



ManhattanLife™

Standing By You. Since 1850.™



Out-of-Pocket Protection Plan

Why Hospital Confinement Protection?

Out-of-Pocket Protection Plan

A Hospital Confinement Protection Insurance Policy

With today's rising cost of medical care and health insurance premiums, many individuals and groups have selected higher deductibles, fewer co-pays and more out-of-pocket costs. This has been done to make health insurance premiums more affordable.*

*National Center Biotechnology Information.

But, out-of-pocket costs may still cause unnecessary burdens on many individuals.



How Does it Work?



- Pays directly to you, unless you assign your benefits to your provider(s).
- Your choice of benefits and premiums.
- Pays in addition to all other insurance.
- No deductibles.
- No networks.

Benefit Highlights

MANDATORY BENEFITS	DAILY INPATIENT HOSPITAL CONFINEMENT BENEFIT** (per hospital admission) If you are confined in a hospital as a resident inpatient*. Pays the daily inpatient benefit you select (maximum of 10 days) (in ME, TX and UT, 31 days) per hospital confinement. In FL, payable for first 20 days of confinement then \$10/\$20 for next 11 days - depending on benefit level selected. This benefit is not payable for the treatment of Mental/Nervous disorders and substance abuse (in UT, or substance disorder).	You may choose a daily inpatient benefit of either: <input type="checkbox"/> \$ 100 a day <input type="checkbox"/> \$ 200 a day
	HOSPITAL ADMISSION BENEFIT (1 per year) (in UT, 1 per each period of confinement) If you are admitted to a hospital as a resident inpatient*. Pays the Hospital Admission Benefit you selected.	You may choose your hospital admission benefit below: <input type="checkbox"/> \$ 2,500 <input type="checkbox"/> \$ 5,000 <input type="checkbox"/> \$ 6,350
	DOCTOR OFFICE VISIT (2 per year) (2 per year, per insured persons)	\$ 50

Optional Riders

OPTIONAL BENEFITS	OUTPATIENT SURGERY BENEFIT*** (2 per year) For surgical services rendered in an Ambulatory Surgical Center or Outpatient Hospital Facility, pays the amount you selected for outpatient surgery.	You may choose a benefit of either: <input type="checkbox"/> \$ 1,000 <input type="checkbox"/> \$ 2,000 <input type="checkbox"/> \$ 3,000
	EMERGENCY ACCIDENT BENEFIT (4 per year) (FL maximum 2 per year) If you sustain an injury which requires emergency care by a physician in a emergency room or urgent care facility, pays the amount per emergency treatment. The treatment must be received within 72 hours of the injury. In FL, this benefit is payable only if you are confined as an inpatient within 24 hours of emergency treatment.	\$ 250 Maximum benefit per injury

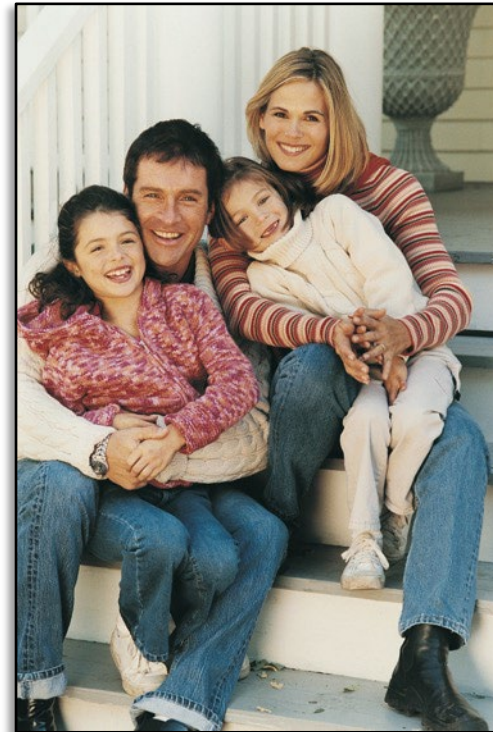
Confined as a resident inpatient means assigned to a hospital bed for an overnight stay for medically necessary reasons resulting from injury or illness on the advice of a physician

A day is a 24-hour period where room and board is charged

Benefits can be paid in a lump sum directly to you!

Underwriting

- The Insured and spouse must be between ages 18 through 64 to apply for individual coverage. Eligibility for coverage is determined by each adult age.
- In computing premiums, the Company uses “Age Last Birthday” on these policy forms. The two-parent family premium is based on the older age. No adult over age 64 is eligible.
- Renewable up to age 70.
- Individual Consideration may be given to applicants with a history of the following:
 - Cataract
 - Lung Disorder
 - Diabetes
 - Hernia
 - Mental or Nervous Disorder



Filing a Claim



[Claim](#)
[Form](#)

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.

Customer Service Contact Info

cservice@ManhattanLife.com

800-669-9030

Application

ManhattanLife Assurance Company of America
10777 Northwest Freeway, Houston, Texas 77092

Application for Insurance

FRAUD: Any 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.

☐ Check if replacing or changing existing coverage in this company. Effective Date: _____

PERSONS PROPOSED FOR INSURANCE								
Last Name	First	Middle	Relationship	Birthdate	Sex	Height ft./in.	Weight lbs.	Social Security Number
			Primary Insured					
			Spouse					
			Child					
			Child					
			Child					
Address			City	State	Zip	Home Telephone ()		
Secondary Address			City	State	Zip	Home Telephone ()		
Payor or Owner if other than Primary Insured				<input type="checkbox"/> Payor <input type="checkbox"/> Owner	Social Security Number	Relationship to Primary Insured		
Employer				Occupation				
Date Employed		Hours Worked/Week		Group Number				
Beneficiary (Estate of Primary Insured unless beneficiary named)				Age	Relationship			

FOR THE PAST 30 DAYS: Have all proposed insureds been performing normal activities and been actively at work full time at their regular occupation? ☐ Yes ☐ No. If "No," explain: _____

WILL THIS POLICY REPLACE OR CHANGE ANY Existing Health Insurance in this or any other company?
☐ Yes ☐ No. If "Yes," complete replacement form where required.

INSURANCE PLAN			
Hospital Indemnity (GAP15)	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Children <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Family		
	Daily Inpatient Hospital Benefit (Choose One)	Inpatient Hospital Admission (Choose One)	Doctors Office Visit
	<input type="checkbox"/> \$100 Per Day <input type="checkbox"/> \$200 Per Day	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,350	<input type="checkbox"/> 2 per year
	Premium \$ _____		
Optional Benefits			
Outpatient Surgery	Emergency Accident	Premium	
<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000	<input type="checkbox"/> \$250	\$ _____	

HOSPITAL INDEMNITY COVERAGE QUESTIONS

- Do all the members to be insured reside in the home of the applicant? ☐ YES ☐ NO. If "No," which member? _____
Explain: _____
- Has any person proposed for coverage been declined for insurance due to health reasons? ☐ YES ☐ NO. If "Yes," provide details and dates: _____
- Has any person had surgery advised by a physician but not yet performed? ☐ YES ☐ NO. If "Yes," provide details: _____

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Please DO NOT Forget

- Replacing or Changing box
- Coverage Type
- Optional Riders

[Take Me to Application](#)



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The End.