ManhattanLife™
Standing By You. Since 1850.

ManhattanLife Lighthouse Series
OmniFlex™
Short-Term Care
Agent Guide

For Agent use only

This is a Short Term Facility Care Insurance Policy
Underwritten by: ManhattanLife Insurance and Annuity Company
and Standard Life and Casualty Insurance Company

AGT-STC 0125

Thank You from ManhattanLife!

First of all, thank you for taking the time to read our Short-Term Care Agent Guide! We realize that you have many carrier and product options to choose from and we sincerely thank you for choosing ManhattanLife!

Who We Are

Who is ManhattanLife? Since 1850, we've defined our brand with our commitment to standing by policyholders and producers with diligence and compassion. For over 170 years we've been a private and closely held company by choice. And as an independent, we have always been free to make decisions that align with our values and core mission – helping policyholders attain and sustain health, wealth and security throughout their lives.

We demonstrate this commitment by striving to honor claims and pay benefits with professionalism and care. For our producers, we are a reliable and independent partner. We stay agile and open minded about customizing products or innovating new policies to meet our policyholders' evolving needs. With a national footprint and licenses to sell in every state and U.S. territory, we are everywhere you want us to be.

The Company's longevity as staying independent in the marketplace is remarkable considering the robust merger and acquisition activity the industry has experienced in modern times. To put its staying power in context, the current average age of S&P 500 Index companies is less than 20 years old. By contrast, operating successfully for over 170 years as an independent is a testimony to ManhattanLife's enduring history and an indicator of the reliability of our future.

The Purpose

The purpose of this Agent Guide is to provide insights into the benefits available with Short-Term Care. In addition, this agent guide should provide direction on topics such as state availability, submitting applications, underwriting process, application fees & rates, preventing processing delays and much more.

Why Short-Term Care?

With the cost of Long-Term Care insurance (LTCi) services continuing to rise and health eligibility requirements making it more difficult to qualify, ManhattanLife has developed OmniFlex™ Short-Term Care insurance (STCi) to address the growing need for coverage with an affordable solution.

Being financially prepared to pay for facility-based care, rehabilitative or professional home health care services can be a major concern for a growing segment of the population. ManhattanLife's new OmniFlex™ STCi plan is designed to financially help individuals who are faced with the physical challenges caused by an injury, illness or medical condition.

Working with ManhattanLife

Working with ManhattanLife has never been easier! One of the tools that will make your life easy is our Agent Resource Center, or as we refer to it, ARC. ARC was developed to ensure producers have easy access to all the brochures, applications and forms that may be needed need. ARC is also where you will find your policy and commission information.

We like to say ManhattanLife Direct 2.0 is where you make your money and ARC is where you protect it!

Here you can find all of our up to date marketing and training collateral. Additional resources include:

- Product Availability Grids
- Policyholder List
- Trainings
- Social Media Collateral
- Commission Earnings
- Ordering Supplies

Please visit https://producer.manhattanlife.com/ and start exploring today!

Table of Contents

Base Plan Highlights & Optional Benefits

One of our main goals when creating the Short-Term Care offering was to provide benefit flexibility, giving insureds the ability to create a plan tailored to their specific needs. A multitude of base benefit levels, multiple benefit and elimination periods and several optional benefits.

Availability

Issue Age	45 - 89
Underwriting	Simplified Issue
Policy Type	Guaranteed Renewable

Base Plan Highlights

Facility Care	
Facility Care Daily Benefit	$50 - $400
Elimination Period	0, 20, 60, or 90 days
Benefit Period	90, 180, 270 or 360 days
Lifetime Maximum Benefit Period	2x Benefit Period
Bed Reservation Benefit	10 days (Lifetime Max 20 days)

Built-in Benefits	
Prescription Drug Benefit	$10 Generic / $25 Brand $300 Policy Year Max
Fast-50™	Waives Elimination Period on Facility Care or Home Health Care Benefits to receive 50% level of accumulated Daily Benefit — perfect for care provided by a spouse, family or friends
Restoration of Benefits	Restores Facility Care or Home Health Care benefits after the 180 days out of care need is satisfied, up to lifetime max benefit period

**$25 One-time Policy Fee Applies*

Optional Benefits

Home Health Care	
Home Health Care Daily Benefit	$50 - $300
Elimination Period	0, 20, 60, or 90 days
Benefit Period	90, 180, 270 or 360 days
Lifetime Maximum Benefit Period	2x Benefit Period

Simple Inflation Benefit	
5% Simple Inflation	If chosen, Simple Inflation applies to Facility Care as well as Home Health Care, if the Home Health Care Rider is also elected

Hospital Indemnity	
Daily Benefit	$50 - $300
Benefit Period	3, 6 or 20 days
Lifetime Maximum Benefit Period	180 days

See policy for details and definitions.

Product Availability Map

Scan this QR Code to view the Product Availabilty Map

Click on this QR Code to download the Product Availability Map on Resource One

Application Fee & Rates

Application Fee

A one-time application fee of $25 is applicable for new policy submissions.

Rates

Short-Term Care rates vary by state and age. Consult the state-specific rate schedule for pricing details.

Spousal Discount

A 10% Spousal Discount is available to eligible individuals applying for OmniFlex Short-Term Care. To qualify for the discount, the following criteria must be met by the two individuals applying for coverage:

- The two must be married.
- The two must live at the same address.
- The two must both apply and be issued a policy.

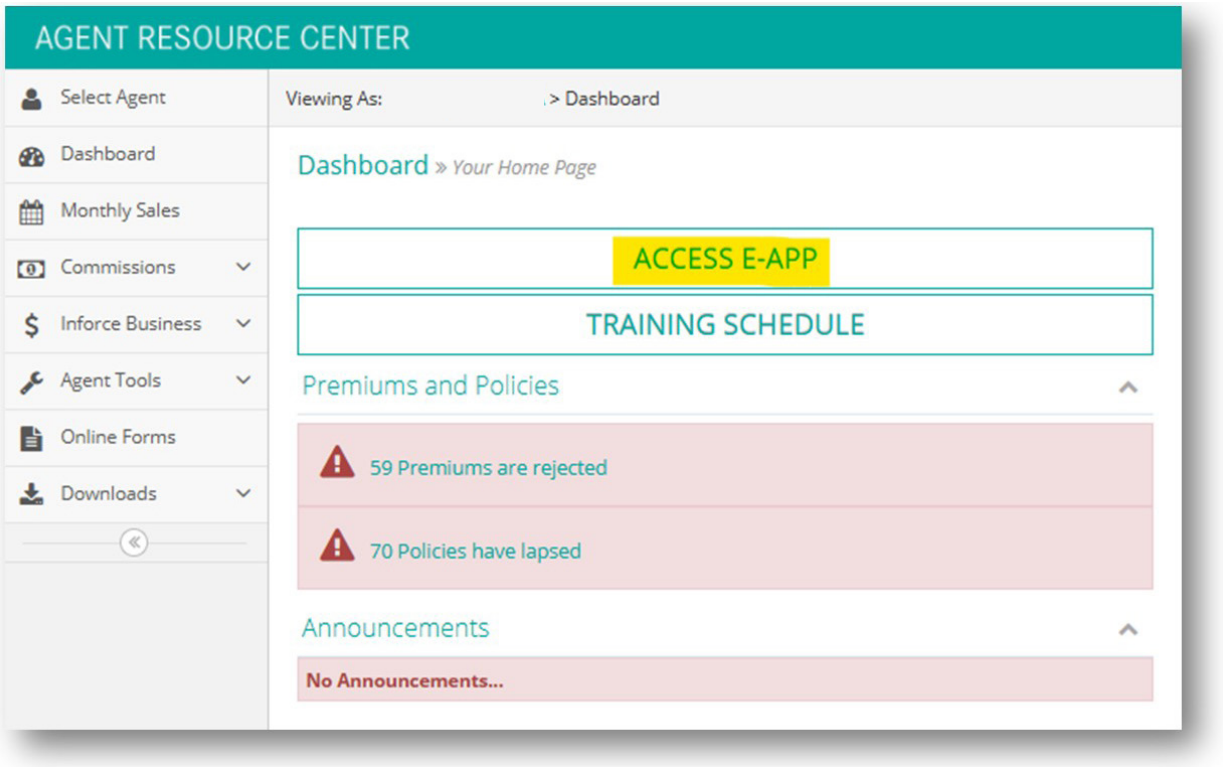
The 10% Spousal Discount is a reduction from the individual price for each policyholder in the same household.

ManhattanDirect 2.0

ManhattanDirect is ManhattanLife's online application submission portal. This resource allows for online application fulfillment and submission in lieu of paper. While ManhattanLife does accept paper applications (outlined below), we recommend using 2.0 whenever possible, as we have found that processing times are faster on average than paper applications.

Accessing ManhattanDirect

ManhattanDirect can be accessed through the Agent Resource Center by selecting the "Launch ManhattanDirect 2.0" button as shown below.



Troubleshooting

Should you need technical assistance for ARC or 2.0, please reach out directly to Sales & Marketing at:

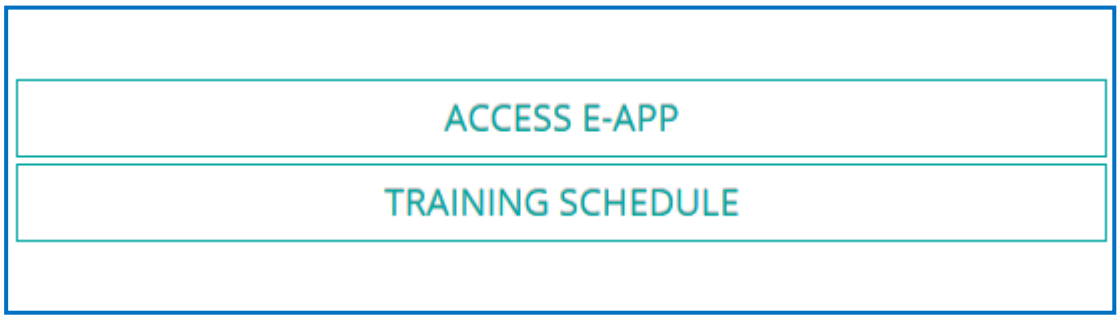
Hotline: 1-888-441-0770.

Email: marketingmail@manhattanlife.com

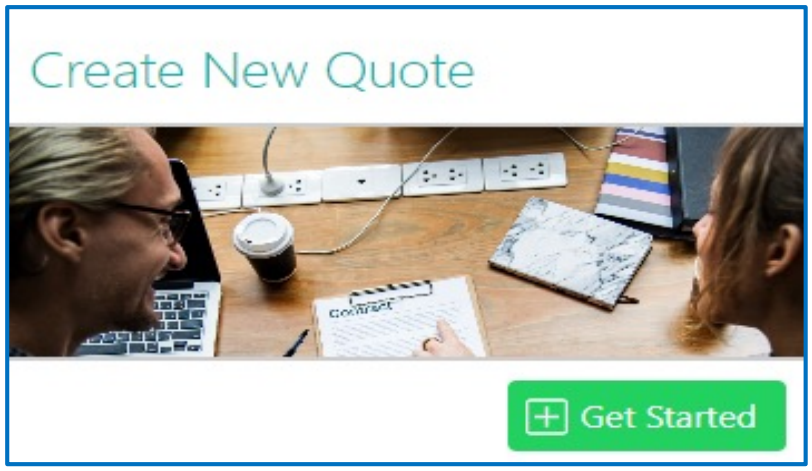
Submitting New Business with ManhattanDirect 2.0

Step 1:
Log into: *https://producer.manhattanlife.com/life/account/login.aspx?AsAgent*

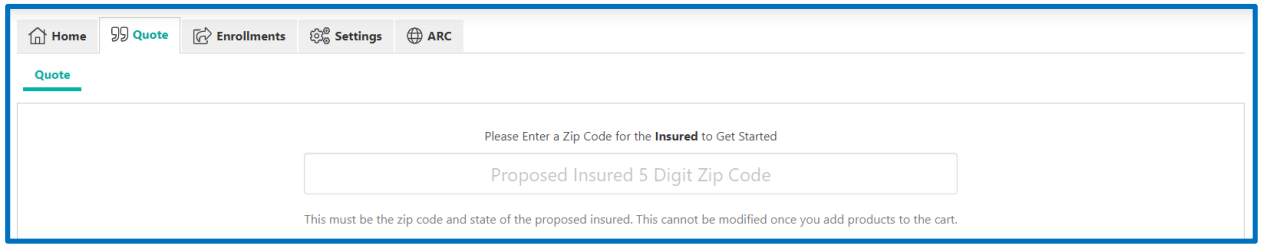
Step 2:
Launch ManhattanDirect 2.0



Step 3:
Select “Get Started”



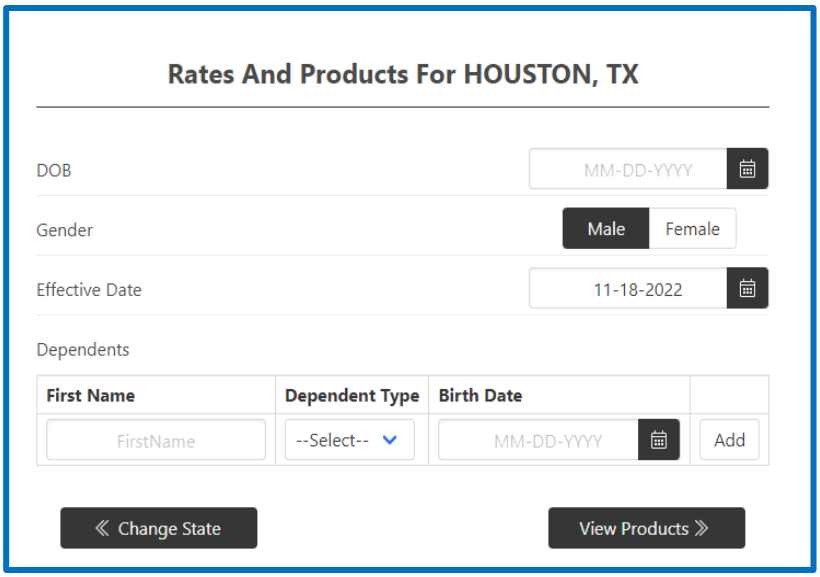
Step 4:
Enter 5-digit Zip Code and select Next



Submitting New Business with ManhattanDirect 2.0 - Continued

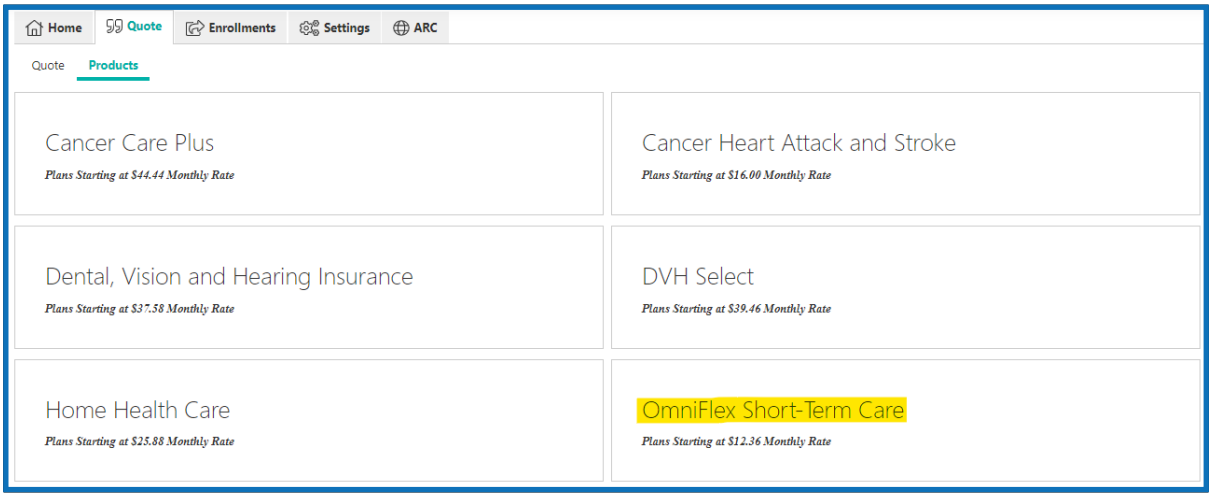
Step 5:

Enter required client information and dependent information, along with Effective Date and select “View Products”



Step 6:

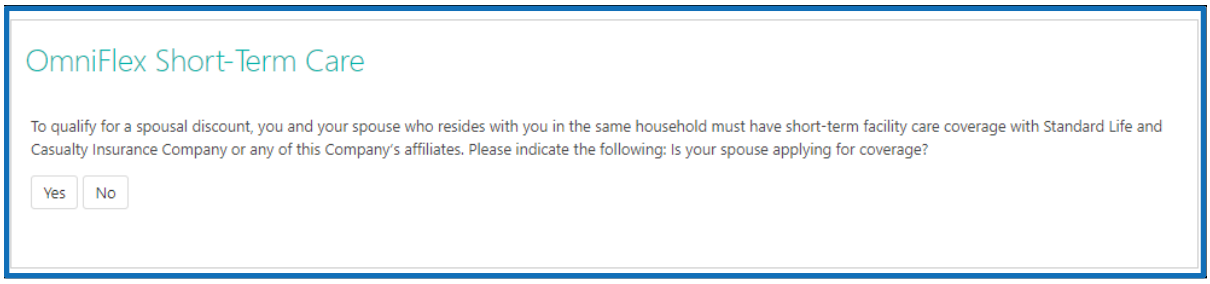
Select Short-Term Care



Submitting New Business with ManhattanDirect 2.0 - Continued

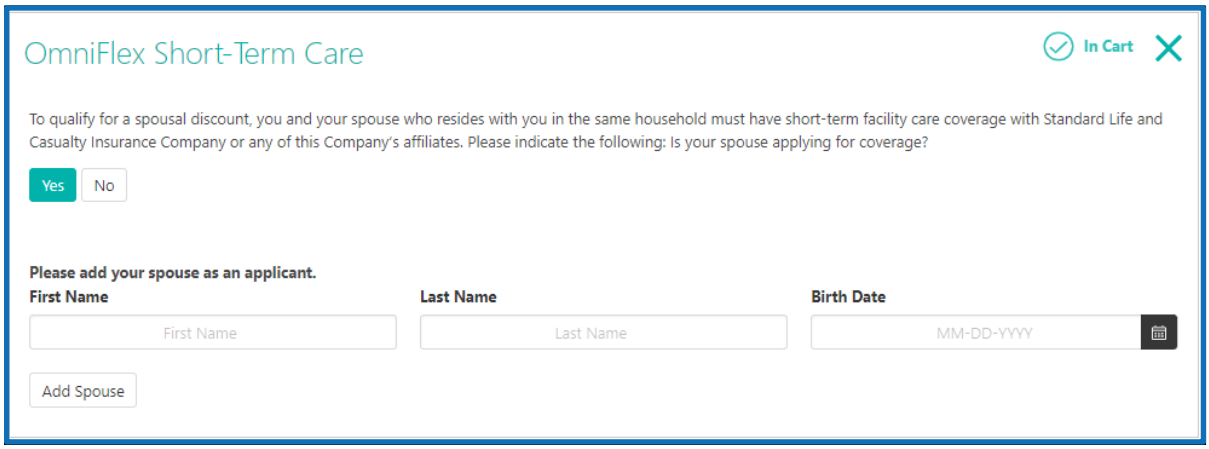
Step 7:

If answered “Yes”, please add additional applicants as shown below.



Step 8:

If yes, please enter additional applicants information below.



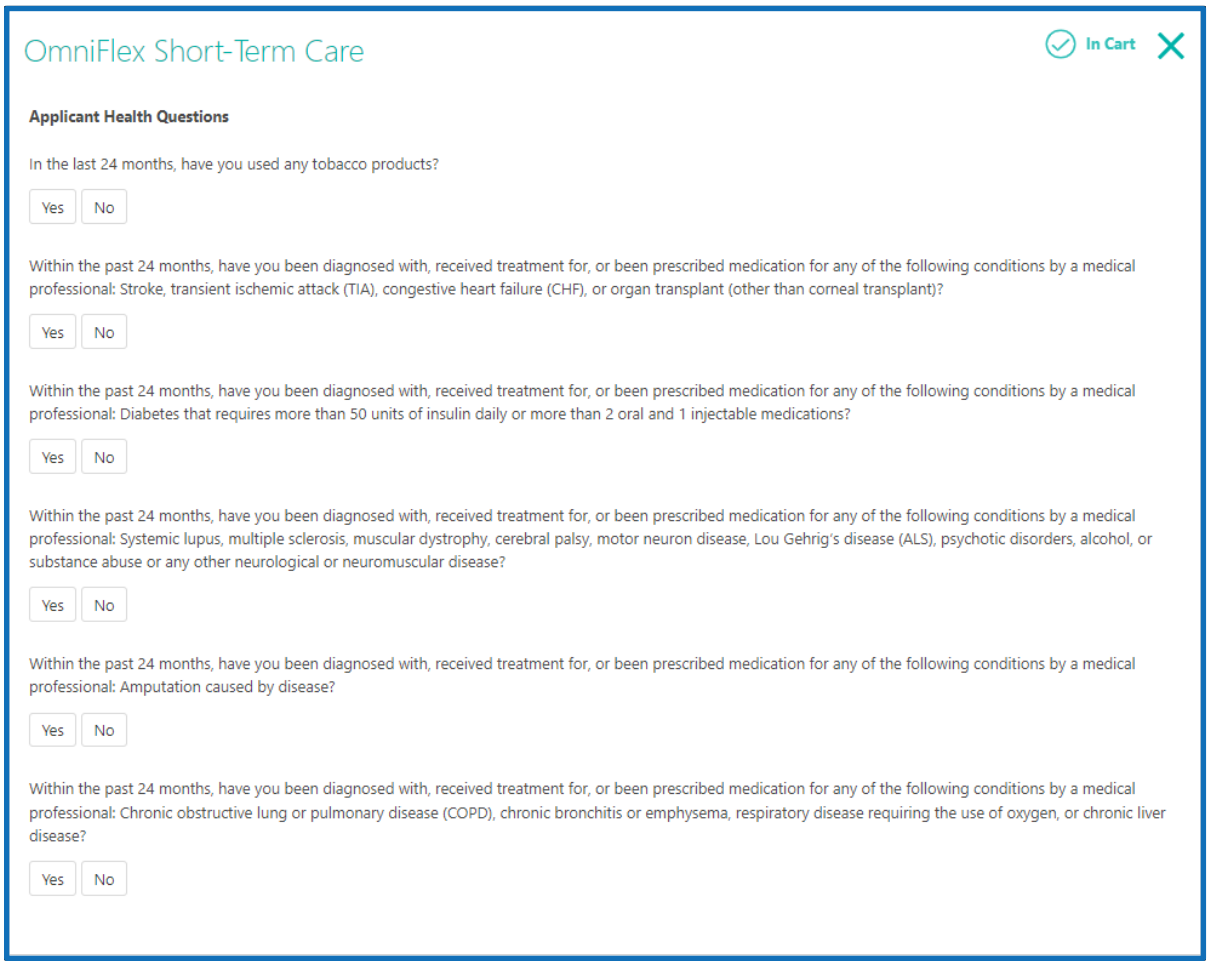
Step 9:

Here you will be presented with the option to run a Quick Quote or a Full Quote. The Quick Quote option bypasses all health questions in order to get a per month estimated per month cost. It is important to communicate to any potential policyholders that there are a few health questions needed for a full quote

Submitting New Business with ManhattanDirect 2.0 - Continued

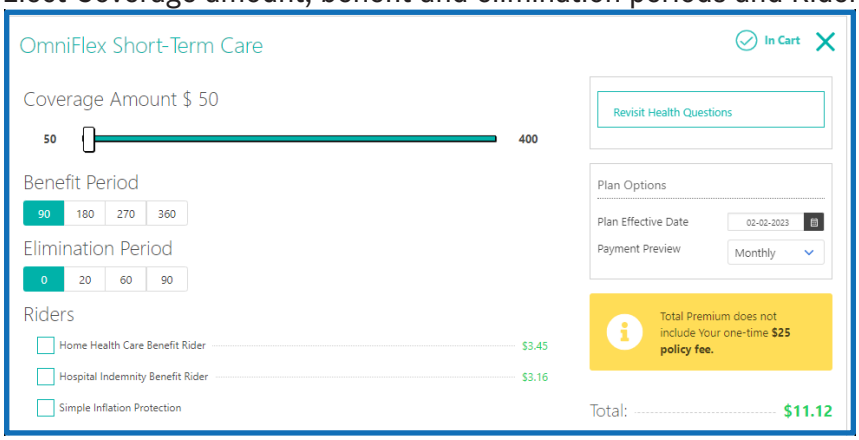
Step 10:

If answered No, continue to Health questions.



Step 11:

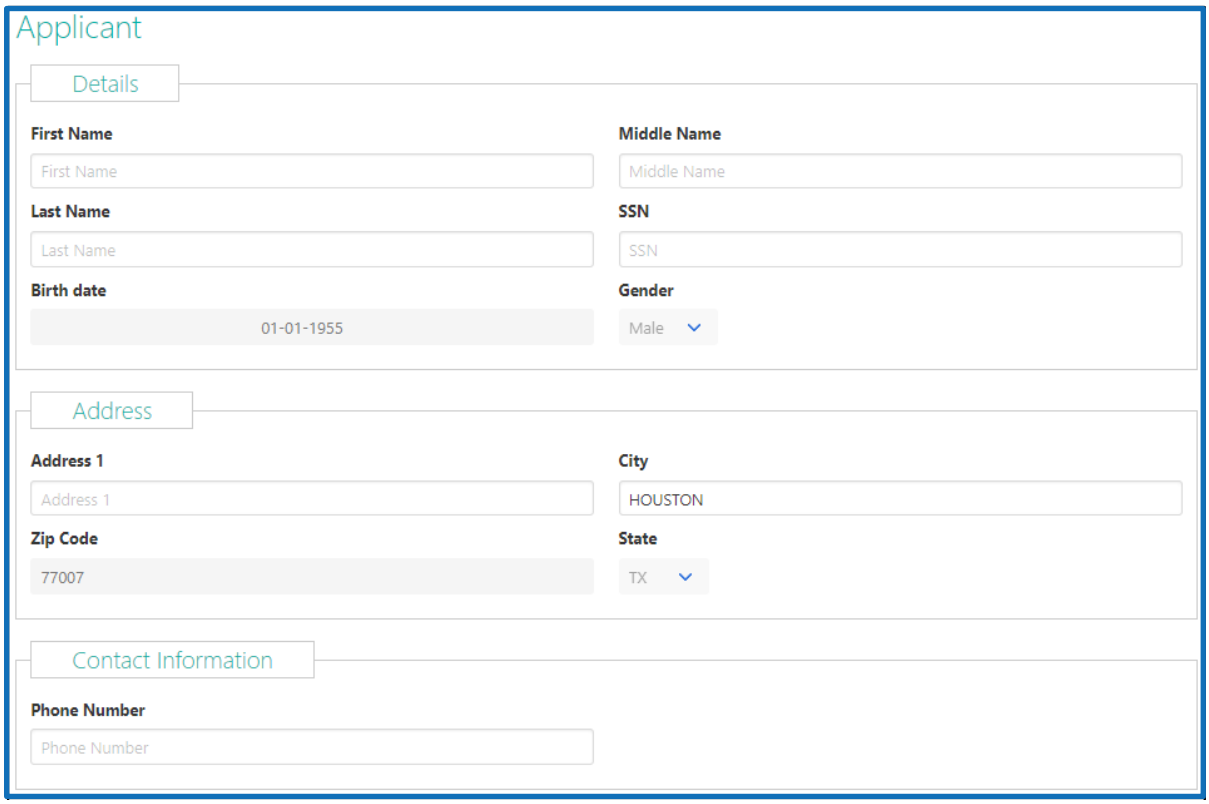
Elect Coverage amount, benefit and elimination periods and Riders to begin enrollment.



Submitting New Business with ManhattanDirect 2.0 - Continued

Step 12:

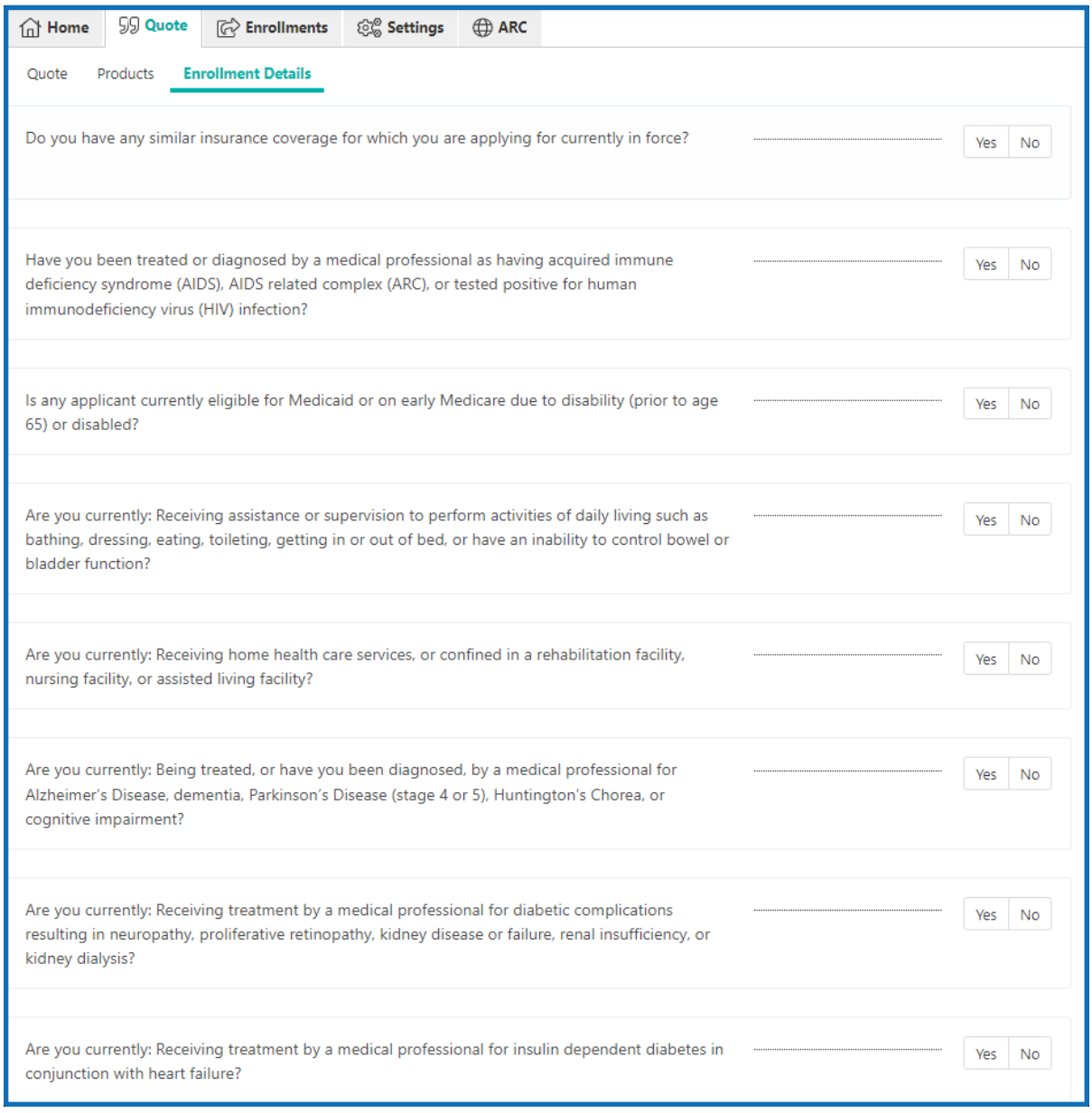
Enter applicant personal information and enter or validate.



Submitting New Business with ManhattanDirect 2.0 - Continued

Step 13:

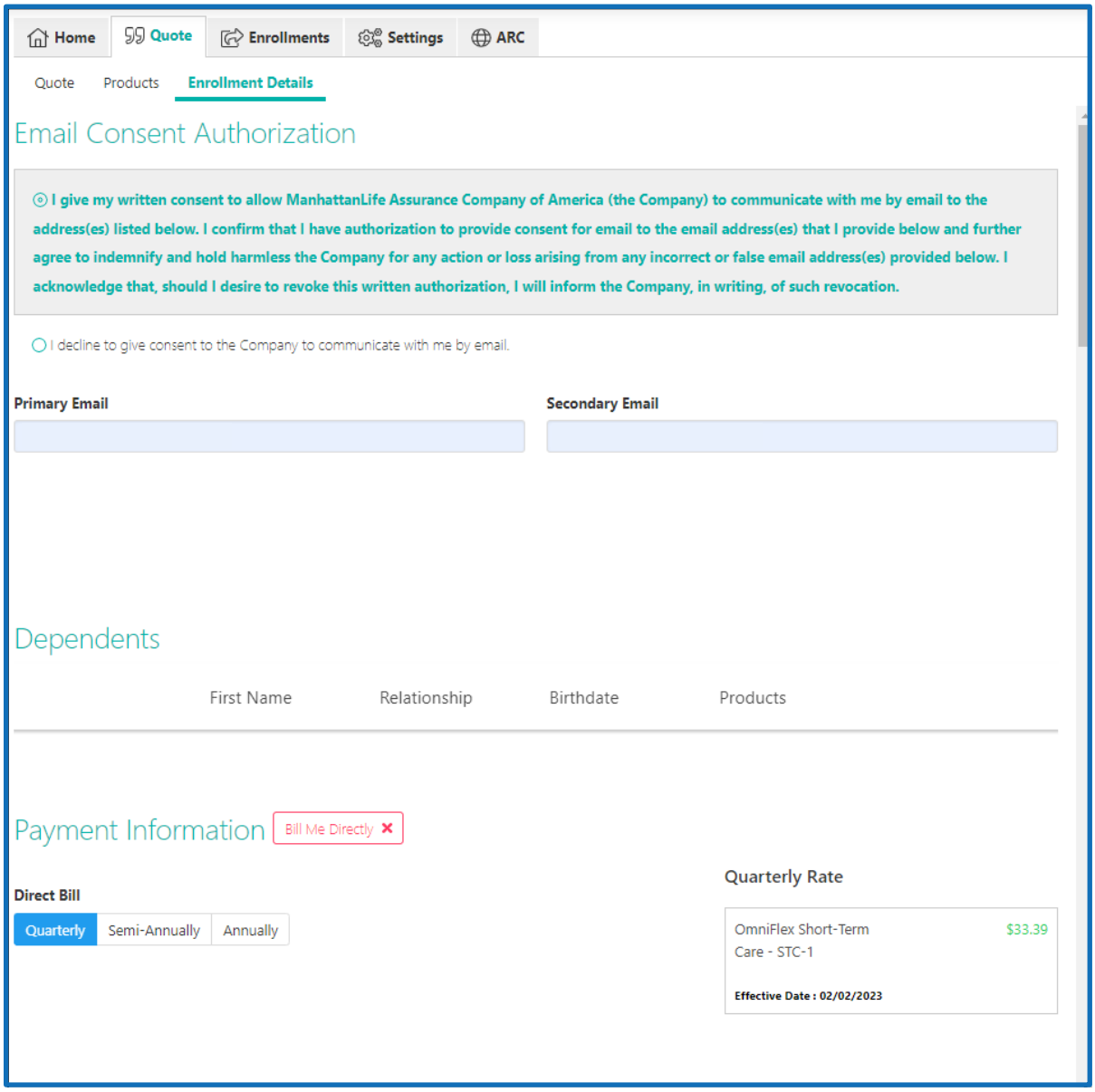
Begin answering application questions.



Submitting New Business with ManhattanDirect 2.0 - Continued

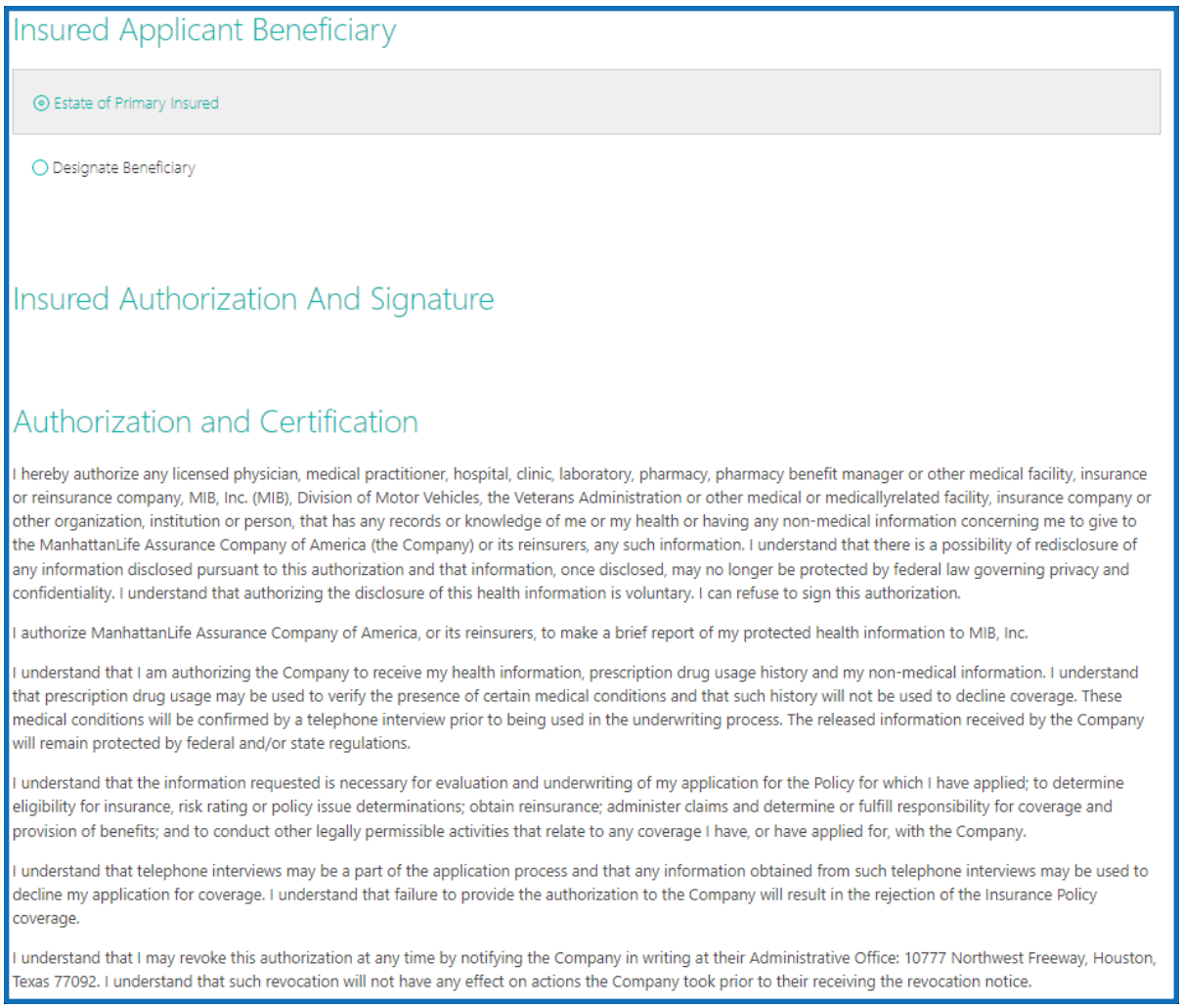
Step 14:

Complete Email Consent Authorization, Payment information, Beneficiary designation and Mother's Maiden name signature.



Submitting New Business with ManhattanDirect 2.0 - Continued

Step 14 Continued:



Insured Applicant Beneficiary

◉ Estate of Primary Insured

○ Designate Beneficiary

Insured Authorization And Signature

Authorization and Certification

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc. (MIB), Division of Motor Vehicles, the Veterans Administration or other medical or medicallyrelated facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to the ManhattanLife Assurance Company of America (the Company) or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize ManhattanLife Assurance Company of America, or its reinsurers, to make a brief report of my protected health information to MIB, Inc.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

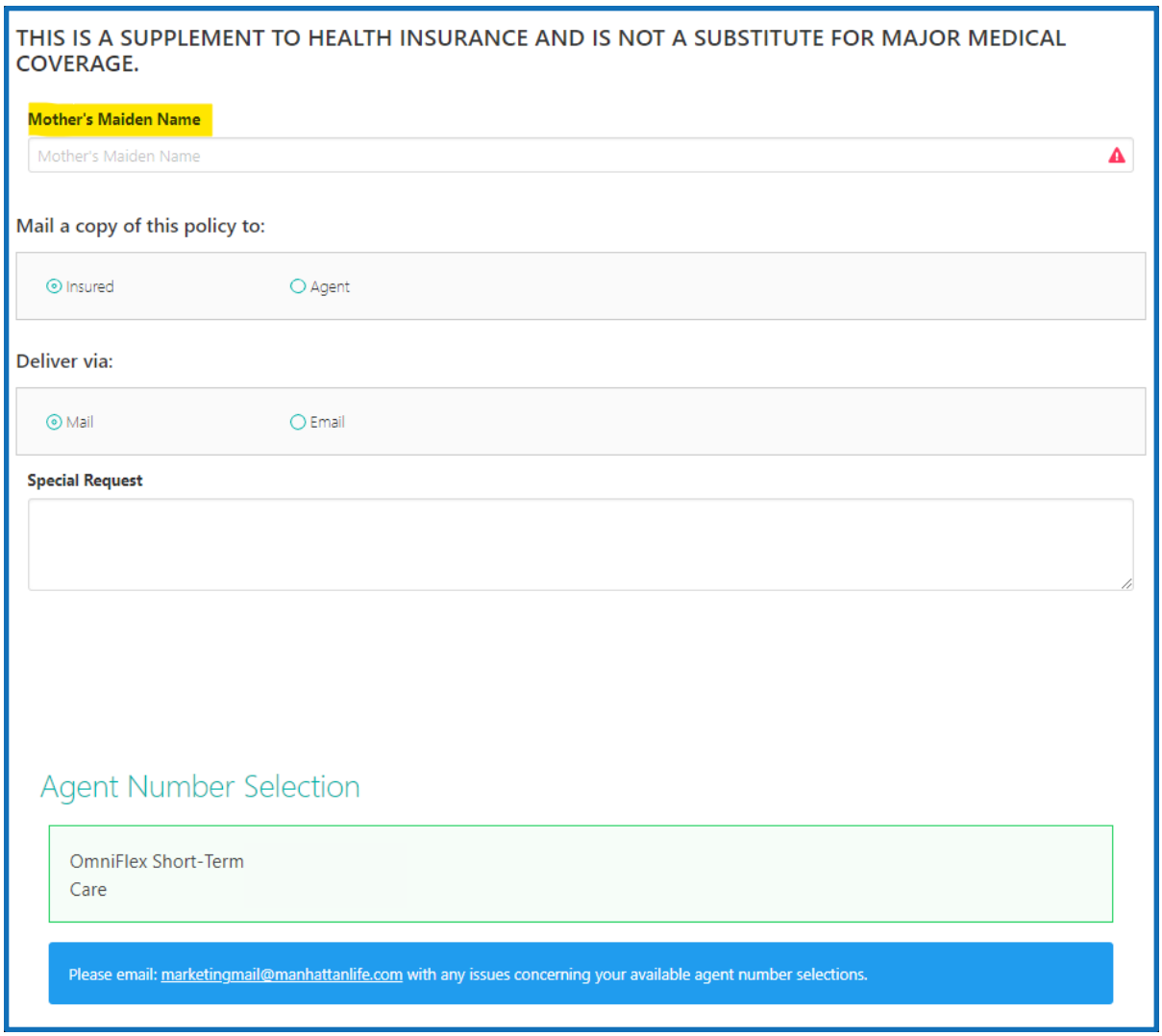
I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to the Company will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: 10777 Northwest Freeway, Houston, Texas 77092. I understand that such revocation will not have any effect on actions the Company took prior to their receiving the revocation notice.

Submitting New Business with ManhattanDirect 2.0 - Continued

Step 14 Continued:



Submitting Paper Applications

As stated above, we always suggest submitting applications through ManhattanDirect, as we have found processing times are generally quicker. We do, however, understand there may be times when this simply isn't possible. In the event a paper application has to be submitted, the agent needs to complete the application with the applicant actively engaged throughout the process. The agent can either be at the same physical location as the applicant/owner, or the application can be processed over the phone. Regardless of how the application process takes place, both the applicant/owner and the agent must physically sign the document. Therefore, if the application is completed over the phone, the agent must fax or send the application to the applicant/owner to obtain their signature before submitting it to ManhattanLife for processing. Below are options for getting paper applications to ManhattanLife for processing.

- Easy Upload – Can then provide the info below on Easy Upload process
- Fax – 1-713-583-2738 Attention: New Business
- Mail – P.O. Box 925568 Houston, TX 77292 OR
  Overnight/Specialty Mail: 10777 Northwest Freeway STE 600 Houston, TX 77092

Easy Upload Feature

The Easy Upload tool can be used to upload applications rather than mailing or faxing them. Please note currently Easy Upload will only accept PDF files. Therefore, the application must be scanned and converted to a PDF to be attached. There are step- by-step instructions located in the "Help" section found to the left of the Easy Upload area within the Agent Resource Center. It should be noted that in order to submit via Easy Upload, you must be logged into our ManhattanDirect 2.0 system

The Easy Upload feature can be found on the home page of the Agent Resource Center(ARC) and was created to enable the submission of paper applications, rather than mailing or faxing them. The Easy Upload feature can be found at the following URL:
https://producer.manhattanlife.com/life/account/login.aspx?AsAgent

Required Forms

Completed Application (pages 1-5)

Whether completing a paper application, or utilizing ManhattanDirect 2.0, please remember only current state-approved applications may be used when applying for coverage. If there is a question as to what application is available, please call our Marketing Department to confirm the correct application form number.

Sales & Marketing Hotline: 1-888-441-0770.
Email: marketingmail@manhattanlife.com

A copy of the completed application will be attached to the policy, becoming part of the contract.

Application

Standard Life and Casualty Insurance Company
Home Office: Salt Lake City, UT
Administrative Office: [P.O. Box 510690, Salt Lake City, UT 84151-0690]
[(800)327-0695]

APPLICATION FOR SHORT-TERM CARE INSURANCE

❑ New Application ❑ Reinstatement Policy No._____ Group No. _____

APPLICANT A – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)		Social Security No.
Beneficiary Name	Requested Future Effective Date *Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	
Special Requests Section		

APPLICANT B – PROPOSED INSURED'S INFORMATION		
Proposed Insured's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Gender (M/F)
Address (Street, City, State, ZIP Code)		
Telephone Numbers (Home, Work, and Cell)		Social Security No.
Beneficiary Name	Requested Future Effective Date *Effective Date will be the date the application is approved by the Company or a future date, whichever is later.*	
Beneficiary Relationship	Mail Policy to: ❑ Agent ❑ Policyowner ❑ Email (Email is available for the Policyowner if the email consent authorization is signed.)	
Special Requests Section		

EXISTING COVERAGE(S)/REPLACEMENT(S)/ELIGIBILITY	APPLICANT A	APPLICANT B
1. Do you have any similar insurance coverage for which you are applying for currently in force?	❑ Yes ❑ No	❑ 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	❑Yes ❑ No

SPOUSAL DISCOUNT INFORMATION

To qualify for a spousal discount, you and your spouse who resides with you in the same household must have short-term facility care coverage with Standard Life and Casualty Insurance Company or any of this Company's affiliates. Please indicate the following:

1. Is your spouse applying for coverage? ❑ Yes ❑ No

2. Does your spouse have a short-term care policy with Standard Life and Casualty Insurance Company or any of this Company's affiliates? If "**YES,**" provide the following information about your spouse: ❑ Yes ❑ No

Spouse's Name (First, Middle, Last)	Birthdate (MM/DD/YYYY)	Social Security No.	Policy No.

AL7060AP (rev. 1122)

Submit Completed Form to: New Business Department, [P.O. Box 510690, Salt Lake City, UT 84151-0690]
Toll Free Telephone Number: [(800)327-0695] FAX: [(801) 538-0392]

1

APPLICATION INFORMATION
Application can be used for 1 or 2 applicants.

ADDRESS
Applicants resident state must match the materials being used.

CURRENT INFORCE COVERAGE
Indicate whether the applicants have existing coverage in-force.

SPOUSAL DISCOUNT
Indicate if applying for a HH discount.

Application- Continued

APPLICANT A - INSURANCE APPLIED FOR

Short-Term Facility Care Insurance Policy

❑ Maximum Daily Base Benefit Amount $50-400 in $10 increments $_____

Elimination Period: 0 20 60 90

Benefit Period: 90 180 270 360

Prescription Drug: $300

Home Health Care Benefit Rider

❑ Maximum Daily Base Benefit Amount $50-300 in $10 increments $_____

Elimination Period: 0 20 60 90

Benefit Period: 90 180 270 360

Simple Inflation Protection

❑ Yes ❑ No

(If "**Yes,**" the simple inflation protection applies to Short-Term Facility Care and Home Health Care, if You choose the Home Health Care Rider)

Hospital Indemnity Benefit Rider

❑ Maximum Daily Base Benefit Amount $50-300 in $10 increments $_____

Benefit Period: 3 6 20

In the last 24 months, have you used any tobacco products? ❑ Yes ❑ No

APPLICANT A - TOTAL PREMIUM: $_____

Total Premium does not include Your one-time $25 policy fee

APPLICANT B - INSURANCE APPLIED FOR

Short-Term Facility Care Insurance Policy

❑ Maximum Daily Base Benefit Amount $50-400 in $10 increments $_____

Elimination Period: 0 20 60 90

Benefit Period: 90 180 270 360

Prescription Drug: $300

Home Health Care Benefit Rider

❑ Maximum Daily Base Benefit Amount $50-300 in $10 increments $_____

Elimination Period: 0 20 60 90

Benefit Period: 90 180 270 360

Simple Inflation Protection

❑ Yes ❑ No

(If "**Yes,**" the simple inflation protection applies to Short-Term Facility Care and Home Health Care, if You choose the Home Health Care Rider)

Hospital Indemnity Benefit Rider

❑ Maximum Daily Base Benefit Amount $50-300 in $10 increments $_____

Benefit Period: 3 6 20

In the last 24 months, have you used any tobacco products? ❑ Yes ❑ No

APPLICANT B - TOTAL PREMIUM: $_____

Total Premium does not include Your one-time $25 policy fee

AL7060AP (rev. 1122)

Submit Completed Form to: New Business Department, 10777 Northwest Freeway, Houston, TX 77092
Toll Free Telephone Number: (800) 672-4535 FAX: (713) 583-2738

2

DAILY BENEFIT AMOUNT

Please ensure the Daily Base Amount is chosen.

ELIMINATION AND BENEFIT PERIODS

These values are also critical to process the application.

RIDERS

Please ensure rider selection are also made when applicable.

Application- Continued

HEALTH QUESTIONS – PART I (If any answer to questions 1-5 below is "YES", you are not eligible for coverage)	APPLICANT A	APPLICANT B
1. Have you been treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or tested positive for human immunodeficiency virus (HIV) infection?	❑ Yes ❑ No	❑ Yes ❑ No
2. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?	❑ Yes ❑ No	❑ Yes ❑ No
3. Are you currently:		
a. Receiving assistance or supervision to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed, or have an inability to control bowel or bladder function?	❑ Yes ❑ No	❑ Yes ❑ No
b. Receiving home health care services, or confined in a rehabilitation facility, nursing facility, or assisted living facility?	❑ Yes ❑ No	❑ Yes ❑ No
c. Being treated, or have you been diagnosed, by a medical professional for Alzheimer's Disease, dementia, Parkinson's Disease (stage 4 or 5), Huntington's Chorea, or cognitive impairment?	❑ Yes ❑ No	❑ Yes ❑ No
d. Receiving treatment by a medical professional for diabetic complications resulting in neuropathy, proliferative retinopathy, kidney disease or failure, renal insufficiency, or kidney dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
e. Receiving treatment by a medical professional for insulin dependent diabetes in conjunction with heart failure?	❑ Yes ❑ No	❑ Yes ❑ No
4. Within the past 12 months, have you been advised to have tests, treatment, or surgery that has not yet been performed or have pending test results?	❑ Yes ❑ No	❑ Yes ❑ No
5. Within the last 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional: Cancer (other than skin cancer in situ), leukemia, lymphoma, malignant melanoma, or cancer that has spread from its original site?	❑ Yes ❑ No	❑ Yes ❑ No
[HEALTH QUESTIONS – PART II (If any answer to question 1 below is "YES", any simple inflation benefit is not available, and the applicant will be limited to a maximum of $100 of daily benefit on the base Policy, Home Health Care Rider, and Hospital Indemnity Rider).	APPLICANT A	APPLICANT B
1. Within the past 24 months, have you been diagnosed with, received treatment for, or been prescribed medication for any of the following conditions by a medical professional:		
a. Stroke, transient ischemic attack (TIA), congestive heart failure (CHF), or organ transplant (other than corneal transplant)?	❑ Yes ❑ No	❑ Yes ❑ No
b. Diabetes that requires more than 50 units of insulin daily or more than 2 oral and 1 injectable medications?	❑ Yes ❑ No	❑ Yes ❑ No
c. Systemic lupus, multiple sclerosis, muscular dystrophy, cerebral palsy, motor neuron disease, Lou Gehrig's disease (ALS), psychotic disorders, alcohol, or substance abuse or any other neurological or neuromuscular disease?	❑ Yes ❑ No	❑ Yes ❑ No
d. Amputation caused by disease?	❑ Yes ❑ No	❑ Yes ❑ No
e. Chronic obstructive lung or pulmonary disease (COPD), chronic bronchitis or emphysema, respiratory disease requiring the use of oxygen, or chronic liver disease?	❑ Yes ❑ No	❑ Yes ❑ No]
[PRESCRIPTION DRUG QUESTIONS – PART III (You must answer this question)	APPLICANT A	APPLICANT B
Has any applicant taken or been prescribed drugs by a medical professional in the last 24 months? If "**Yes**" complete the chart below.	❑ Yes ❑ No	❑ Yes ❑ No

APPLICANT A	APPLICANT B	Prescribed Medication	Date Prescribed	Frequency and Dosage	Diagnosis/onset Date
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				
❑	❑				]

AL7060AP (rev. 1122)

Submit Completed Form to: New Business Department, [P.O. Box 510690, Salt Lake City, UT 84151-0690]
Toll Free Telephone Number: [(800)327-0695] FAX: [(801) 538-0392]

3

HEALTH QUESTIONS

Please answer each health question. Questions not answered will likely result in delays in processing.

PRESCRIPTION DRUG QUESTIONS

Here again it is vitally important to list any medication history for the insured. Not doing so could delay the approval process.

Application- Continued

AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, LLC (MIB), Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to the Standard Life and Casualty Insurance Company (the Company) or its reinsurers, any such information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal law governing privacy and confidentiality. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

I authorize Standard Life and Casualty Insurance Company, or its reinsurers, to make a brief report of my protected health information to MIB, LLC.

I understand that I am authorizing the Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by the Company will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with the Company.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to the Company will result in the rejection of the Insurance Policy coverage.

I understand that I may revoke this authorization at any time by notifying the Company in writing at their Administrative Office: [P.O. Box 510690, Salt Lake City, UT 84151-0690]. I understand that such revocation will not have any effect on actions the Company took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits, or, for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be as valid as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete, and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE ADMINISTRATIVE OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED.

WARNING: 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.

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant A's signature (or their authorized representative)

Signed at _____, on _____ X _____
(City and State) (Month/Day/Year) Applicant B's signature (or their authorized representative)

AGENT(S) STATEMENT: I, the undersigned agent, also certify that to the best of my knowledge, replacement ❑ is ❑ is not involved at this time.

X _____ _____ _____ _____ % _____
Signature of Agent | Printed Agent's Name | Agent No. | % Credit | State ID No.

X _____ _____ _____ _____ % _____
Signature of Agent | Printed Agent's Name | Agent No. | % Credit | State ID No.

NOTICE: All premium checks must be made payable to Standard Life and Casualty Insurance Company. Do not make the check payable to the agent or leave the payee blank.

AL7060AP (rev. 1122)

Submit Completed Form to: New Business Department, [P.O. Box 510690, Salt Lake City, UT 84151-0690]
Toll Free Telephone Number: [(800)327-0695] FAX: [(801) 538-0392]

4

APPLICANT SIGNATURE(S)

Fill out all information complete and accurate.

Sign and date accordingly.

If someone other than the applicant signs, Power of Attorney paperwork must be provided.

Wet signatures are required for paper applications. Currently there are no electronic signature options for paper applications.

Required Application Information

Whenever possible we highly recommend utilizing our ManhattanDirect 2.0 enrollment platform, as paper submissions often have undue delays. If an application is submitted with incomplete, unclear, or missing information critical to the risk evaluation process, a new application may be required, or an amendment to the application will be issued. Critical information includes, but is not limited to:

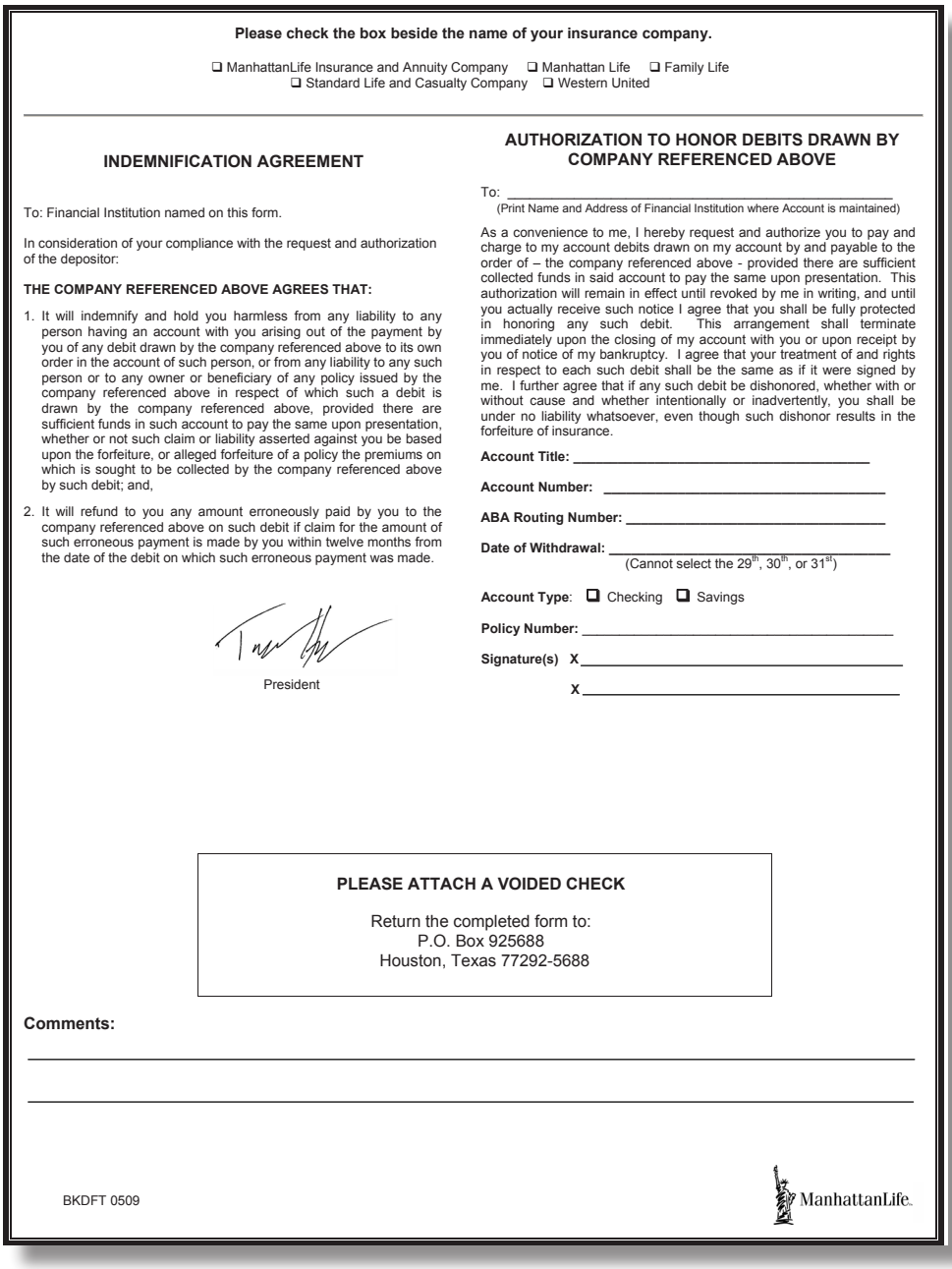
- Complete residential address
- Date of birth
- Plan selection
- Correct Premium
- Bank draft date/Policy effective date
- Eligibility questions
- Applicant's signature
- Agent's signature
- Agent Number

Top Reasons for Application Delays

- The application is received at the administrative office more than 30 days from the signature date, or if the signature date is in the future.
- Pending Agent Appointment. ManhattanLife practices "Just in Time" appointments and processing of applications. What does this mean? This means that we will not run a background check and solidify appointments until your 1st piece of business is submitted. This could result in a 24-48 hr delay for this initial deal, so please keep that in mind.
- Signature stamps are not allowed on applications. Please ensure a physical signature is captured.
- If the amount quoted on the application is less than the modal premium we calculate, we will contact the agent to verify that it is acceptable to process the bank draft for the amount that we have calculated. We will amend the modal premium.
- Provide all medication information and history.
- Information listed on application does not align with Personal Health Interview (PHI).

Bank Draft Authorization Form

If client's elects to pay premiums via bank draft, please ensure the bank draft authorization form is submitted along with the paper application.



Please check the box beside the name of your insurance company.

❑ ManhattanLife Insurance and Annuity Company ❑ Manhattan Life ❑ Family Life
❑ Standard Life and Casualty Company ❑ Western United

INDEMNIFICATION AGREEMENT

To: Financial Institution named on this form.

In consideration of your compliance with the request and authorization of the depositor:

THE COMPANY REFERENCED ABOVE AGREES THAT:

1. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of the payment by you of any debit drawn by the company referenced above to its own order in the account of such person, or from any liability to any such person or to any owner or beneficiary of any policy issued by the company referenced above in respect of which such a debit is drawn by the company referenced above, provided there are sufficient funds in such account to pay the same upon presentation, whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture of a policy the premiums on which is sought to be collected by the company referenced above by such debit; and,
2. It will refund to you any amount erroneously paid by you to the company referenced above on such debit if claim for the amount of such erroneous payment is made by you within twelve months from the date of the debit on which such erroneous payment was made.

President

AUTHORIZATION TO HONOR DEBITS DRAWN BY COMPANY REFERENCED ABOVE

To: _____
(Print Name and Address of Financial Institution where Account is maintained)

As a convenience to me, I hereby request and authorize you to pay and charge to my account debits drawn on my account by and payable to the order of – the company referenced above - provided there are sufficient collected funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such debit. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of and rights in respect to each such debit shall be the same as if it were signed by me. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

Account Title: _____

Account Number: _____

ABA Routing Number: _____

Date of Withdrawal: _____
(Cannot select the 29th, 30th, or 31st)

Account Type: ❑ Checking ❑ Savings

Policy Number: _____

Signature(s) X_____

X_____

PLEASE ATTACH A VOIDED CHECK

Return the completed form to:
P.O. Box 925688
Houston, Texas 77292-5688

Comments:

_____

_____

BKDFT 0509

ManhattanLife

PAYMENT OPTION AUTHORIZATION SIGNATURE(S)

For individuals wishing to have their monthly premiums collected via electronic ACH, please ensure correct routing and direct deposit account information is listed.

ACH information can be found on the bottom of the insureds check.

The Bank Draft authorization form can be found at:
ManhattanLIfe.com > File A Claim > Individual and Worksite > Health & Accident

*****Make sure Signature on the Bank Draft Authorization matches the signature card at the bank.*****

Policy Issue Guidelines

The policy issued is specific to the state of residence. The applicant's state of residence controls the application, forms, premium, and policy issued. If an applicant has more than one residence, the state where the federal income taxes are filed should be considered the state of residence.

Multiple Policies

An individual can only have one ManhattanLife Short-Term Care Insurance policy in place at any given time.

Replacements

A replacement takes place when an applicant wishes to exchange an existing ManhattanLife OmniFlex™ Short-Term Care policy for another OmniFlex™ Short-Term Care policy of lesser (downgrade) or greater (upgrade) value. An upgrade will be processed via a new paper application, including Underwriting. A $25 application fee applies.

Downgrades will be processed via email or written request sent to the following:

Email: TBD
Address: TBD

Underwriting

The goal of ManhattanLife and group of companies is to issue insurance policies as quickly and efficiently as possible, while ensuring proper evaluation of each risk. To accomplish this goal, writing agents may be contacted via email to advise him/her of any problem(s) with an application.

Complete applications will be reviewed and processed within 48-72 hours. It is very important to ensure the entire application is filled out completely, including all health questions. This greatly helps reduce processing timeframes.

If you (agent) or insured are unsure about past medical conditions, impairments, or terminology, please provide any additional comments that could provide additional insight to our underwriters.

Underwriting Continued

Health Questions

- Health Questions Part I – If any answers to questions 1-5 on Part 1 of the application health questions is "Yes", the client IS NOT eligible for coverage.
- Health Questions Part II – If any answer to question 1 on Part II of the application health questions is "Yes", any Simple Inflation benefit IS NOT available, and the applicant will be limited to a MAXIMUM $100 daily benefit on the base Policy, Home Health Care Rider, and Hospital Indemnity Rider.)
- Prescription Drug Questions Part III – Please be as through as possible when completing this section.

Telephone Interviews

There may be instances when a telephone interview is necessary to verify information within the application. In the event we are unable to complete a phone interview, additional medical records may be required.

** Any deviations from the application and information gathered during a Phone Interview could result in processing delays. Please be aware that agents and/or an agent's representative may not be present or on the line while a phone interview is being conducted.*

Pharmaceutical Information

Standard Life has implemented a process to support the collection of pharmaceutical information for underwritten Short Term care applications. To obtain the pharmaceutical information, the Authorization and Certification section must be signed by the applicant. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This additional information will not be solely used to decline coverage.

Medications/Therapeutic Use Reference

These medications are a list of prescription drugs and their common therapeutic use. These prescription drugs are not limited to the treatment of the conditions indicated. This list is by no means complete since it would be impossible to list every medication in an easy reference guide.

Mirapex/Pramipexole & Requip/Ropinirole-complete Phone Health Interview & verify diagnosis, if used to treat restless leg syndrome and dose/frequency < 4mg QD, may be considerable.

Truvada/Emtricitabine Tenofovir-complete Phone Health Interview & verify diagnosis & how prescribed, if used as a preventative measure only, may be considered.

- Medications in **red** will result in a decline.
- Medications in **teal** will require a Phone Health Interview to determine diagnosis.

MEDICATION	CONDITION	DECLINE	LIMITED BENEFITS
Abilify	Schizophrenia/Bipolar Disorder		Y
Abiraterone Acetate	Cancer	Y	
Aggrenox	Prevent Blood Clot/Stroke		Y
Albuterol	Asthma/COPD		Y
Alkeran	Cancer	Y	
Altace	High Blood Pressure/ Congestive Heart Failure		Y
Anastrozole	Breast CA	Y	
Antabuse	Alcoholism		Y
Aranesp	Anemia in pts w/Chronic Renal Failure & CA Chemotherapy		
Aricept	Alzheimer's Disease/Memory Loss	Y	
Arimidex	Breast CA	Y	
Aripiprazole	Schizophrenia/Bipolar		Y
Atacand	Heart Failure/High Blood Pressure		
Atrovent	COPD/Asthma		Y
Avastin	Cancer	Y	
Avonex	MS		Y
Azathioprine	Prevent Kidney Transplant Rejection/RA		
AZT	HIV/AIDS	Y	
Benazepril	CHF/Renal Failure/High Blood Pressure		
Benztropine	Parkinson's Disease		
Bevacizumab	Cancer	Y	

MEDICATION	CONDITION	DECLINE	LIMITED BENEFITS
Bicalutamide	Prostate CA	Y	
Breo	COPD/Asthma		Y
Bumex	Fluid Retention/CHF		
Busulfan	Leukemia	Y	
Carbidopa	Parkinson's Disease	Y	
Carvedilol	CHF/High Blood Pressure		Y
Casodex	Prostate CA	Y	
CellCept	Transplant Anti-Rejection/Lupus		Y
Chlorambucil	Leukemia	Y	
Chlordiazepoxide	Anxiety/Alcoholism		Y
Chlorpromazine	Schizophrenia		Y
Ciclosporin	Dry Eyes/Organ Transplant Rejection/RA/ Psoriasis/Nephrotic Syndrome		
Clonazepam	Seizures/Panic Disorder		Y
Clopidogrel	Prevent Blood Clot/Stroke		Y
Clozapine	Schizophrenia		Y
Clozaril	Schizophrenia		Y
Cogentin	Parkinson's Disease		
Cognex	Alzheimer's Disease	y	
Combivent	COPD		Y
Comtan	Parkinson's Disease		
Copaxone	MS (injection)		Y
Coreg	CHF/High Blood Pressure		Y
Cyclophospha-mide	Cancer	Y	
Cyclosporine	Dry Eyes/Organ Transplant Rejection/RA/ Psoriasis/Nephrotic Syndrome		
Cytoxan	Cancer	Y	
Daclatasvir	Hepatitis C		Y
Daklinza	Hepatitis C		Y
Darbepoetin Alfa	Anemia in pts w/Chronic Renal Failure & CA Chemotherapy	Y	
Darunavir	HIV	Y	
Diazepam	Anxiety/Alcohol Withdrawal/Muscle Spasms		Y

MEDICATION	CONDITION	DECLINE	LIMITED BENEFITS
Diovan	Heart Failure/High Blood Pressure		
Diuril	Fluid Retention/CHF		Y
Donepezil	Alzheimer's Disease/Memory Loss	Y	
Eliquis	Prevent Blood Clot/Stroke in pts w/A Fib		Y
Enalapril	CHF/High Blood Pressure		Y
Entacapone	Parkinson's Disease		
Entresto	Chronic Heart Failure	Y	
Erlotinib	Cancer	Y	
Eulexin	Prostate CA	Y	
Exelon	Alzheimer's Disease	Y	
Extavia	MS		Y
Femara	Breast CA	Y	
Fluoxetine	Panic Disorder/Depression		Y
Fluphenazine	Schizophrenia/Psychosis		Y
Fosinopril	Heart Failure/High Blood Pressure		
Galantamine	Alzheimer's Disease	Y	
Gengraf	Prevent Organ Transplant Rejection		Y
Geodon	Schizophrenia/Bipolar		Y
Gleevec	Leukemia	Y	
Haldol	Mood Disorders/Schizophrenia		Y
Harvoni	Hepatitis C		Y
Heparin	Prevent Blood Clots (injection)		Y
Hexalen	Ovarian CA	Y	
Hydrea	Sickle Cell Anemia/Cancer/Blood Disorders		
Hydroxychloro-quine	RA/Lupus		Y
Hydroxyurea	Sickle Cell Anemia/Cancers/Blood Disorders		
Hygroton	Fluid Retention/CHF		
Imuran	Prevent Kidney Transplant Rejection/RA		
Indapamide	High Blood Pressure/CHF		
Interferon	MS/Hepatitis C		
Ipratropium	COPD/Asthma		Y
Keytruda	Lung Cancer	Y	

MEDICATION	CONDITION	DECLINE	LIMITED BENEFITS
Klonopin	Panic Disorder/Seizures		Y
Lamictal	Seizures/Bipolar Disorder		Y
Latuda	Bipolar Disorder/Schizophrenia		Y
Ledipasvir	Hepatitis C		Y
Letrozole	Breast CA	Y	
Leukeran	Leukemia	Y	
Levodopa	Parkinson's Disease		
Librium	Anxiety/Alcoholism		Y
Lisinopril	CHF/High Blood Pressure		Y
Lithium	Manic Depressive Disorder/Bipolar Disorder		Y
Lodosyn	Parkinson's Disease		
Lotensin	High Blood Pressure/CHF/Renal Failure		
Loxitane	Schizophrenia		Y
Lozol	High Blood Pressure/CHF		Y
Lupron	Prostate CA (injection)	Y	
Lurasidone	Bipolar Disorder/Schizophrenia		Y
Maraviroc	HIV	Y	
Megace	Tx of loss of appetite/wt loss d/t AIDS, advanced Breast CA, Endometrial CA	Y	
Mellaril	Schizophrenia		Y
Memantine	Alzheimer's Disease	Y	
Mercaptopurine	Acute Lymphocytic Leukemia/Ulcerative Colitis/Crohn's		Y
Methotrexate	Cancer/RA	Y	
Midamor	High Blood Pressure/CHF		Y
Mirapex	RLS/Parkinson's Disease		
Monopril	Heart Failure/High Blood Pressure		
Mycophenolate	Transplant Anti-Rejection/Lupus		Y
Myleran	Leukemia	Y	
Namenda	Alzheimer's Disease	Y	
Navane	Schizophrenia		Y
Neoral	Prevent Organ Transplant Rejection		Y
Olanzapine	Schizophrenia/Bipolar Disorder		Y

MEDICATION	CONDITION	DECLINE	LIMITED BENEFITS
Olysio	Hepatitis C		Y
Peg-Intron	Hepatitis C (injection)		Y
Pembrolizumab	Lung Cancer	Y	
Permax	Parkinson's Disease		
Perphenazine	Schizophrenia		Y
Plaquenil	RA/Lupus		Y
Plavix	Prevent Blood Clot/Stroke		Y
Pramipexole	RLS/Parkinson's Disease		
Prezista	HIV	Y	
Proair	Asthma/COPD		Y
Procrit	Anemia in pts w/Renal Failure, HIV, CA		
Prograf	Prevent Organ Transplant Rejection		Y
Prolixin	Schizophrenia/Psychosis		Y
Prozac	Panic Disorder/Depression		Y
Pulmicort	Asthma/COPD		Y
Purinethol	Acute Lymphocytic Leukemia/Ulcerative Colitis/Crohn's		Y
Quetiapine	Bipolar Disorder/Schizophrenia		Y
Ramipril	CHF/High Blood Pressure		Y
Razadyne	Alzheimer's Disease	Y	
Rebif	MS		Y
Reminyl	Alzheimer's Disease	Y	
Requip	RLS/Parkinson's Disease		
Rheumatrex	Cancer/RA	Y	
Rilutek	ALS		Y
Riluzole	ALS		Y
Risperdal	Schizophrenia/Bipolar Disorder		Y
Risperidone	Schizophrenia/Bipolar Disorder		Y
Rivastigmine	Alzheimer's Disease	Y	
Ropinirole	RLS/Parkinson's Disease	Y	
Sacubitril/ Valsartan	Chronic Heart Failure	Y	
Selegiline	Depression/Parkinson's Disease	Y	

MEDICATION	CONDITION	DECLINE	LIMITED BENEFITS
Selzentry	HIV	Y	
Seroquel	Schizophrenia/Bipolar Disorder/Major Depression		Y
Simeprevir	Hepatitis C		Y
Sinemet	Parkinson's Disease		
Sofosbuvir	Hepatitis C		Y
Sovaldi	Hepatitis C		Y
Spironolactone	High Blood Pressure/CHF/Edema		Y
Tacrine	Alzheimer's Disease	Y	
Tacrolimus	Prevent Organ Transplant Rejection		Y
Tamoxifen	Cancer	Y	
Tarceva	Cancer	Y	
Tasmar	Parkinson's Disease		
Tegretol	Seizures/Bipolar Disorder		Y
Tetrabenazine	Huntington's Disease/Chorea	Y	
Thorazine	Schizophrenia		Y
Tolcapone	Parkinson's Disease		
Trexall	Cancer/RA		
Valium	Anxiety/Alcohol Withdraw/Muscle Spasm		Y
Vasotec	CHF/High Blood Pressure		Y
Xeloda	Colon/Breast CA	Y	
Xenazine	Huntington's Disease/Chorea	Y	
Zaroxolyn	Fluid Retention/CHF		Y
Zestril	CHF/High Blood Pressure		Y
Ziprasidone	Schizophrenia/Bipolar Disorder		Y
Zoloft	Panic Disorder/Depression/PTSD		Y
Zyprexa	Schizophrenia/Bipolar Disorder		Y
Zytiga	Cancer	Y	

Medications/Therapeutic Use Reference

Want instant access to this medication list on your phone? Scan this QR!

Situations Requiring a New Application

A new application is required if white-out or liquid paper has been used on the application, or a change was made to the application and not initialed by the applicant.

If the incorrect state-approved application was submitted. Only the most recent state-approved application will be accepted. If the status of the available application is in question, please call Sales & Marketing to confirm the application form number.

Eligibility Questions

Ineligible conditions include:

For the Base Plan

- Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV), Arthrogryposis Dysfunction-Cholestasis (ARC).
- Eligible for Medicaid, or on early Medicare due to disability or are disabled.
- Receiving assistance or supervision to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed, or having an inability to control bowel or bladder function.
- Received home health care services, or confined in a rehabilitation facility, nursing facility, or assisted living facility.
- Being treated or have been diagnosed by a medical professional for Alzheimer's Disease, dementia, Parkinson's disease (stage 4 and 5), Huntington's Chorea, or cognitive impairment.
- Receiving treatment by a medical professional for diabetic complications resulting in neuropathy, proliferative retinopathy, kidney disease or failure, renal insufficiency, or kidney dialysis.
- Been advised to have tests, treatment or surgery that has not been performed or for which test results are pending within the last 12 months.

Note: Answering "No" to all the medical questions on the application does not guarantee acceptance. The underwriter reviews the applicant's entire medical history when making their decision.

Application Status

For your convenience, you may access *https://producer.manhattanlife.com/life/account/login.aspx?AsAgent* at any time to verify the processing status of a submitted application.

Declined Appeals

If the applicant wishes to appeal his/her declined application, a written request must be submitted by the applicant to the Underwriting Manager within 60 days of the decision. If more than 60 days have passed since the decline, the applicant will be required to submit a new application and a telephone interview will be completed. All appeals require medical records pertaining to the condition for which the applicant was declined. It is the responsibility of the applicant to obtain his/her medical records, as Standard Life does not make such requests. Medical records must be submitted to the Underwriting Department directly from the physician's office and will not be accepted if submitted by the applicant or agent. Please note that Standard Life does not reimburse any fees associated with obtaining medical records or other supporting documentation pertaining to the requested appeal. The written request and medical records may be faxed to 1-713-583-2738 and directed to the attention of the Short-Term Care Underwriting Manager. The request and records may also be mailed to the physical address or post office box noted on page 25 of this Guide.

Application Status Codes

- **Data Entry:** In the process of being keyed into the computer system
- **Pending Agent Appointment:** Application processed, but pending agent appointment
- **Pending PHI:** Pending telephone interview with applicant
- **Withdrawn:** Application closed due to insufficient information or documentation. The application can also be withdrawn at the insured or agent's request.
- **Declined:** Not eligible for coverage

Application Assistance

If you have any questions about the application or about how to answer any of the questions on the application, please call Standard Life at **1-800-672-4535**

Amendments/Endorsements

An Amendment and/or Endorsement to the application will be generated for the following reasons:

- Any question left blank or answered incorrectly (as determined by a telephone interview).
- An error or unclear answer for the plan selection and/or underwriting risk classification.
- An error or unclear answer for the date of birth, sex, and/or address.
- An error or unclear answer for the modal premium.

Withdrawn Policies

Applicants who wish to withdraw an issued policy can return the insurance policy indicating they do not wish to keep the insurance policy or may be in the form of a signed letter or other signed written statement.

An applicant with a withdrawn insurance policy should be encouraged to return the insurance policy. To receive a full refund of premium, the request to not take the insurance policy must either be post- marked (if sent via mail) or received by the Company (if faxed) within the 30-day free look window. A full refund of the premium for withdrawn insurance policies will be processed 21-days after the date the check was deposited (to ensure the check has cleared the bank). If the applicant requests the refund prior to that, the applicant's financial institution will be contacted to verify the check has cleared. The refund check and a letter confirming the insurance policy was withdrawn will be mailed to the applicant. A copy of the letter will also be mailed to the writing agent.

Any commissions paid to the writing agent(s) will be reversed.

Methods of Payment

The method of premium payment should be selected on page 5 of the application with the modal premium written in the designated field. The modal premium does not include the insurance policy fee (if applicable).

The available premium payment modes are as follows:

Direct bill*	**Bank Draft**
Annual	Annual
Semiannual	Semiannual
Quarterly	Quarterly
	Monthly

ManhattanLife 2.0 defaults to Monthly.

The amount of each modal premium is calculated by multiplying the annual Policy premium by the applicable modal factors. The modal premiums for Your Policy are shown on the Policy Schedule.

Premium Payment Mode	Modal Factor
Semi-Annually	0.52
Quarterly	0.25
Monthly	0.0833

Methods of Payment - Continued

Bank Draft

Pay initial and renewal premiums by bank draft
A completed Bank Draft Authorization form must accompany the application. If drafting from a checking account, a voided check must be submitted. If the applicant wishes to draft from a savings account, the Bank Draft Authorization form must be filled out in its entirety. If the information provided is incomplete or unclear, Standard Life will require proof of the routing number and account number from the financial institution.

NOTE: If the initial EFT is returned non-sufficient funds (NSF), a second attempt will be made on the 5th business day after we are notified by the Bank. If the second attempt is unsuccessful, payment will be called due, the policy will transition to quarterly direct bill mode, and the initial premium will be required to activate the coverage. If the initial premium is drafted successfully and any renewal premiums are returned NSF, a second attempt will be made on the 5th business day after we are notified by the Bank. If the second attempt is unsuccessful, payment will be called due, and the policy will transition to quarterly direct bill mode.

Direct Bill

- Acceptable forms of payment:
- Personal checks
- Electronic bill pay (from applicant)
- Business check (business owner must be applicant or spouse of applicant)
- Employer-paid retiree benefits (“retiree” or “retirement benefits” should be stated on the memo line)

The Following Forms of Payment are *NOT* Acceptable:

- Temporary checks
- Personal checks from any individual outside of the applicant’s immediate family (immediate family is considered as spouse, parent, child, sibling)
- Business check from a business not owned by the applicant or spouse
- Third party checks

Claims

Restoration of Benefits

Some policyholders and agents have been confused when reading the policy language related to restoration of benefits. It is important to note and acknowledge that ManhattanLife is administering this benefit as outlined below.

- After receiving facility care, or home health care benefits, if the insured has not received any benefits for 180 days, we will restore their benefit period to its original benefit period.
- This restoration of benefits is regardless of whether or not the insured has used their entire benefit period.
- The insured would still be subject to the lifetime maximum benefit period outlined in the policy.

Contact Us

New business, claims, administration, and overnight mailing address:

Standard Life and Casualty Insurance Company
10777 Northwest Freeway
Houston, TX 77092
or
P.O. Box 925568 Houston, TX 77292

Toll-free number: 1-800-672-4535
Option 1: Direct dial extension
Option 2: Standard Life contact information
Option 3: Commissions
Option 4: Application status
Option 5: Customer Service: Policyholder Services, Billing & Premiums.
Option 6: Marketing
Option 7: Provider benefits, eligibility, and claims status
Option 8: PHI
- Option 2 for OmniFlex™ Short Term Care
Option 9: Pre-Qual
- Option 2 for OmniFlex™ Short Term Care

Website: www.manhattanlife.com

ManhattanLife Marketing Department

Call 1-888-441-0770 for Marketing Support, Agent Licensing, Agent Portal Assistance or Supplies.
Marketing Support and Agent Licensing Fax: 1-713-821-6512

For direct access to the Agent Resource Center portal:

https://producer.manhattanlife.com

Fax Numbers:

New Business/Customer Service/Underwriting Fax: 1-713-583-2738

For additional information that has been requested, please include application number

Claims Fax number: 1-713-583-0677

To ensure quick processing, please include the policy number on any claims inquiries.

ManhattanLife™
Standing By You. Since 1850.

Underwritten by:
ManhattanLife Insurance and Annuity Company
10777 Northwest Freeway, Houston, TX 77092

Standard Life and Casualty Insurance Company
PO Box 510690; Salt Lake City, UT 84151-0690

Thank you again for taking the time to learn about our Short-Term Care product. Should you have any additional questions or need more clarity, please do not hesitate to reach out to Sales & Marketing directly at:
888-441-0770 or
marketingmail@manhattanlife.com

Scan to download and view an electronic copy of this guide!

Visit our website:
https://www.manhattanlife.com/

Follow us on social media:

YouTube