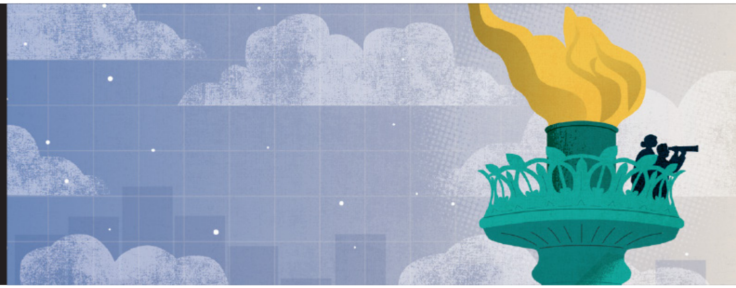
ManhattanLife™
Standing By You. Since 1850.

# Disability Income Benefits

This is Group Disability Income Insurance



## *Designed Especially for:*
BASCME

### DISABILITY INCOME – Accident* (DICERT)**

Pays a Monthly Benefit for Total Disability or Presumptive Disability if you are unable to work due to a Covered Injury. Monthly Benefits begin after your elimination period.** Monthly Benefits continue while your Total Disability lasts or until the end of your benefit period.

### DISABILITY INCOME – Sickness* (DICERT)**

Pays a Monthly Benefit for Total Disability or Presumptive Disability if you are unable to work due to a Covered Sickness. Monthly Benefits begin after your elimination period.** Monthly Benefits continue while your Total Disability lasts or until the end of your benefit period.

- If you are hospitalized as a resident bed patient for a Covered Sickness or Covered Accident, Benefits will begin on the first day admitted.

**The premium for this policy includes coverage for both Accident and Sickness*
***Elimination period does not apply to Presumptive Disability.*

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**Waiver of Premium** – All Premiums that are due after you have received Total or Presumptive Disability Benefits for 90 consecutive days will be waived for as long as Benefits are payable, at no additional charge.

- Pays in addition to any other insurance, 50% if Workers' Compensation or similar law pays.
- Childbirth and complications of pregnancy are covered as a sickness.
- Policy may be continued if employee changes jobs.
- Guaranteed Renewable to age 70.
- One rate regardless of age or sex.
- Pre-existing conditions covered after 12 months.

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Underwritten by ManhattanLife Insurance and Annuity Company
TWRBASCME-GDI 0722

## DEFINITIONS (May Vary State to State):

**COVERED INJURY** means bodily injury or injuries caused by an accident and sustained by an Employee on or after the Certificate Effective Date that must result directly and independently of all other causes. The accident must occur while Your coverage is in force under this Certificate. A Covered Injury includes pyogenic infections incurred through an accidental cut or wound and all injuries because of one accident.

**COVERED SICKNESS** means illness or disease of an Employee that a Physician diagnoses or first recommends treatment for, after the Certificate Effective Date and occurs while Your coverage is in force. Covered Sickness includes inguinal, umbilical or postoperative hernia and bacterial infections. We will consider Normal Pregnancy a Covered Sickness if the inception of the pregnancy occurs after the Certificate Effective Date and while Your coverage is in full force. The Company may require medical evidence to determine the inception date of the pregnancy.

**TOTAL DISABILITY, TOTALLY DISABLED** means You, as the result of a Covered Injury or a Covered Sickness that occurs while You are not Actively at Work: and

1. Are unable to engage in any employment or occupation for which You are qualified or for which You become qualified by reason of education, training or experience;
2. Are not engaged in any employment or occupation for wage or for profit; and
3. Are receiving care by a Physician, which is appropriate for the condition causing Your Total Disability.

**ELIGIBILITY FOR EMPLOYEES:** This Certificate provides coverage for all Employees who are a member of the Eligible Class of Employees. You will be eligible for coverage on the Group Policy Effective Date if You are a member of the Eligible Class of Employees shown on the Employer's application for the Group Policy.

If You become a member of the Eligible Class of Employees after the Group Policy Effective Date, You will be eligible for coverage on the Requested Effective Date shown in Your application, or the date We approve Your application, whichever is later.

Evidence of insurability satisfactory to the Company may be required.

**EFFECTIVE DATES:** Your coverage begins at 12:01 a.m., Standard Time, provided You have paid the required premium, at Your address on the latest of either:

1. The date You become eligible for coverage; or
2. The date enrollment occurs if You do not enroll within 31 days after first becoming eligible.

You must be actively at Work on the date Your coverage is to be effective. If You are not Actively at Work on that date, coverage will be effective on the first date You are Actively at Work.

**RENEWABLE PROVISION:** We Issue Group Policy for the period from 12:01 a.m., Standard Time at the Group Policyholder's address on the Group Policy Effective Date to the first Group Policy Anniversary Date; it will be renewed unless it is terminated as set forth in the Group Policy.

## EXCLUSIONS

The Group Policy does not cover Total Disabilities or Partial Disabilities caused by or in connection to:

1. suicide or any attempt whether sane or insane; in MO, "insane" does not apply;
2. intentional self-inflicted injury whether sane or insane; in MO, "insane" does not apply;
3. termination or suspension of any professional license or certification for any reason other than Total Disability;
4. Mental or Nervous Disorders;
5. service in the armed forces or units auxiliary thereto. Premiums will be refunded on a pro-rata basis for any Employee who enters military services and all coverage for that Employee will be suspended until military service is over;
6. war or any act of war, whether declared or undeclared, while serving in the military service or any auxiliary attached thereto;
7. commission of, or attempt to commit, an assault or a felony; in MN "assault"; does not apply,
8. except in MN and SD, alcoholism or drug addiction or sickness or injury from the (In MT, voluntary) use of alcohol and/or the use of drugs not prescribed by a Physician;
9. participating in any form of flight aviation other than as a fare-paying passenger in a fully licensed, passenger carrying aircraft;
10. mountaineering, parachuting, or hang-gliding; or
11. participating in any sport or hazardous activity for wage, compensation or profit, or racing any type vehicle in any organized event.
12. In MN only, bodily injuries received while operating a motor vehicle under the influence of alcohol as evidence by blood alcohol level in excess of the state legal intoxication limit.

## LIMITATIONS

**FOREIGN TRAVEL:** If You become Totally Disabled while You are outside the United States, the Elimination Period will not begin until You return to the United States provided You are still Totally Disabled on that date.

**PRE-EXISTING CONDITIONS:** The Group Policy does not provide benefits for Total or Partial Disabilities due to a Pre-Existing Condition unless You incur a covered loss due to pre-existing conditions at least 12 months after:

1. the date this Certificate became effective; or
2. with respect to any amount of increased Monthly Benefits, the effective date of such increased Monthly Benefit amount;

and We have not specifically excluded the Pre-Existing Condition by name or specific description.

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This brochure is presented as a matter of general information and is not a contract of insurance. Benefits are only available after the Effective Date of the Policy. For specific details about Benefits, including Definitions, Limitations and Exclusions, refer to Policy Form DICERT (or the state variation). Plans may vary by state and are not available in all states.

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**Policy Form Numbers:** DICERT, DICERT ID, DICERT LA, DICERT MT, DICERT OK, DICERT TX (including state variations)

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Underwritten by ManhattanLife Insurance and Annuity Company, 10777 Northwest Freeway, Houston, Texas 77092.

TWRBASCME-GDI 0722

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# ManhattanLife Disability Rates

## Benefit Association for State, County and Municipal Employees (BASCME)

### Disability Plan (Occ 1)
**14/14 Elimination**

| | 6 Month Benefit | 1 Year Benefit |
|---|---|---|
| | Bi-Weekly Deduction | Bi-Weekly Deduction |
| $ 600 per month Benefit | $10.76 | $13.55 |
| $ 700 per month Benefit | $12.55 | $15.81 |
| $ 800 per month Benefit | $14.34 | $18.07 |
| $ 900 per month Benefit | $16.14 | $20.33 |
| $ 1000 per month Benefit | $17.93 | $22.59 |
| $ 1100 per month Benefit | $19.72 | $24.85 |
| $ 1200 per month Benefit | $21.52 | $27.11 |
| $ 1300 per month Benefit | $23.31 | $29.37 |
| $ 1400 per month Benefit | $25.10 | $31.63 |
| $ 1500 per month Benefit | $26.90 | $33.89 |
| $ 1600 per month Benefit | $28.69 | $36.14 |
| $ 1700 per month Benefit | $30.48 | $38.40 |
| $ 1800 per month Benefit | $32.27 | $40.66 |
| $ 1900 per month Benefit | $34.07 | $42.92 |
| $ 2000 per month Benefit | $35.86 | $45.18 |
| $ 2100 per month Benefit | $37.65 | $47.44 |
| $ 2200 per month Benefit | $39.45 | $49.70 |
| $ 2300 per month Benefit | $41.24 | $51.96 |
| $ 2400 per month Benefit | $43.03 | $54.22 |
| $ 2500 per month Benefit | $44.83 | $56.48 |
| $ 2600 per month Benefit | $46.62 | $58.73 |
| $ 2700 per month Benefit | $48.41 | $60.99 |
| $ 2800 per month Benefit | $50.20 | $63.25 |
| $ 2900 per month Benefit | $52.00 | $65.51 |
| $ 3000 per month Benefit | $53.79 | $67.77 |

TWRBASCME-DIR14/14 0123

**ManhattanLife Insurance and Annuity Company** **Application for Insurance**
10777 Northwest Freeway, Houston, Texas 77092

**FRAUD:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

☐ Check if replacing or changing existing coverage in this company. **Policy Number** ____________

| PERSONS PROPOSED FOR INSURANCE | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Last Name | First | Middle | Relationship | Birthdate | Sex | Height | Weight | Social Security Number |
| | | | Primary Insured | / / | | | | |
| | | | Spouse | / / | | | | |
| | | | Child | / / | | | | |
| | | | Child | / / | | | | |
| | | | Child | / / | | | | |

| Address | City | State | Zip | Home Telephone ( ) |
|---|---|---|---|---|

| Employer | Date Employed | Hours Worked/Wk |
|---|---|---|

| Occupation | Monthly Income $ | Group Number |
|---|---|---|

| Payor or Owner if other than Primary Insured | ☐ Payor ☐ Owner | Social Security No. - - | Relationship to Primary Insured |
|---|---|---|---|

| Beneficiary | Age | Relationship |
|---|---|---|

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

**USED TOBACCO** in the past 12 months? Primary Insured ______ Yes ______ No Spouse ______ Yes ______ No

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

| INSURANCE PLANS | | | | | | Monthly Premium |
|---|---|---|---|---|---|---|
| **DISABILITY** **Primary Insured Only** | Monthly Ben. | Elim. Period | Benefit Period | Building Benef. Rider | 50% Ben. Red. Unless % selected | |
| Occ. Class Injury | $ ______ | $ ______ | $ ______ | ☐ | here ______ | |
| ☐ 1 ☐ 2 ☐ 3 Sickness | $ ______ | $ ______ | $ ______ | | | |

| RIDERS | AD &D | Emerg. Acc. | Hosp. Inj. | Hosp. Indem. | Outpatient Sick. | Spec. Inj. | 1st Hosp. Conf. | ______ | Monthly Premium |
|---|---|---|---|---|---|---|---|---|---|
| Primary Insured | $ ______ | $ ______ | $ ______ | $ ______ | $ ______ | ☐ | ☐ | $ ______ | |
| Spouse | $ ______ | $ ______ | $ ______ | $ ______ | $ ______ | ☐ | ☐ | $ ______ | |
| Children | $ ______ | $ ______ | $ ______ | $ ______ | $ ______ | ☐ | ☐ | $ ______ | $ ______ |

~~If Guaranteed Issue requirements are met, medical underwriting will be waived.~~

1. ~~**HAS ANY PROPOSED INSURED:** In the last 10 years been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) and/or tested positive for HIV (Human Immunodeficiency Virus)? _____ Yes _____ No~~
2. ~~**HAS ANY PROPOSED INSURED:** In the past 2 years had a driver's license suspended/revoked? _____ Yes (License # ____________ State ________) ________ No.~~
3. ~~**HAS ANY PROPOSED INSURED:** Consulted a Physician, received any medical treatment or been hospitalized or confined during the past 3 years? _____ Yes _____ No~~
4. ~~**IS ANY PROPOSED INSURED** currently covered or eligible for Medicare? _____ Yes _____ No. If Yes, a "Guide to Health Insurance for People with Medicare" must be given to any proposed Insured age 65 or over.~~
5. ~~List the amount of any other individual disability insurance currently applied for or in force for the Primary Insured:~~
$____________

CDI-APP10

**Details of "Yes" answers.** Attach additional sheet if necessary.

| Question No. | Name | Date | Type of Injury/Illness | Doctor/Hospital & Address | Fully Recovered? | Medication Taken |
|---|---|---|---|---|---|---|
| | | | | | | |

| Home Office Corrections and/or Additions Only |
|---|
| |

**Authorization to Obtain and Release Information:** I hereby AUTHORIZE any licensed physician, medical practitioner, pharmacy or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB) 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 ManhattanLife Insurance and Annuity Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service ManhattanLife Insurance and Annuity Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. 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 ManhattanLife Insurance and Annuity Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I AGREE that all answers given in this application are complete and true to the best of my knowledge and belief, and that this application is to be attached to and made a part of the policy. I AGREE that a photographic copy of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of this Authorization. This Authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing. I ACKNOWLEDGE receipt of the Notice of Information Practices and the Medical Information Bureau Disclosure Notice.

I agree and understand that no insurance coverage will be in force until the effective date specified by the Company. No Agent or Broker is authorized to make or modify any policy or waive any of ManhattanLife's rights or requirements or waive the answer to any question in the application. No change to the policy will be valid until approved by an Officer of the Company which must be noted on or attached to the policy. The policy with this application and any endorsements, riders or other papers, if any, is the entire contract of insurance. I hereby apply for insurance coverage to be issued solely and entirely in reliance upon the written answers to the foregoing questions and/or information obtained by the Company in its underwriting process. I and my agent certify that I have read or had read to me all the questions and answers in this completed application and such answers to the best of my (our) knowledge and belief are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the acceptance of the risk or hazard assumed by the Company may bar the right to any recovery under any policy(s) issued contracts, waive any Company rights or requirements or waive any information the Company requests.

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

Signed at ______________________ this __________ day of __________ 20 __________
City, State

X ______________________ X ______________________ X ______________________

**Signature of Primary Insured** (Parent if person to be insured is less than 15 years old) — Payor/Owner (if other than Proposed Insured) — Spouse

X *Dava Gordy* — Dava Gordy — 07THA34 — ________ % — ________

Signature of Agent — Agent's Name (printed) — Agent No. — % Credit — State ID No.

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

## PREMIUM DEDUCTION AUTHORIZATION TO THE EMPLOYER

You are hereby authorized to deduct $ ______________________ from my pay according to the deduction mode indicated below, until further notice from me, and remit to ManhattanLife Insurance and Annuity Company 10777 Northwest Freeway, Houston, Texas 77092.

Premiums will be deducted ☐ Weekly ☐ Monthly ☐ Bi-Monthly ☐ Other Specify ______________

Name ______________________________ Date ______________________

Employee's Signature ______________________ Agent's Signature ______________

## BANK DRAFT AUTHORIZATION TO HONOR CHECKS DRAWN BY MANHATTANLIFE INSURANCE AND ANNUITY COMPANY

To ______________________________________________

Your Bank's Address ______________________________________

As a convenience to me, I hereby request and authorize you to pay and charge my account checks drawn on my account by and payable to the order of ManhattanLife Insurance and Annuity Company of Houston, Texas provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually received such notice I agree that you shall be fully protected in honoring such check. I further agree that if any such checks 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.

Date ____________________ X ______________________________

____________________ Your signature Exactly as it appears on Bank Records Account No.

**To obtain further information, contact**
**ManhattanLife Insurance and Annuity Company**
**10777 Northwest Freeway, Houston, TX 77092**

**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 will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicant 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, ManhattanLife Insurance and Annuity Company 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 procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (781) 751-6000. 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.