

THE MANHATTAN LIFE INSURANCE COMPANY

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

APPLICATION DATA - PLEASE PRINT LEGIBLY

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

COVERAGE DATA

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

NON-MEDICAL DECLARATIONS

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

2. Have you or any proposed insured engaged in or do you plan to engage in any form of motorized racing, scuba diving, parachuting, hang gliding, ballooning or mountain climbing? (If yes, complete Avocation Questionnaire) Yes No

3. Have you made any flights as a pilot or a crew member of any aircraft in the past three years or do you intend doing so? (if yes, complete Aviation Questionnaire) Yes No

4a. Name and address of personal physician (if none, so state) _____

b. Date and reason last consulted _____

If "Yes" to any part of item 1, submit full details below. An additional piece of paper may be attached if necessary.

Question #	Illness or nature of injury	Date	Doctor's full name & Address

AUTHORIZATION TO OBTAIN INFORMATION

I HEREBY AUTHORIZE any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to The Manhattan Life Insurance Company its reinsurers or its legal representative, any and all such information. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me.

I UNDERSTAND the information obtained by use of the Authorization will be used by The Manhattan Life Insurance Company to determine eligibility for insurance and eligibility for benefits under an existing policy. I KNOW that I may request to receive a copy of the Authorization, that this Authorization shall be valid for two and one half years from the date shown below.

I AGREE that a photographic copy of this Authorization shall be as valid as the original, and that this Authorization shall be valid for two and one half years from the date shown below. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief.

I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

AGREEMENT

No insurance will take effect unless and until:

- the policy is issued and delivered to the owner(s);
- the first premium has been paid to and accepted by Manhattan Life; and
- there has been no change in the insurability of the Proposed Insured since the date of this application.

If this application is declined, any premiums received by Manhattan Life will be refunded.

No Agent or Broker is authorized to make or modify any policy or waive any of Manhattan Life's rights or requirements or waive the answer to any question in the Application.

Dated at _____ this _____ day of _____, 20____. _____
 Witness (Licensed Resident Agent)

Signature of Owner (if other than Proposed Insured) _____ Signature of Proposed Insured _____ Signature of Proposed Spouse _____

CERTIFICATION

Under penalties of perjury, I certify that: (1) the tax identification/social security number given above is correct; and (2) I am not subject to back-up withholding either because I have not been notified that I am subject to back-up withholding as a result of a failure to report all interest or dividends, or the Internal Revenue Service has notified me that I am no longer subject to such withholding.

 Date City or Town State Signature of Owner

Agent's Statement

To the best of your knowledge, will the insurance applied for replace existing annuity or life insurance in any company(s)?..... Yes No

If a replacement(s), and if state regulations require it, have you given the applicant:

a. Notice to Applicant Regarding Replacement of Life Insurance?..... Yes No

b. Completed all replacements forms, if required in your state?..... Yes No

Have you complied with state regulations on disclosure?..... Yes No

All information recorded by me on this application is true and accurate to the best of my knowledge.

Application Split

Agent No. Agent Name Case %

Special Request: _____

Agent No. Soliciting Agent Signature Date

() _____
 Soliciting Agent Phone #

Received from _____ the sum of \$ _____ paid with an application to The Manhattan Life Insurance Company.

Conditional Receipt

The application bears the same date as the receipt.

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

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

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Conditional Receipt (continued) The Manhattan Life Insurance Company

Coverage under this receipt is also subject to these limitations:

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

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

Dated this _____ day of _____, 200____ By: _____

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Signature of Agent

Notice of Information Practices

Including Fair Credit Reporting Act Notice and MIB, Inc. Notice

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

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

Notice of Information Practices (continued)

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

MIB, Inc. Notice

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

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INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

Definition of Replacement

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

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

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

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

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

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

Yes No

Date: _____ Signature of Agent: _____

THE MANHATTAN LIFE INSURANCE COMPANY

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

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

**Life Solutions Universal Life Illustration
To Be Provided With The Policy**

Applicants Name: _____

Social Security #: _____

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

Field Underwriter/Agent/Representative Signature: _____

Field Underwriter/Agent/Representative Print Name: _____

Agency: _____ Date: _____

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

Applicant: _____ Date: _____

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

The Manhattan Life Insurance Company
Indemnification Agreement

To: Financial Institution named on this form.
In consideration of your compliance with the request and authorization of the depositor:

THE MANHATTAN LIFE INSURANCE COMPANY 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 Manhattan Life Insurance Company 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 Manhattan Life Insurance Company in respect of which such a debit is drawn by The Manhattan Life Insurance, 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 Manhattan Life Insurance by such debit; and,
2. It will refund to you any amount erroneously paid by you to The Manhattan Life Insurance Company 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

The Manhattan Life Insurance Company
Authorized in a resolution adopted by the Board of Directors **The Manhattan Life Insurance Company** on December 2, 1969.

05-1012-0397

AUTHORIZATION TO HONOR DEBITS DRAWN BY
The Manhattan Life Insurance Company
Windsor, CT

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 Manhattan Life Insurance Company - 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 _____ Date _____

MLIC Contract # _____
(Policy or Loan No.)

Signature(s) X _____
X _____

ATTACH SAMPLE VOIDED CHECK

