

**THE MANHATTAN LIFE INSURANCE COMPANY**

**Administration Address:**  
 5 Waterside Crossing, Third Floor, Windsor, CT 06095

**APPLICATION DATA - PLEASE PRINT LEGIBLY**

1a. Full Name of Proposed Insured: _____		b. Phone #: _____		c. <input type="checkbox"/> Male <input type="checkbox"/> Female	
2. Address: _____ <small>No. and Street or R.F.D. _____ City or Town _____ State _____ Zip Code _____</small>					
3a. Birthdate: _____	b. Age Last Birthday: _____	c. Place of Birth: _____	d. Height _____	e. Weight: _____	f. Tax I.D. or Soc. Sec. # _____
4a. Occupational Duties: _____			b. How long? ____ Years ____ Months Annual Salary \$ _____		
5. Have you been actively performing all duties of your occupation or profession on a full-time basis (at least 30 hours per week) for the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No					
6a. Do you currently smoke cigarettes? <input type="checkbox"/> Yes <input type="checkbox"/> No			c. Applicant's Driver's License #: _____		
b. Do you or have you used any form of tobacco in the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			Spouse's Driver's License #: _____		
7. Beneficiary: (Print full name and relationship to Proposed Insured) Primary _____ Secondary _____					
8. Complete for Spouse Term Rider					
Spouse's Name _____		Sex _____	Date of Birth _____	Social Security # _____	Ht _____ Wt _____
9. Complete for Children's Term Rider (include only children):					
Child's Name _____		Sex _____	Date of Birth _____	Relationship _____	Ht _____ Wt _____
a. _____		_____	_____	_____	_____
b. _____		_____	_____	_____	_____
c. _____		_____	_____	_____	_____
10. Is there any other life insurance policy(ies) in force on the life of any of the above listed applicants? <input type="checkbox"/> Yes <input type="checkbox"/> No. If Yes, please list the name of the insurance company and the amount of coverage for each applicant. _____					

**COVERAGE DATA**

1a. Plan: _____		b. Basic Amount: \$ _____		c. Death Benefit (Universal Life): <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2	
2. Additional Benefits: <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> Spouse Term Rider <input type="checkbox"/> Child Term Rider <input type="checkbox"/> Waiver of Monthly Deductions <input type="checkbox"/> Other: _____					
3. Scheduled Premium (Universal Life) \$ _____ Premiums Payable: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly Additional First Year Premium \$ _____ <input type="checkbox"/> MDD <input type="checkbox"/> Other _____ Premium notices to be sent to Insured's: Residence _____ Business _____ Other (name and mailing address) _____					
4. Will this insurance replace, change or use cash value of any existing insurance or annuity issued by any company? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "Yes" complete the requirement(s) of the state where the application is signed and list details below.)					
Proposed Insured _____		Company _____		Coverage Amount _____	ADB Amount _____
					1035 Exchange <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Owner: This policy will be owned and controlled by <input type="checkbox"/> Proposed Insured <input type="checkbox"/> Other (give name, relationship and address below)					
7. Special Requests: _____					

**NON-MEDICAL DECLARATIONS**

1. To the best of your knowledge and belief, have you or any proposed Insured:		Yes	No
a. ever had or been informed you had:			
• heart attack, bronchial or lung disease, stroke or disorder of blood vessels including high blood pressure?		<input type="checkbox"/>	<input type="checkbox"/>
• cancer, leukemia, nonlymphoma Hodgkins disease, diabetes, kidney or liver disorder?		<input type="checkbox"/>	<input type="checkbox"/>
• mental illness or any disease of the brain or nervous system?		<input type="checkbox"/>	<input type="checkbox"/>
b. within the last 5 years, ever had surgery?		<input type="checkbox"/>	<input type="checkbox"/>
c. ever been treated for or had any known indication of alcoholism or addiction to the use of habit-forming drugs?		<input type="checkbox"/>	<input type="checkbox"/>
d. ever been diagnosed or treated by a member of the medical profession as having an acquired immune deficiency syndrome (AIDS), an AIDS related condition (ARC) or tested positive for the human immune deficiency virus (HIV)?		<input type="checkbox"/>	<input type="checkbox"/>
e. have you seen a physician for any health or physical condition not listed elsewhere?		<input type="checkbox"/>	<input type="checkbox"/>
f. have you taken any medication in the last year or are you currently taking any?		<input type="checkbox"/>	<input type="checkbox"/>



**Notice of Information Practices  
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice**

**To obtain further information contact:  
The Manhattan Life Insurance Company  
5 Waterside Crossing, Third Floor, Windsor, CT 06095**

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Administrative Office at the above address. You may receive a copy of such report by contacting the reporting agency. Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. However, in certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Administrative Office at the address on the front of this NOTICE.

**MIB, Inc. Notice**

While the information regarding your insurability is treated as confidential, The Manhattan Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, The Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, Telephone (617) 426-3660. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

ML-SIUL-NP-NY

**Conditional Receipt**

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_ paid with an application to The Manhattan Life Insurance Company.  
The application bears the same date as the receipt.

We agree to insure each proposed insured person, according to the terms of the policy applied for, on the effective date defined below, subject to the following terms and conditions precedent:

1. Your payment at least equals the minimum initial premium for the coverage applied.
2. Your check is honored the first time it is presented for payment.
3. We receive the application within 30 days and all medical examinations or tests within 60 days of the date of this receipt.
4. We are satisfied that each proposed insured person was insurable and acceptable under our underwriting rules for the plan and amount of coverage exactly as applied for on the effective date, which is the latest of:
  - a. The date of the application;
  - b. The date of the latest medical examinations and tests required by our underwriting rules; or
  - c. The date, if any, specifically requested in the application.

Coverage under this receipt is also subject to these limitations:

1. The maximum amount payable under this receipt is the smaller of:
  - a. The amount of all death benefits applied for in the application, including any accidental or supplemental death benefits, if applicable; or
  - b. \$250,000, if any proposed insured person is age 0-59, less the amount of insurance benefits payable by us on the death of the Primary Insured under any other current applications and conditional receipts or
  - c. \$100,000, if any proposed insured person is Age 60 or older, less the amount of insurance benefits payable by us on the death of the Primary Insured under any other current applications and conditional receipts.
2. Coverage ends, without notice, on the earlier of 60 days from the effective date or the date of notification of approval, declination or cancellation of the application. The policy and insurance applied for will take effect on the date the application is approved. In no event will coverage under this receipt and under the policy issued under this application be effective at the same time.
3. Coverage is void in the event of death by suicide or self-inflicted injury, while sane or insane.
4. No agent is authorized to alter or waive any of the above conditions or any of the Company's rights or requirements.
5. If any one of the conditions in this receipt is not fulfilled, our only liability is for the refund of any payment made.

All checks should be made payable to The Manhattan Life Insurance Company. Do not make checks payable to the Agent or leave the Payee blank.

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 200\_\_\_\_ By: \_\_\_\_\_  
Signature of Agent

ML-SIUL-CR-NY

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK**

**Definition of Replacement**

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

- 1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated?  
 Yes       No
  
- 2) Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values?  
 Yes       No
  
- 3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?  
 Yes       No
  
- 4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?  
 Yes       No
  
- 5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?  
 Yes       No
  
- 6) Continued with a stoppage of premium payments or reduction in the amount of premium paid?  
 Yes       No

If you have answered Yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent is required to provide you with a completed "Disclosure Statement" and the "Important Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts."

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION:

Yes    No

Date: \_\_\_\_\_ Signature of Agent: \_\_\_\_\_

THE MANHATTAN LIFE INSURANCE COMPANY

Administrative Office:  
Five Waterside Crossing, Third floor  
Windsor, CT 06095

Phone: 888-222-0843 Fax: 860-298-9538

Life Solutions Universal Life Illustration  
To Be Provided With The Policy

Applicants Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

The undersigned Field Underwriter/Agent/Representative certifies that no illustration(s) conforming to the coverage(s) applied for was used in this sale.

Field Underwriter/Agent/Representative Signature: \_\_\_\_\_

Field Underwriter/Agent/Representative Print Name: \_\_\_\_\_

Agency: \_\_\_\_\_ Date: \_\_\_\_\_

The undersigned Applicant(s) acknowledges that no illustration(s) conforming to the coverage(s) applied for was provided and understands that an illustration(s) conforming to the coverage(s) as issued will be provided no later than at the time of certificate or policy delivery.

Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

This form MUST accompany the Life Solutions Universal Life application when an illustration conforming to the coverage applied for was not used in the sales process.