food and Drug Administration

All screenings may not be available for your plan(s). Please refer to our Policy Certificate for complete listing or give us a call.

Policyholder's Name _____ Policy No. _____
(If this is a name change, provide a copy of an updated driver's license, government issued ID, marriage license or divorce decree.)

Date of Birth _____

Mailing Address _____ City _____

State _____ ZIP Code _____ Phone No. _____

Claimant Name: _____ **Date of Birth** _____

Provider Information:

Printed Name of Physician _____ Specialty _____

Phone No. _____ Street Address _____

City _____ State _____ ZIP Code _____

The above Statements are true to the best of my knowledge and belief.

_____ _____ _____

Policy Holder Signature | Printed Name | Date

Direct Deposit Authorization

ManhattanLife

Check Action

☐ New ☐ Change ☐ Cancel

Account Type

☐ Checking ☐ Savings

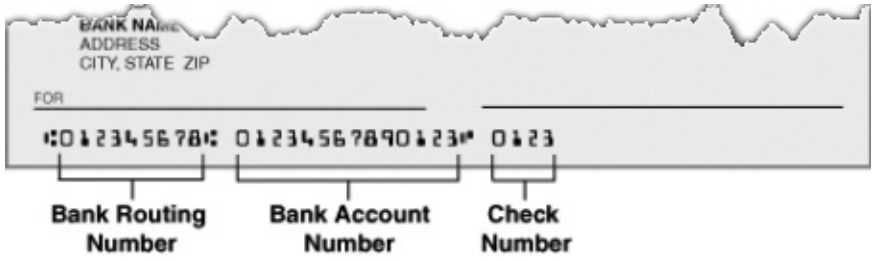
Ownership of Account

☐ Self ☐ Other

Bank Name_____

Bank Routing Number_____ Bank Account Number_____

Policy Holder's Name _____ Policy Number _____



Terms and Conditions For Annuitants Participating In The Direct Deposit Program

You have the option of having your Benefits deposited directly into your account at your financial institution. If you do choose to participate in this Direct Deposit Program, please read the following terms and conditions for participation carefully before making your decision. Not all polices may qualify.

1. Once the Form is received by ManhattanLife, **there may be a delay of up to four weeks before the reimbursements begin being deposited** directly into your account. You will receive checks for any reimbursements before that time.
2. **It is your responsibility to notify ManhattanLife of any changes to your account immediately.** Complete this form indicating that the action is a CHANGE and return it to the address below. Once received, again there may be a delay of up to four weeks before the new information will be processed. You will receive checks for any reimbursements before that time.
3. **You can cancel participation in Program at any time.** To cancel participation, complete this Form indicating that the action is a CANCEL, and return it to the address on the front. Your participation will be canceled as of the effective date on the Form or as soon as the Form has been received and processed, whichever one is later.
4. **If an electronic transfer is returned** to ManhattanLife or cannot be made to your account, ManhattanLife will investigate the cause. If the situation cannot be resolved quickly, a reimbursement check will be mailed to you. You will continue to receive your reimbursements by mail until the situation is resolved. You will be notified of any action taken.
5. This agreement may be canceled by your financial institution or ManhattanLife. **Your participation will be canceled automatically if you terminate participation in the above Account(s).**

I certify that I have read and understand the Terms and Conditions on this form. By signing this agreement, I authorize ManhattanLife to initiate credit entries to the Account(s) indicated above for the purpose of reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ _____ _____

Signature Printed Name Date

Authorization to Release Information
For the Use and Disclosure of Protected Health Information

ManhattanLife™

Patient's Name_____**Policy No.** _____

TO: Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or dental services or supplies; any employer, group policyholder, contract holder or insurer, benefit plan administrator, administrator, The Index System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, State or Local Government Agency, including Social Security Administration and Veterans Administration.

I authorize the use and/or disclosure of my protected health information and other related information as described below:

1. My authorization applies to that information obtained by all health care professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiology reports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/AIDS, communicable diseases, alcohol or drug abuse, and mental health, as such information may relate to my claim for benefits. This information may be used and/or disclosed pursuant to this Authorization.
2. I authorize all health care professionals to disclose my protected health information to ManhattanLife,
3. My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.
4. I authorize the release of information concerning Social Security benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.
5. I authorize only designated staff of ManhattanLife to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.
6. I understand that, if my protected health information is disclosed to someone who is not required to comply with federal privacy protection regulations, such information may be re-disclosed and would no longer be protected.
7. I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Attn: Claims Department PO Box 926169 Houston, TX 77292 . This revocation shall become effective on the date it is received by ManhattanLife. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.

This Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.

A photocopy or facsimile of this authorization shall be valid as the original.

_____ _____ _____
Signature *Printed Name* *Date*

I have legal authority* under the laws of the State of_____to make health care decisions on behalf of _____, the individual to whom the use and/or disclosure of protected health information above applies and execute this Authorization in my capacity as Authorized Representative thereof.

_____ _____ _____
Name of Authorized Representative/Parent or Guardian *Relationship to Applicant* *Date*

**A copy of the legal authority document must be on file with ManhattanLife.*