ManhattanLife™

Standing By You. Since 1850.™

PAID Enhanced

Benefit Highlights

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The **PAID Enhanced** plan helps pay for out-of-pocket expenses and provides benefits to families for many accidents that can happen without warning.

Our plan pays benefits for Accidents, big and small.

BENEFIT HIGHLIGHTS INCLUDE:

- Accidental Death
- Hospital Admission and Confinement*
- Intensive Care Unit*
- Air and Ground Ambulance*
- Emergency Room Treatment
- Burns*
- Emergency Dental
- Lodging
- Transportation
- Surgery*
- Physical Therapy*

Also included are benefits for dislocations, fractures, dismemberment, eye injuries, and major diagnostic exams. Benefits are outlined on the following page, and the policy explains in detail any limitations and/or exclusions.

**Denotes expanded benefits*

PRODUCT FEATURES

- Helps you pay for out-of-pocket expenses
- 2 options: 24-hour, or off-the-job only
- Issue ages 18 - 64
- Guaranteed renewable to age 70, subject to our right to change premium rates
- Choose one or two units

Optional Rider

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OPTIONAL ANNUAL WELLNESS BENEFIT RIDER*

$60 paid each year per covered person under the policy for any one of the following examinations:

- Annual Physical Examination
- Dental Exam
- Mammogram
- Pap Smear
- Eye Examination
- Immunization
- Flexible Sigmoidoscopies
- PSA Test
- Ultrasounds
- Blood Screening Test

The Policy must be in force 30 days before this benefit is payable.

PAID Benefits

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PAID BENEFITS

BENEFIT DESCRIPTION	ONE-UNIT	TWO-UNITS
Accidental Death Within 90 days** of covered accident and caused by resulting injury/ injuries. (in UT, 180 days)	$25,000 Employee $10,000 Spouse* $5,000 Child	$50,000 Employee $20,000 Spouse* $10,000 Child
Accidental Death (Via Common Carrier) Death must occur within 90 days** of covered accident while fare-paying passenger on a common carrier (plane, bus, train). (in UT, 180 days)	Accidental Benefit will be doubled	Accidental Benefit will be doubled
Accidental Dismemberment We will pay the applicable lump sum benefit indicated in the policy for dismemberment. A Covered Accident must occur within 90 days of the accident (in UT, 180). Benefits will be paid only once per Covered Person, per Covered Accident.	$625 - $40,000	$625 - $40,000
Air Ambulance Air transportation within 48 hours. Once per Covered Accident. (in PA, 30 days)	$1,000	$2,000
Ambulance Ground transportation within 90 days. Once per Covered Accident.	$100	$200
Ambulatory Surgical Center Facility and/or Outpatient Hospital Facility Max 1 per Accident.	$100	$200
Appliances Payable when a Covered Person receives a medical appliance, prescribed by a physician, as an aid in personal locomotion for on or Off-the-Job Injuries sustained in a Covered Accident. Benefits are payable for the following types of appliances: a wheelchair, a leg brace, a back brace, a walker, and/or a pair of crutches.	$125 per Covered Accident, per Covered Person.	$125 per Covered Accident, per Covered Person.
Blood, Plasma, and Platelets Transfusion, administration, cross-matching, typing and processing required within 90 days of a Covered Accident. Once per Covered Accident.	$300 primary insured $200 Spouse*/dep child	$300 primary insured $200 Spouse*/dep child

Over **40** Total Payable Benefits!

Burn Treated within 72 hours of a Covered Accident. Once per Covered Accident. *Spouse and Child (in PA, 30 days)	Size & Degree up to $10,000	Size & Degree up to $20,000
Chiropractor Visit Max 5 visits per Covered Accident	$35 per day	$70 per day
Concussion We will pay if any Insured Person is diagnosed by a Physician with a concussion as a result of a Covered Accident. Payable once per Covered Accident.	$100	$200
Coma We will pay if any Insured Person is comatose in a Hospital setting for a duration of at least seven days as a result of a Covered Accident. Payable once per Covered Accident.	$5,000	$10,000
Dislocations Diagnosed within 90 days, correction with anesthesia by Physician and corrected by Open (surgical) or Closed (non-surgical) reduction.	$50 - $2,000 (policy contains complete schedule)	$100 - $4,000 (policy contains complete schedule)
Emergency Dental Work Once per Covered Accident regardless of teeth involved.	$150 repairs with crown $50 for extraction	$300 repairs with crown $100 for extraction
Emergency Room Treatment Treatment sought within 72 hours*** of Covered Accident. (in PA, 30 days)	$200	$200
Epidural Pain Management Payable when a Covered Person is prescribed, receives and incurs a charge for an epidural administered for pain management in a hospital or a physician's office for injuries sustained in a Covered Accident.	$100 paid no more than twice per Covered Accident, per Covered Person.	$100 paid no more than twice per Covered Accident, per Covered Person.

** In NV, Spouse or Domestic Partner; ** in PA, 90 days does not apply; *** in TX, 72 hour limit does not apply*

PAID Benefits Cont.

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BENEFIT DESCRIPTION	ONE-UNIT	TWO-UNITS
Eye Injury Treated by a physician within 90 days of Covered Accident. Must require surgery or removal of a foreign object.	$200	$200
Fractures Fractures requiring Surgical or Non-Surgical reduction within 90 days of Covered Accident. (In IN, 6 months)	$25 - $2,500 (any Insured) (policy contains complete schedule)	$50 - $5,000 (any Insured) (policy contains complete schedule)
Gunshot Wounds* Unintentional wound requiring confinement within 24 hours and surgery within 72 hours after the injury. Primary insured only.	$500	$500
Hospital/Intensive Care Unit Admission Confined within 180 days. Once per Covered Accident. (minimum of 20 hours)	$1,000 If admitted directly to ICU, add $500	$2,000 If admitted directly to ICU, add $1,000
Hospital Confinement Confined within 180 days. Maximum of 365 days.	$150 per day	$300 per day
Hospital Intensive Care Unit Confinement Within 30 days of Covered Accident. Maximum of 15 days. ICU paid in addition to Hospital Confinement	$300 per day	$600 per day
Knee Cartilage - Torn Treated by a physician within 60 days of Covered Accident. Must be repaired within 180 days. (In IN, 6 months of Covered Accident and within 185 days for repair)	$500 *(less any benefit paid for arthroscopic surgery previously performed)* $100 for exploratory surgery	$1,000 *(less any benefit paid for arthroscopic surgery previously performed)* $200 for exploratory surgery
Laceration Lacerations requiring repair by a physician within 72 hours of a Covered Accident.	$50 - $400 (based on length of lacerations, see policy)	$100 - $800 (based on length of lacerations, see policy)
Lodging Companion Lodging when Insured is confined to a hospital more than 100 miles from home. Maximum of 30 days. (In PA, 75 miles)	$100 per night	$100 per night
Major Diagnostic Exams Angiogram, CT and CTA scan; MRI, MRA, or EEG as result of a Covered Accident.	$100 per calendar year	$200 per calendar year
Paraplegia We will pay if any Insured Person's lower portion of their body and both legs become completely paralyzed and cannot be recovered as the result of a Covered Accident.	$2,500	$5,000
Physicians Office Visit Within 60 days of Covered Accident. Once per Covered Accident. (in IN, 6 months)	$75	$150
Physicians Follow-up Office Visits First follow-up must occur within 30 days of initial Physician Office Visit.	$25 / Max 6	$50 / Max 8
Physical Therapy Payable when a Covered Person receives emergency treatment for injuries sustained in a Covered Accident and later advised to seek treatment from a licensed physical therapist. Physical therapy must start within 30 days** of the Covered Accident or discharge from hospital and take place within six months after the accident.	$35 per treatment per day, to a maximum of ten treatments per Covered Accident, per Covered Person.	$70 per treatment per day, to a maximum of ten treatments per Covered Accident, per Covered Person.
Prosthesis Payable when a Covered Person requires use of a prosthetic device as a result of on or Off-the-Job injuries sustained in a Covered Accident. This benefit is not payable for repair or replacement of prosthetic devices, hearing aids, wigs, or dental aids, to include false teeth.	$750 once per Covered Accident, per Covered Person.	$1,500 once per Covered Accident, per Covered Person.

**Benefit not approved in PA; **In IN, Physical Therapy must begin within 6 months.*

PAID Benefits Cont.

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BENEFIT DESCRIPTION	ONE-UNIT	TWO-UNITS
Quadriplegia We will pay if any Insured Person's all four extremities (both arms and both legs) of their body become completely paralyzed and can not be recovered as a result of a Covered Accident.	$5,000	$10,000
Rehabilitation Unit - Admission We will pay the first day an insured person is transferred to a Rehabilitation Unit of a Hospital for treatment of an injury sustained in a Covered Accident. This benefit will not be payable for the same day(s) that the Hospital Confinement Benefit is paid.	$500	$1,000
Rehabilitation Unit Payable when a Covered Person is admitted for a Hospital Confinement and is transferred to a bed in a rehabilitation unit of a hospital for treatment for injuries sustained in a Covered Accident.	$150 per day, limited to 30 days for each Covered Person, per period of Hospital Confinement and limited to a calendar year maximum of 60 days.	$150 per day, limited to 30 days for each Covered Person, per period of Hospital Confinement and limited to a calendar year maximum of 60 days.
Ruptured Disc We will pay for any and all ruptured disc(s) in the spine suffered by an Insured Person as the result of a Covered Accident. This amount will be paid once per Covered Accident.	$500	$1,000
Surgery Within 72 hours after a Covered Accident to repair internal injuries caused by the Covered Accident. Hernia repair not covered.* Once per Covered Accident.	$1,000 for thoracic, open abdominal $100 for exploratory surgery	$2,000 for thoracic, open abdominal $200 for exploratory surgery
Tendon/Ligament/Rotator Cuff We will pay for the surgical repair of any and all torn, ruptured, or severed tendons, ligaments, or rotator cuff which an Insured Person suffered as the result of a Covered Accident. Must be performed by a Physician within 90 days after the Covered Accident. (in IN, 6 months)	$500 Exploratory: $100	$1,000 Exploratory: $200
Transportation Round trip when hospital confined and distance is more than 100 miles round trip from residence. Three round trips per Covered Accident.	$300 round trip	$300 round trip
Urgent Care Facility Within 60 days of Covered Accident. Once per Covered Accident.	$225	$225
X-Ray Max 1 per Calendar Year	$50	$100

**Does not apply in VA.*

Rates

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PAID Rates

(available on individual or payroll deduction)

Forms AK7025, AK7024 Accident Policy Rate Schedule								
	Weekly Premium		Bi-Weekly Premium		Semi-Monthly Premium		Monthly Premium	
	One Unit	Two Units	One Unit	Two Units	One Unit	Two Units	One Unit	Two Units
24-Hour Coverage								
Individual	$4.23	$5.08	$8.46	$10.15	$9.17	$11.00	$18.33	$22.00
Individual/ Spouse*	$5.96	$7.38	$11.92	$14.77	$12.92	$16.00	$25.83	$32.00
Individual/ Child	$5.96	$7.38	$11.92	$14.77	$12.92	$16.00	$25.83	$32.00
Family	$7.69	$9.69	$15.38	$19.38	$16.67	$21.00	$33.33	$42.00
Off-the-Job Coverage Only								
Individual	$3.58	$4.15	$7.15	$8.31	$7.75	$9.00	$15.50	$18.00
Individual/ Spouse*	$5.60	$6.75	$11.19	$13.50	$12.13	$14.63	$24.25	$29.25
Individual/ Child	$5.60	$6.75	$11.19	$13.50	$12.13	$14.63	$24.25	$29.25
Family	$6.52	$8.08	$13.04	$16.15	$14.13	$17.50	$28.25	$35.00

Wellness Rider**				
	Weekly Premium	Bi-Weekly Premium	Semi-Monthly Premium	Monthly Premium
Individual	$0.69	$1.38	$1.50	$3.00
Individual/ Spouse*	$1.38	$2.77	$3.00	$6.00
Individual/ Child	$1.38	$2.77	$3.00	$6.00
Family	$2.08	$4.15	$4.50	$9.00

- Family Coverage
- Individual Child
- 1-2 Units Available (2 units increases benefits)
- 24-Hour or Off-the-job coverage

Underwriting

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- Simplified underwriting is used based upon the insured's answers on the application. Policies are issued on an accept/reject basis.
- In computing premiums, the Company uses "Age Last Birthday" on these policy forms. The two-parent family premium is based on the older age for bank draft sales and the employee's age for payroll sales. No adult over age 64 is eligible for coverage
- Policy Form AK7024, and AK7025 is issued from age 18 to 64. Rates are tiered at:
  - Individual only
  - Individual plus Spouse
  - Individual plus child
  - Family

Filing a Claim

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Visit Manhattan Life's Homepage and Select "File A Claim"

↓

Download and Fill Out Medical Accident Claim Form

↓

Fax Claim Form to

713-583-0677

OR

EASY UPLOAD MOBILE APP:

The Easy Upload mobile app or the Easy Form Upload tool found on the Client Services site can be used to securely send documents to us regarding a specific Life & Health policy or Annuity contract, even if you aren't a registered contract/policy holder. Simply click on the Start Uploading button. You will need to know the contract/policy number and the owner's zip code to use this feature.

cservice@ManhattanLife.com

1-800-669-9030

Application

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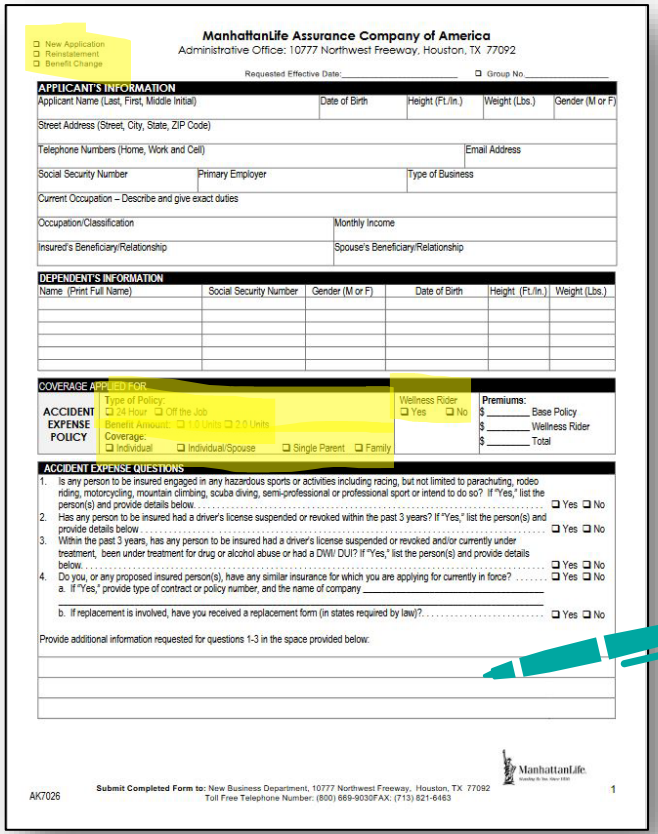
Take Me to Generic Application



ManhattanLife Assurance Company of America
Administrative Office: 10777 Northwest Freeway, Houston, TX 77092

❑ New Application
❑ Reinstatement
❑ Benefit Change

Requested Effective Date:_____ ❑ Group No._____

APPLICANT'S INFORMATION

Applicant Name (Last, First, Middle Initial)	Date of Birth	Height (Ft./In.)	Weight (Lbs.)	Gender (M or F)
Street Address (Street, City, State, ZIP Code)				
Telephone Numbers (Home, Work and Cell)			Email Address	
Social Security Number	Primary Employer		Type of Business	
Current Occupation – Describe and give exact duties				
Occupation/Classification		Monthly Income		
Insured's Beneficiary/Relationship		Spouse's Beneficiary/Relationship		

DEPENDENT'S INFORMATION

Name (Print Full Name)	Social Security Number	Gender (M or F)	Date of Birth	Height (Ft./In.)	Weight (Lbs.)

COVERAGE APPLIED FOR

ACCIDENT EXPENSE POLICY

Type of Policy:
❑ 24 Hour ❑ Off the Job
Benefit Amount: ❑ 1.0 Units ❑ 2.0 Units
Coverage:
❑ Individual ❑ Individual/Spouse ❑ Single Parent ❑ Family

Wellness Rider
❑ Yes ❑ No

Premiums:
$_____ Base Policy
$_____ Wellness Rider
$_____ Total

ACCIDENT EXPENSE QUESTIONS

1. Is any person to be insured engaged in any hazardous sports or activities including racing, but not limited to parachuting, rodeo riding, motorcycling, mountain climbing, scuba diving, semi-professional or professional sport or intend to do so? If "Yes," list the person(s) and provide details below. ❑ Yes ❑ No
2. Has any person to be insured had a driver's license suspended or revoked within the past 3 years? If "Yes," list the person(s) and provide details below ❑ Yes ❑ No
3. Within the past 3 years, has any person to be insured had a driver's license suspended or revoked and/or currently under treatment, been under treatment for drug or alcohol abuse or had a DWI/ DUI? If "Yes," list the person(s) and provide details below. ❑ Yes ❑ No
4. Do you, or any proposed insured person(s), have any similar insurance for which you are applying for currently in force? ❑ Yes ❑ No
   a. If "Yes," provide type of contract or policy number, and the name of company _____
   b. If replacement is involved, have you received a replacement form (in states required by law)? ❑ Yes ❑ No

Provide additional information requested for questions 1-3 in the space provided below:

AK7026

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: (800) 669-9030FAX: (713) 821-6463

1

Please DO NOT Forget

- Application Type
- Coverage Type
- Optional Riders

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The End.