VB Accelerated Benefit Claim Form
Employee Statement

The offering company(ies) listed below, severally or collectively, as the content may require, are referred to in the Claim Form as **"ManhattanLife Insurance Company."**

This claim form should be used with the intents and purposes for claiming for an accelerated benefit in which the member has been advised by their attending or treating physician that their condition is terminal.

Employee Information:

Policy Holder'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.)

Mailing Address _____ Social Security No. _____

City _____ State _____ ZIP Code _____ Date of Birth _____

Daytime Phone number _____

Do you wish to apply for accelerated benefits under any other policies issued to you by ManhattanLife, its subsidiaries or affiliates?

☐ Yes ☐ No If yes, please provide policy ID no. _____

Employer's Name _____

Street Address _____ Phone Number _____

City _____ State _____ ZIP Code _____

Occupation _____

Claim Information:

Date of the first diagnosis _____

Describe the onset and nature of your illness: _____

Physician Information: *Attending or Treating Physicians:*

Physician's Name	Address	Telephone & Fax Number

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 7)

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

_____ _____ _____

Signature *Printed Name* *Date*

- **Submit the Employee, Employer and Physician statements to prevent delays in processing. All three sections are required before the Accelerated Benefit Claim can be reviewed.**
- **Sign and date the authorization on page 2 and include when returning the claim form.**
- **Retain a copy of all information submitted for your records**

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

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

VB Accelerated Benefit Claim Form
Employee Statement

Benefit Agreement

For value received, the receipt of which is hereby acknowledged, I, the undersigned, as the member, do hereby agree to the payment of fifty (50) percent of the life insurance in force on the life of the member as an Accelerated Benefit. I do hereby release all of my right, title and interest as to this fifty (50) percent of the life insurance in force and do acknowledge that at the time of the payment of the life insurance as a claim due to the death of the member, the life insurance amount will be reduced by said Accelerated Benefit.

In consideration of the ManhattanLife payment to me of the Accelerated Benefit, I, the member, do hereby release, discharge and hold ManhattanLife and its affiliates and subsidiaries, their agents, officers, directors, and employees, harmless from any and all claims, demands, or causes of action which might arise out of ManhattanLife payment including indemnification against any awards, judgments or settlements, including litigation costs and attorney fees.

Payment from an Accelerated Benefit may be taxable. Assistance should be sought from your personal tax advisor. ManhattanLife is not responsible for any tax or other effects from an Accelerated Payment or loss of eligibility for any State or Federal Program.

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

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____

Signature *Printed Name* *Date*

Release of Benefit Agreement – Irrevocable Beneficiary or Irrevocable Assignment

I, _____, Irrevocable Beneficiary or Irrevocable Assignor designated for Policy Number_____insuring the Life of_____,do hereby surrender rights to 50% of the Life Insurance benefit to be paid to_____ as an Accelerated Death Benefit. I release ManhattanLife from all claims to this benefit that I may have as the Irrevocable Beneficiary or the Irrevocable Assignor.

I certify that I have received a copy of this Agreement and authorize this release and agreement shall be binding upon me, my heirs, administrators and assigns.

_____ _____ _____

Irrevocable Beneficiary or Irrevocable Assignor Signature *Printed Name* *Date*

Direct Deposit Authorization

ManhattanLife

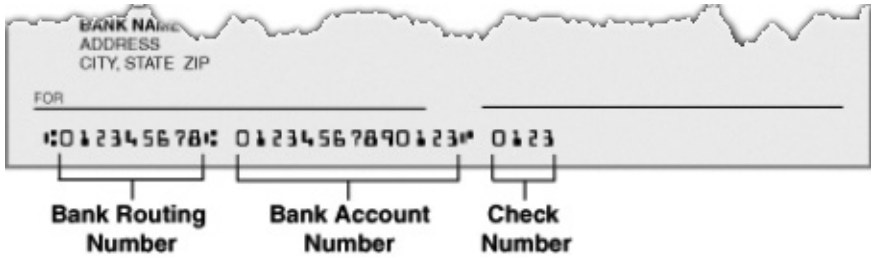
Check Action			Account Type		Ownership of Account	
☐	☐		☐	☐	☐	☐
New	Change	Cancel	Checking	Savings	Self	Other

Policy Holder's Name _____ Policy Number _____

Bank Name _____

Bank Routing Number _____ Bank Account Number _____

Account Holder's Name _____



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 _____

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PO Box 926169
Houston TX 77292

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

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

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

Patient's Date of Birth _____

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.*

VB Accelerated Benefit Claim Form
Employer Statement

Employer Information:

Employer's Name _____

Employer Address _____ City _____ State _____

ZIP Code _____ Contact Name _____

Phone Number _____ Group Number _____

Fax Number _____

Employee's Name _____ Policy No. _____

Date of Birth _____ Social Security No. _____

Street Address _____

City _____ State _____ ZIP Code _____

Employee's Date of Hire _____ Date Employee Last Worked _____

Employee's Annual Salary _____ Actual Hours Worked per Week _____

Date of last paycheck _____

Reason for stopping work:

☐ Sickness ☐ Granted LOA ☐ Laid Off ☐ Accident

☐ Dismisssed ☐ Resigned ☐ Retired ☐ Other _____

Are they still an employee? ☐ Yes ☐ No If No, when did employment terminate _____

Reason for termination of employment: _____

_____

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

_____

Printed Name of Persons Completing Form

_____

Signature of Authorized Representative

_____ _____

Title Date

VB Accelerated Benefit Claim Form
Physician Statement

Patient Information:

Patient's Name _____ Date of Birth _____

Is the condition due to an injury or sickness arising from the patient's employment? ☐ Yes ☐ No ☐ Unknown

Treatment Information:

All sections regarding condition, functional ability, and prognosis should be carefully reviewed and completed based on the Insured's current condition.

Diagnosis (including any complications) _____

Date of patient's Diagnosis _____ Date of last patient visit _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

Subjective symptoms _____

Objective findings (including current X-rays, EKG, laboratory data and any clinical findings)

_____

_____

Please provide the name and address of other treating physician(s):

Physician's Name	Address	Phone Number

Impairment:

Is your patient capable of performing the following activities of daily living independently?

Activity:	**Yes**	**No**
Bathing	☐	☐
Dressing	☐	☐
Continence/Toileting	☐	☐
Eating	☐	☐
Transferring	☐	☐

If your patient has a cognitive impairment, please answer the following questions.

Is the impairment expected to be permanent? ☐ Yes ☐ No

Does your patient require Substantial Supervision to protect them from threats to his or her health and safety? ☐ Yes ☐ No

VB Group Accelerated Benefit Claim Form
Physician Statement

Prognosis:

Note that progress notes and/or medical records may be requested at any time to substantiate condition. Do you expect a fundamental or marked change in the patient's condition?

☐ Less than 1 Month ☐ 1 Month ☐ 2- 3 Months ☐ 4-6 Months ☐ Other _____

Life expectancy: ☐ 6 months or less ☐ 9 months or less ☐ 12 months or less ☐ 24 months or less

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

Comments:

_____

_____

_____

_____

_____

_____

_____

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

Printed Name of Physician _____ Phone No. _____

Street Address _____ Specialty _____

City _____ State _____ ZIP Code _____

_____ _____

Signature of Attending Physician Date

Claim Form Addendum: Fraud Warning and State Versions

Any person who knowingly, and with intent to injure, defraud, or deceive an insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of insurance fraud, which is a felony.

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. **Alaska** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law. **Arkansas** 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 to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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. **Delaware** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony. **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. **Idaho** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony. **Indiana** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony. **Kentucky** Any person who knowingly and with intent to defraud any insurance company or other person files a 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. **Louisiana** 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. **Maine** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **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. **Minnesota** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime. **New Hampshire** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20. **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 Mexico** 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 civil fines and criminal 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 a 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. **Ohio** Any person who, with 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 is guilty of insurance fraud. **Oklahoma** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **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. **Puerto Rico** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years. **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. **Tennessee** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **Texas** Any person who knowingly presents a 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. **Virginia** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **Washington** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. **West Virginia** 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.