ManhattanLife™

VB Accident, Critical Illness and Hospital Indemnity Health Screening Benefit Claim Form

This claim form can be used to request reimbursement for your Health Screening Benefits under your Critical Illness, Accident or Supplemental Health plan. 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
- ☐ Stress (EKG)
- ☐ Serum Protein Electrophoresis
- ☐ Oral Cancer Screening using ViziLite, OraTest or Dental Code D0431
- ☐ Biometric Screening - **Critical Illness and Hospital Indemnity Plans only**
- ☐ Hemocult 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

Policyholder's Name _____ Policy No. _____

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 Date

Mail to:
ManhattanLife
VB Claims
PO Box 926169
Houston, TX
77292

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

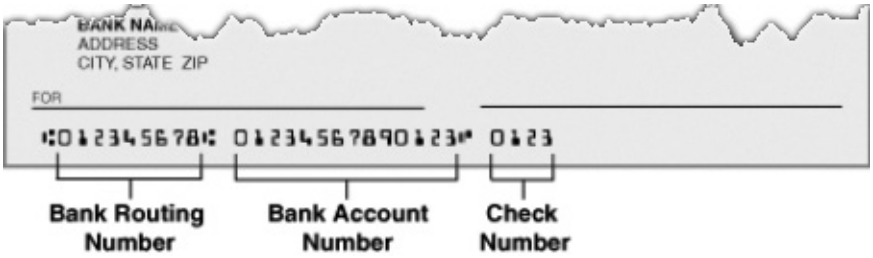
Direct Deposit Authorization

ManhattanLife™

Check Action			Account Type		Ownership of Account		
☐	☐	☐	☐	☐	☐	☐	☐
New	Change	Cancel	Checking	Savings	Self	Joint	Other

Bank Name _____

Routing Number _____ Bank Account Number _____



Policyholder's Name _____

Policy No. _____

Terms and Conditions for Participation 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 Insurance Company **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 Insurance Company if 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 Insurance Company or cannot be made to youraccount, ManhattanLife Insurance Company will investigate the cause. f 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 Insurance Company. **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 Insurance Company to initiate credit entries to the Account(s) indicated above for reimbursements from my Account(s) and to initiate, if necessary, debit entries and adjustments for any credit entries made in error.

_____ ____/____/____

Signature **Date**

If the account is a joint account or in someone else's name, that individual must also sign to indicate agreement with the statement above.

_____ ____/____/____

Signature **Date**

ManhattanLife VB
Claims
PO Box 926169
Houston, TX 77292

Customer Service: 1-855-448-682
Fax: 1-502-405-7107
Email:
vbclaimssubmissions@manhattanlife.com

State Specific Fraud Warning Statements

ManhattanLife

Any Person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notify all state and federal law enforcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to You and/or any party on Your behalf, based on fraudulent or misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia: Any Person who, with the intent to defraud or knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Rhode Island: 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.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: 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.

Kentucky, Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Kansas: Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.