The offering Company(ies) listed below, severally or collectively, as the content may require, are referred to in this authorization as "We" or "ManhattanLife."

Accident Insurance products insuredby ManhattanLife Assurance Company of America, Manhattan Life Insurance Company.

Any Person, who withthe intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. (See State Specific Fraud Warning Statements on pages 3-4)

The below Statements are true to the best of my knowledge and belief.		
	/ /	
Signature of Subscriber	Date	
Is the claim for the: Subscriber Dependent		
*If your accident plan includes the disability rider and you are filin completed.	g for disability benefits, a disability claim form must also be	
Subscriber's Name-	MemberID	
Mailing Address		
State ZIP Code Date of Birth / Patient Name Date of Birth /	Daytime Phone number)	
Date of Accident/Time of Accident First date treated for injury// Was this accident caused or contributed to by a medical condition? If yes, what is the medical condition	Yes No	
Did this accident occur at work? Yes No If yes Have you or do you intend to file a Workers' Compensation or Occ		
Please provide specific details of how your accident occurre Where did the accident occur:	edto aidin the correct processing of yourclaim:	
Details on how the accident/injury occurred and type of injury:		
 Was this a motor vehicle accident in which the patient was the drive Police Report.) Was the patient tested for alcoholor drugs? No Yes (If yes) Did the accident result in the patient's death? No Yes Was the patient treated by a physician orin a hospital as a result Yes, submit the UB04 itemized hospital bill, or HCFA 1500 itemized 	es, please submitthe bloodalcohol reportor drug screening.) (If yes, please submit the certified death certificate.) It of this injury?	



Mail to: Manhattan Life Claims P.O. Box 926169 Houston, TX 77092

	thorization to release information - For the Use and Disclosure of Protected Health Information ient's NameMemberID	
der Ind	Any physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility or provider of medical or al services or supplies; any employer, group policy holder, contract holder or insurer, benefit plan administrator, administrator, The ex System, business entities, financial institutions, consumer reporting agencies, educational institutions, or any Federal, te or Local Government Agency, including Social Security Administration and Veterans Administration.	
Lai	thorize the use and/or disclosure of my protected health information and other related information as described below:	
1.	My authorization applies to that information obtained by all healthcare professionals. This information may include my medical records, laboratory reports, prescription medication records, and radiologyreports in the possession of all health care professionals. For purposes of this authorization, medical information specifically includes confidential information regarding HIV/ AIDS, communicable diseases, alcohol ordrug abuse, and mental health, as such information may relate to my claim for benefits. This information maybe used and/or disclosed pursuant to this Authorization.	
2.	I authorize all health care professionals to disclose my protected health information to ManhattanLife Assurance Company of America, ManhattanLife Insurance Company.	
3.	My authorization applies to work information and history, including, but not limited to, job duties, earnings and personnel records, client lists, any and all other work-related information for contractual work performed; information on any insurance coverage and claims filed, including all records and information related to such coverage and claims.	
4.	I authorize the release of information concerning SocialSecurity benefits, including, but not limited to, monthly benefit and payment amounts, entitlement dates and entitlement details, and information from my Master Beneficiary Record.	
5.	I authorize only designated staff of ManhattanLife Assurance Company of America, Manhattan Life Insurance Company, to receive, in writing, by photocopy, facsimile, or by telephone, my protected health information.	
6.	I understand that, if my protected health information is disclosed to some one who is not required to comply with federal privacy protection regulations, such information maybe re-disclosed and would no longer be protected.	
7.	I understand that I have a right to revoke this Authorization at any time. My revocation must be in writing in a letter addressed to ManhattanLife Assurance Company of America, or Manhattan Life Insurance Company PO Box 926169, Houston, TX 77092. This revocation shall become effective ont he date it is received by ManhattanLife Assurance Company of America or Manhattan Life Insurance Company. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this Authorization.	
Th	s Authorization is given in connection with a claim for benefits. I intend that it be valid for the duration of the claim.	
Αp	notocopy or facsimile of this authorization shall be valid as the original.	
I c	ertify that I have received a copy of this Authorization and authorize the use and/or disclosure of my protected alth information as contemplated herein for all records or records for dates of service to	
Sig	nature Printed Name Date	
_	ve legal authority* under the laws of the State ofto make healthcare decisions on behalf	
of ap	, the individual to whom the use and/or disclosure of protected health information above plies, and execute this Authorization in mycapacity as Authorized Representative thereof.	
	//	
	me of Authorized Representative/ Relationship to Applicant Date rent or Guardian	
*A	copyof the legal authority document must be on file with ManhattanLife.	
If y	ouhave any questions when completing this form, please call 1-888-645-6410.	



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Claims
P.O. Box 926169
Houston, TX 77092

Travel Expense Rider
Please check the type of travel benefityouare claiming for:
Meals Use of Personal Vehicle Lodging Expenses for common carriers of transportation
Please check who accompanied you for your accident treatment:
Attended alone Spouse or Friend Multiple adults
Please include travel receipts for reimbursement of
Before mailingyour claim form, please be sure you have includedall items listedable to prevent delay in processing fyour claim. Attach an itemized billing from your provider that includes the dates of service, characteristics.



- ve
- ge amount, diagnosis, and procedure codes. UBO4&HCFA 1500
- Retain a copy of all information submitted for your records.

If you have any questions when completing this form, please call 1-855-448-6982.

Mail to the following address:

Manhattan Life OrFax to: 1-502-445-7107 Claims P.O. Box 926169 Houston, TX 77092

State Specific Fraud Warning Statements

ManhattanLife:

Any Personwho, with the intent to defraud or knowing that he/she is facilitating a fraudagainst an insurer, submits and Application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud. We may notifyall state and federal lawen forcement agencies of any suspected Fraud, as determined by Us. We reserve the right to recover any payments made by Us that were made to Youand/orany party on Yourbehalf, b ase don fraudulentor misrepresented information.

Alaska, Delaware, Idaho, Indiana, Maine, Minnesota, New Hampshire, New Mexico, Ohio, Oklahoma, Tennessee, Texas, Washington, West Virginia:

Any Personwho, with the intent to defraudor knowingly submits an application or claim containing a false or fraudulent statement may be subject to prosecution and punishment for insurance fraud.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knówingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas, Louisiana, Rhode Island:

Any person who knowingly presents a false or fraudulentclaim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime andmaybe subject to fines and confinementin prison.

Arizona:

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California:

For your protection California law requires the following statement to appear onthis form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guiltyof a crime and maybe subject to fines and confinement in state prison.



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State Specific Fraud Warning Statements

Colorado:

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies

District of Columbia:

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida

Any personwho knowinglyand withintent to injure, defraud, or deceive any insurer files a statement of claimor an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky, Pennsylvania:

Any person who knowingly and with intent to defraudany insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Kansas:

Any person who, knowingly and with intent to defraud, presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written, electronic, electronic impulse, facsimile, magnetic, oral, or telephonic communication or statementas part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for paymentor otherbenefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto.

Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material there to, commits fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Virginia:

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.



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