



MANHATTAN
INSURANCE GROUP SM

Critical Choice Webinar



FAMILY LIFE
INSURANCE COMPANY SM



MANHATTAN
INSURANCE GROUP SM

Since 1982



CENTRAL UNITED LIFE
INSURANCE COMPANY SM

Since 1963



THE MANHATTAN LIFE
INSURANCE COMPANY SM

Since 1850



FAMILY LIFE
INSURANCE COMPANY SM

Since 1949



WESTERN UNITED LIFE
ASSURANCE COMPANY SM

Since 1963

Critical Choice Selling Points

- Simplified Issue
- Accept ITIN
- 4 health related questions
- Spanish Application (on-line and paper)
- Do not need to see client in person
- E-Signature Mother's Maiden Name



Life Benefit

□ 20 Year simplified issue level term

❖ Issue ages 18-55

□ 15 Year simplified issue level term

❖ Issue ages 56-60

Life Benefit Amounts

\$25,000

\$50,000

\$100,000

Critical Illness Benefit

❖ Benefit will be payable for the first occurrence of one of the following conditions:

- Life threatening cancer
- Heart attack
- Major organ transplant
- Paralysis
- Renal failure
- Stroke

The amount of this benefit is 50% of the Life Benefit

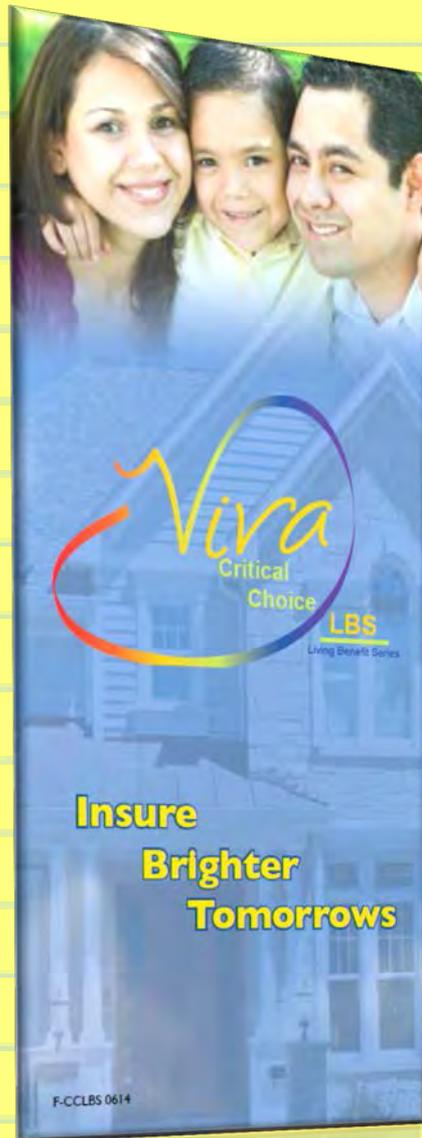
Critical Illness Benefit Amounts

\$12,500

\$25,000

\$50,000

Three Convenient Plans



	PLAN A	PLAN B	PLAN C
Life Benefit	\$25,000	\$50,000	\$100,000
Critical Illness Benefit	\$12,500	\$25,000	\$50,000

First Occurrence?



Date of Diagnosis

- Heart attack or stroke
- Life threatening cancer



Date of Transplant Surgery

- Major organ transplant



Date of Surgery

- Major heart surgery or angioplasty



The Earlier of the Date Dialysis Begins OR Date Renal Transplantation Takes Place

- Renal failure

Additional Benefits

A reduced benefit will be payable for specified procedures. This benefit is a percentage of the amount payable for the critical illness benefit.

- 25% - coronary by-pass surgery, heart valve surgery, or aortic surgery.
- 10% - Angioplasty surgery or cancer in situ.

Payable only once



When a Critical Illness Benefit is Paid...

When a partial benefit is paid, the face amount of the life benefit will be reduced by the amount of the benefit paid.

Premiums will be reduced to reflect the reduction.



Paul purchased a Critical Choice policy, with \$100,000 life benefit and \$50,000 critical illness benefit.

He had a heart attack 4 years into the policy, so the \$50,000 benefit was paid.

Paul has peace of mind because he still has a \$50,000 life benefit AND his monthly premiums have been reduced accordingly.

Underwriting Questions

Health Related Questions



1. Tobacco, in any form, in the last 12 months
2. Medical condition past 7 years (i.e. heart trouble, stroke, cancer, diabetes, liver or kidney disease, etc.)
3. Illegal drugs last 7 years
4. Denied insurance due to health reasons?

Wait!!! There's more...

This applies to the life benefit only

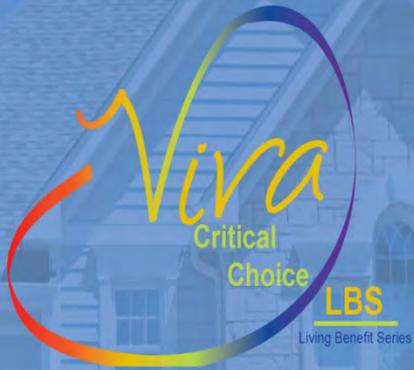


□ Conversion

- During the first 10 policy years, or prior to age 70, whichever comes first.
- No evidence of insurability will be required.

□ Renewal

- Renewable to age 95 at ART rates



**Insure
Brighter
Tomorrows**

**Insure
Brighter
Tomorrows**

**Insure
Brighter
Tomorrows**

**Insure
Brighter
Tomorrows**

Smoker Monthly Bank Draft

Age	\$25,000	\$50,000	\$100,000
18-25	\$15.33	\$25.27	\$43.07
26	\$15.38	\$25.36	\$43.52
27	\$15.54	\$25.68	\$44.33
28	\$15.79	\$26.17	\$45.67
29	\$16.27	\$27.14	\$47.88
30	\$16.94	\$28.46	\$50.81
31	\$17.73	\$30.06	\$54.36
32	\$18.71	\$32.02	\$58.64
33	\$19.88	\$34.35	\$63.86
34	\$21.23	\$37.06	\$69.89
35	\$22.79	\$40.16	\$76.72
36	\$24.54	\$43.70	\$83.43
37	\$26.50	\$47.61	\$90.81
38	\$28.64	\$51.89	\$98.82
39	\$31.07	\$56.75	\$107.82
40	\$33.82	\$62.24	\$117.99
41	\$36.89	\$68.38	\$129.20
42	\$40.33	\$75.27	\$141.71
43	\$44.01	\$82.62	\$154.98
44	\$48.54	\$91.67	\$171.27
45	\$53.40	\$101.41	\$188.60
46	\$58.39	\$111.38	\$207.81
47	\$63.79	\$122.18	\$228.60
48	\$69.64	\$133.88	\$251.19
49	\$75.94	\$146.47	\$275.49
50	\$82.74	\$160.08	\$301.73
51	\$90.19	\$174.98	\$330.35
52	\$98.28	\$191.16	\$361.53
53	\$107.11	\$208.80	\$395.37
54	\$116.47	\$227.55	\$431.33
55	\$126.35	\$247.30	\$469.22
15 Year Term			
56	\$126.69	\$251.98	\$479.84
57	\$139.48	\$273.56	\$521.46
58	\$151.06	\$296.71	\$566.06
59	\$163.21	\$321.44	\$613.89
60	\$177.37	\$349.34	\$667.62

EXCLUSIONS AND LIMITATIONS

We do not cover any Critical Illness resulting from:

- War, declared or undeclared or any act of war, riot or insurrection.
- An intentionally self-inflicted injury or an attempted suicide.
- The Covered Insured committing or attempting to commit a felony or being engaged in an illegal occupation.
- The Covered Insured being under the influence of alcohol or drugs, excluding those drugs that were prescribed by a Physician and taken in the dosage and manner prescribed.
- Cosmetic surgery, other than from a cosmetic surgery for the reconstruction or repair of damage from an injury or illness.
- The Covered Insured operating, riding in or descending from any aircraft. This does not apply while the Covered Insured is a passenger on a licensed, commercial, non-military aircraft regularly offered over an established passenger route.
- The Covered Insured participating in hazardous activities such as parachuting, hang gliding sports, bungee jumping, rock climbing, or any motorized race or speed contest.
- A Critical Illness that occurs during the Waiting Period. (The Waiting Period for Life-Threatening Cancer and Non-Invasive Cancer in situ Cancer is 90 days. For any other Critical Illness, the Waiting Period is 30 days. If diagnosis of a Critical Illness is made during the Waiting Period, the company will return the premiums paid for this rider.)

DISCLOSURE: The accelerated Benefit offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the Accelerated Benefits qualify for favorable tax treatment the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to Accelerated Benefits are complex. You are advised to consult with qualified tax advisor about circumstances under which you could receive Accelerated Benefits excludable from income under federal law.

DISCLOSURE: Receipt of an Accelerated Benefit may affect you, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.



10777 Northwest Freeway, Houston, Texas 77092
1-800-877-7705

Viva
Critical Choice
LBS
Living Benefit Series

**Insure
Brighter
Tomorrows**

BMC
AGENCY, INC

1529 Sam Rittenberg Blvd, Suite 200
Charleston, S.C. 29407
Toll Free: 800-357-2342
Fax: 843-763-1602

F-CCLBS 0614

lgarza@manhattanlife.com
marketingmail@manhattanlife.com



For assistance, please contact:

MARKETING TEST AGENCY

1234 TEST ST
TEST, TX 77777

☎ 777-777-7777

📠 777-777-7777

✉ test@test

Language:

Critical Choice

Insure Brighter Tomorrows

As easy as 1... 2... 3

1. Tell us about you

2. Get a Quote

3. Apply Online

Tell us about you

Birth Date: * 30 Year Gender: * Tobacco User?: * State: *

Payment Mode: * Effective Date: *

Get a Quote





For assistance, please contact:

MARKETING TEST AGENCY

1234 TEST ST
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☎ 777-777-7777 📠 777-777-7777

✉ test@test

Language:

Critical Choice

Insure Brighter Tomorrows

As easy as 1... 2... 3

1. Tell us about you

2. Get a Quote

3. Apply Online

Tell us about you

Birth Date: * 30 Year Gender: * Tobacco User?: * State: *
Payment Mode: * Effective Date: *

Plan Name:

Plan Premium:

Plan A - \$12,500 Critical Illness /
\$25,000 Term Life

\$11.77

Plan B - \$25,000 Critical Illness /
\$50,000 Term Life

\$18.14

Plan C - \$50,000 Critical Illness /
\$100,000 Term Life

\$29.70

Apply



Applicant's Information

Name: * First Name Last Name SSN/ITIN: * Gender: * Select Marital Status: * Select

Height: * Select 0 Weight: * lb

Email Address: * Home Phone: * Work Phone:

Employer's Name: * Occupation/Duties: *

Residential Address

Address 1: * Address 2: City: *

State: * Select Zip: *

Mailing Address

Same as Residential Address

Address 1: * Address 2: City: *

State: * Select Zip: *

Premium Payer

Other than Applicant

Name: First Name Last Name

Address: City: State: Select Zip:

Phone: Email Address: *

Children Information

of Children 1

Child 1:

Name: * First Name Last Name Gender: * Select Birthdate: *Year Height: Select 0

Weight: * SSN:

Beneficiary

Primary:

Name: * First Name Last Name SSN: Benefit %: *

Relationship: * Select

Add Primary

Add Contingent

Billing

Payment By:*

Representation & Questions

Does any proposed insured have any existing life or annuity policies? Yes No*

If Yes, please provide amount in force:

Will insurance now applied for replace any insurance or annuity? Yes No*

Is this insurance intended to replace any other life insurance now in force? Yes No*

If Yes, give name of Company and Policy Number:

Has any proposed insured used tobacco in any form within the past 12 months? Yes No*

In the past seven (7) years, has any person to be insured been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, organ transplant, paralysis, loss of 2 or more limbs, blindness, AIDS, AIDS related complex, or immune deficiency, mental illness requiring medication, treatment for alcoholism or drug abuse or has been hospitalized or advised to have any diagnostic tests or surgery for any condition?

Yes No*

If Yes, please provide details:

In the last seven (7) years have any of the proposed insured's used narcotics, cocaine, hallucinogens, barbiturates, heroin, marijuana or any other drugs not prescribed by a physician? Yes No*

Have you ever been denied insurance due to health reasons? Yes No*

If Yes, please provide details:

Mail Policy To:

AUTHORIZATION AND DISCLOSE INFORMATION:

Family Life Insurance Company and its reinsurers may obtain medical and other information in order to evaluate my application for insurance. I/we authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or pharmacy related facility or other medical related facility, insurance company, the MIB, Inc., Ingenix or other organization, other health care provider or governmental agency to provide Family Life Insurance Company or its reinsurers any and all medical records or knowledge, including entire medical records, to determine insurance and claim eligibility. This authorization will be valid for 30 months from the date signed. The information may involve me, or any care, treatment or advice of me. This includes information relating to alcohol or drug abuse, mental disease or information which may be considered a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). Family Life may report such information to the Medical Information Bureau or to other insurance companies to which I have or may apply. This authorization will be valid for 2 years. A photocopy of this authorization will be as valid as the original. I, or my authorized representative may receive a copy of this authorization upon request. If applicable, I also have the right to receive notice of the reason for any adverse underwriting decision.

FRAUD WARNING:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or knowingly makes a false statement in an application for insurance may be guilty of criminal offense under state law. I agree that no insurance shall be in effect until: (a) a policy has been issued; and (b) the first premium is paid while my insurability remains unchanged and then only if I am actually in the state of health represented in this application. I state that the answers set forth above, are full, complete and true to the best of my knowledge and belief. The answers are to be the basis of any insurance issued. I also acknowledge that I have received the Investigative Consumer Reports notification and the MIB Notice attached to this application. All Statements made by or on behalf of the insured or annuitant shall be deemed to be representations and warranties.

By submitting your Mother's maiden name you are electronically signing the application thereby giving us authorization to obtain information as well as agreeing the terms and conditions.

Mother's maiden name:*

Submit



For assistance, please contact:

MARKETING TEST AGENCY

1234 TEST ST
TEST, TX 77777

☎ 777-777-7777 📞 777-777-7777

✉ test@test

Your application has been submitted successfully!

Thank you very much!

We may contact you for further information.

**If you have any questions or need assistance,
please contact our authorized representative
noted above.**

[View the Application](#)

[Submit Another Application](#)

[View/Choose Another Product](#)

[I am Done](#)



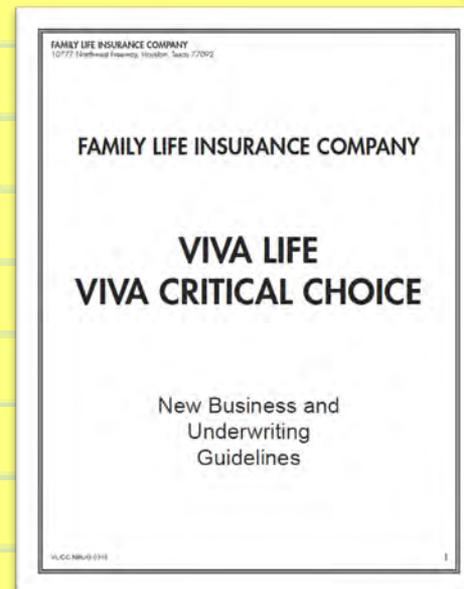
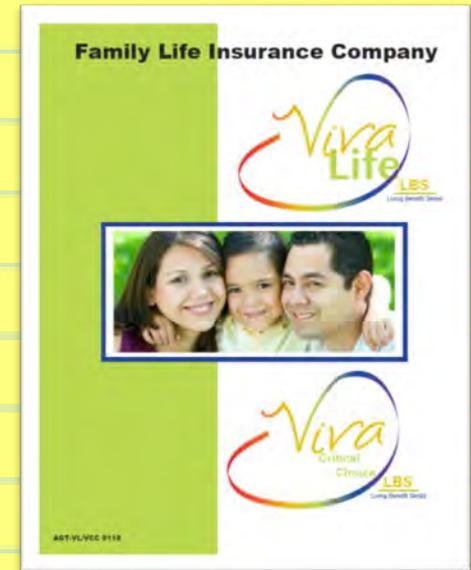
Non-Tobacco Monthly Rates

Nonsmoker Monthly Bank Draft

Age	\$25,000	\$50,000	\$100,000
18-25	\$10.55	\$15.71	\$25.02
26	\$10.66	\$15.93	\$25.47
27	\$10.82	\$16.25	\$26.10
28	\$11.09	\$16.79	\$27.09
29	\$11.40	\$17.40	\$28.30
30	\$11.77	\$18.14	\$29.70
31	\$12.26	\$19.10	\$31.55
32	\$12.80	\$20.21	\$33.66
33	\$13.46	\$21.54	\$36.23
34	\$14.22	\$23.04	\$39.15
35	\$15.09	\$24.77	\$42.44
36	\$15.93	\$26.46	\$45.63
37	\$16.85	\$28.31	\$49.23
38	\$17.88	\$30.36	\$53.15
39	\$18.98	\$32.56	\$57.38
40	\$20.27	\$35.15	\$62.19
41	\$21.64	\$37.89	\$67.50
42	\$23.19	\$40.97	\$73.40
43	\$24.87	\$44.33	\$79.83
44	\$26.77	\$48.15	\$87.03
45	\$28.91	\$52.43	\$95.22

Agent's Guide

Review our Agent's Guide and underwriting guidelines for more details.



Paper Application

Application

To



P.O. Box 924408 • Houston, Texas 77292-4408 • 1-800-877-7705 • www.familylifeins.com

Policy # _____

Group # _____

PROPOSED INSURED Last Name		First	M.I.	Sex <input type="checkbox"/> F <input type="checkbox"/> M	Age	Birth Date	Ht.	Wt.	Occupation
Address			City			State		Zip	
SSN/ITIN		Home Phone # ()			Work Phone # ()				
E-mail		Marital Status <input type="checkbox"/> M <input type="checkbox"/> S		Hire Date		Employer Name			
BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED									
Beneficiary			SSN/ITIN		Relationship to Insured				
Contingent Beneficiary			SSN/ITIN		Relationship to Insured				
OWNER (Unless noted, Owner will be Proposed Insured.) Name					SSN/ITIN				
Address			Phone # ()		Relationship to Insured				
BASE POLICY INFORMATION Plan: <input type="checkbox"/> Critical Choice									
<input type="checkbox"/> Term Life \$25,000			<input type="checkbox"/> Term Life \$50,000			<input type="checkbox"/> Term Life \$100,000			
RIDERS <input type="checkbox"/> Critical Illness (<input type="checkbox"/> \$12,500 <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000)									
BILLING MODE <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (Bank Draft or Credit Card Only)									
BILLING METHOD <input type="checkbox"/> List Bill <input type="checkbox"/> Direct Bill (<input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly only) <input type="checkbox"/> Monthly Credit Card <input type="checkbox"/> Monthly Bank Draft									
Group # _____			Group Name _____			MODAL PREMIUM AMOUNT \$ _____			
Does any proposed insured have any existing life or annuity policies? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please provide amount in force: _____									
Will insurance now applied for replace any insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No									

COMPLETE THE FOLLOWING (Check the box with the correct answer)

- Has any proposed insured used tobacco in any form within the past 12 months? Yes No
 - In the past seven (7) years, has any person to be insured received medical care for or had treatment (including medication) for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, organ transplant, paralysis, loss of 2 or more limbs, blindness, AIDS, AIDS related complex, or immune deficiency, mental illness requiring medication, treatment for alcoholism or drug abuse or has been hospitalized or advised to have any diagnostic tests or surgery for any condition? Yes No
 - In the last seven (7) years have any of the proposed insured's used narcotics, cocaine, hallucinogens, barbiturates, heroin, marijuana, or any other drugs not prescribed by a physician? Yes No
 - Have you ever been denied insurance? Yes No
- If yes to questions 2-3 above please explain: _____

INSURED'S 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, Inc., 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 Family Life Insurance Company (hereinafter called the Company) or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected.

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; to obtain reinsurance; to 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.

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, or change in policy benefits. I understand that this authorization will be valid 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 treated in the same manner 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 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.

F-VLCCAP 0914



- Mail
- Fax
- E-mail
- FTP Site
- Must see client
- Live Signature

Visit Our Website

The screenshot displays the Manhattan Insurance Group Agent Resource Center. The top navigation bar includes links for Home, Commissions, Inforce Business, Agent Tools, Downloads, My Profile, and Back Office. The user is logged in as Catherine Blanco. The main content area is titled 'PRODUCT DOWNLOADS' and features a search interface with 'Quick Search' and 'Advanced Search' tabs. The search criteria are set to 'Texas' for the region and 'All Companies' for the company. The search results table lists various documents for 'Critical Choice', including applications, brochures, and an agent guide.

MANHATTAN INSURANCE GROUP

Welcome CatherineBlanco • Feedback

Language: English-US

AGENT RESOURCE CENTER

Agent: Home Commissions Inforce Business Agent Tools Downloads My Profile Back Office

You are here: Agent Selection > Downloads > Forms

PRODUCT DOWNLOADS

Quick Search **Advanced Search**

1. Select Region and/or Company:

Region: Texas Company: All Companies

2. Search by Product Name or Document Number (optional):

Critical Choice

Search

Result(s)

Product	Document Type	Document Number	Document Name
Critical Choice	APP	F-VLCCAP_0914_CC	Critical Choice Application
	APP	F-VLCCAP-SP0914_CC	Critical Choice Application - Spanish
	BROCHURE	F-CC_0614	Critical Choice Brochure
	BROCHURE	F-CCLBS_0614	Critical Choice Brochure
	BROCHURE	F-CC-SP_0614	Critical Choice Brochure - Spanish
	BROCHURE	F-CCLBS-SP_0614	Critical Choice Brochure - Spanish
	GUIDE	AGT-VL-VCC_0115	Viva Life / Critical Choice Agent Guide

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Review

**Just a
reminder...**



- Simplified Issue
- Accept ITIN
- 4 Question on-line and paper application
- Spanish Application (on-line and paper)
- Do not need to see client in person
- E-Signature Mother's Maiden Name

"Fast Start" Bonus



Welcome to Family Life . . . Make 4 Sales in your First 30 Days and Receive \$100.
Just complete the information below and return to J. Alan Vala at Family Life.

Agent

Agent Name

007

Agent Number

0001234

Policy #

Policy #

Policy #

Policy #

James Bond

Client Name

Client Name

Client Name

Client Name



Go Texans!

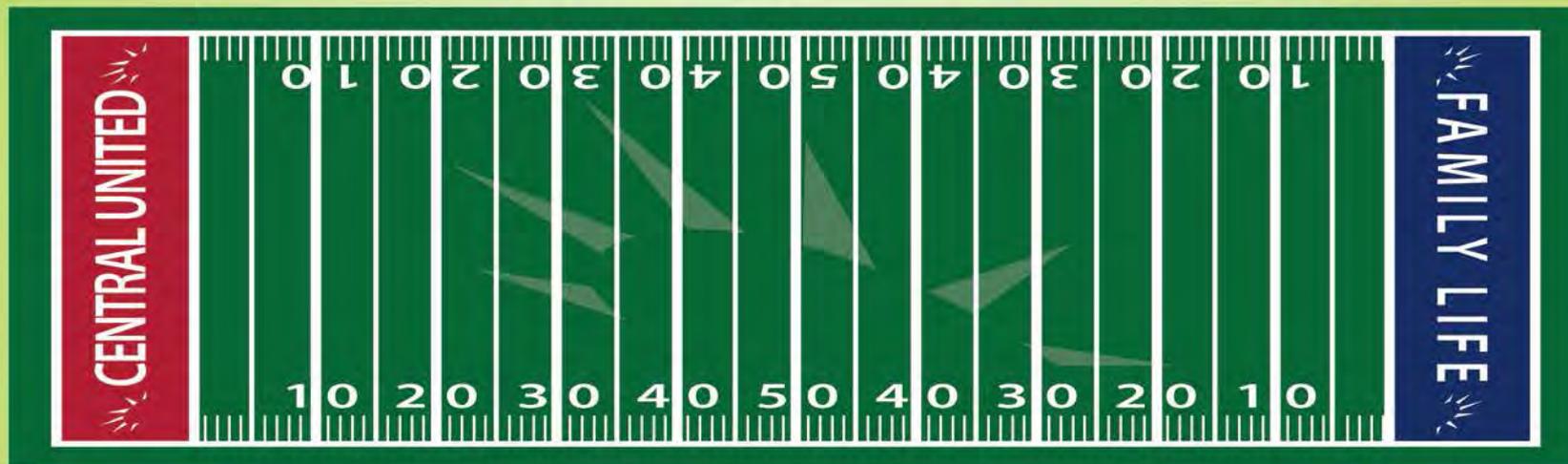
Are you ready.... for some Football!

Go Texans!



Houston Texans vs Indianapolis Colts
Thursday October 8, 2015

Contest Period June 1 - August 31, 2015



12 Winners Recieve . . .

- * Airfare to Houston for Associate and Spouse or Guest
- * Two nights hotel at the Sheraton Brookhollow Hotel
- * Home Office visit
- * Pre-Game party at NRG Stadium
- * Houston Texans Tickets

CENTRAL UNITED LIFE
INSURANCE COMPANY SM

FAMILY LIFE
INSURANCE COMPANY SM



Experience

Italy

in 2016



Venice



Rome



Imagine Yourself . . .

In Rome

- trying your hand in the "mouth of truth"
- making a wish at the Trevi Fountain
- or walking the paths of gladiators in the Colosseum

In Venice

- sipping coffee at the Piazza San Marco
- riding a gondola under the Rialto Bridge
- or touring Ca'D'oro a 15th century gothic palace



Chairman's
Club
2016

Contest Period
May 1, 2015
to
April 30, 2016

Chairman's Club 2016



Qualifications

Marketing Director = \$500,000 npap*

General Agent = \$300,000 npap*

Call Center = \$250,000 npap* (with 80% first year persistency)

Personal = \$100,000 npap*

New Agent Contract after September 1, 2015 = \$75,000 npap*

125% credit for Cancer Care CP4000 sales

150% credit for new Cancer Care CP4000 sales when submitted with a new group and with a minimum of 5 Cancer Care Lives

Please Note: credit for other product sales will be the normal amount.

**Net paid annualized premium*

Chairman's Club Qualifications

MANHATTAN/CENTRAL UNITED/FAMILY LIFE INSURANCE COMPANIES

The following guidelines will be followed to qualify associates and agency managers for the 2016 Chairman's Club Conference:

1. The qualification period will be from May 1, 2015 to April 30, 2016. Only net paid annualized premium produced during the qualification period will count for conference qualification. Qualification numbers are not final until April 30, 2016.
2. The Company will confirm qualification for the conference by a personal invitation to the associate.
3. Only active contracted and producing associates in good standing at the time of the conference will be eligible to attend the conference.
4. Business written on an associates own life or on immediate family members will not be eligible for qualification for the conference. Immediate family members include spouse, mother, father, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, and children.
5. Business written on another associate in the agency will not be eligible for qualification for the conference.
6. Production credit is not transferable among associates or agency managers.
7. Multiple associate qualifications are not allowed.
8. A minimum portfolio persistency of 85% is required.
9. If an associate qualifies for the conference on a personal, agency or Marketing Director basis, the associate will only be awarded one qualification.
10. Cash will not be paid in lieu of attending the conference.
11. The qualifying associate will be allowed to bring their spouse or guest. A guest can not be a contracted associate with the Company. Children are welcome at the expense of the associate.
12. The Company reserves the right to modify or cancel the event if deemed necessary.
13. In accordance with IRS rules and regulations, associates attending our Chairman's Club Conference will receive 1099 earnings for the fair market value of the trip. Please consult your tax advisor if you have any questions concerning your income reporting requirements.
14. Any exceptions to the above guidelines or special requests must be approved by the Director of Marketing of the Company.

**President's Club
2016**

ASPEN

**Join us at the prestigious
St. Regis Aspen Resort**



Contest Period
May 1, 2015 - April 30, 2016

Qualifications

Marketing Director:	\$400,000 with 3 qualifiers in attendance
Agency:	\$250,000 NPAP
Personal:	\$50,000 NPAP

Guidelines

MANHATTAN/CENTRAL UNITED/FAMILY LIFE INSURANCE COMPANIES

The following guidelines will be followed to qualify associates and agency managers for the 2016 President's Club Conference:

1. The qualification period will be from May 1, 2015 to April 30, 2016. Only net paid annualized premium produced during the qualification period will count for conference qualification. Qualification numbers are not final until April 30, 2016.
2. 50% premium credit for First Choice, Group Dental, Vision, Employer Paid Group Life, and Employer Paid Group Accident.
3. The Company will confirm qualification for the conference by a personal invitation to the associate.
4. Only active contracted and producing associates in good standing at the time of the conference will be eligible to attend the conference.
5. Business written on an associates own life or on immediate family members will not be eligible for qualification for the conference. Immediate family members include spouse, mother, father, brother, sister, mother-in-law, father-in-law, brother-in-law, sister-in-law, and children.
6. Business written on another associate or their family in the agency will not be eligible for qualification for the conference.
7. Production credit is not transferable among associates or agency managers.
8. Multiple associate qualifications are not allowed.
9. A minimum portfolio persistency of 85% is required.
10. If an associate qualifies for the conference on a personal, agency or Marketing Director basis, the associate will only be awarded one qualification.
11. Cash will not be paid in lieu of attending the conference.
12. The qualifying associate will be allowed to bring their spouse or guest. A guest can not be a contracted associate with the Company. Children are welcome at the expense of the associate.
13. The Company reserves the right to modify or cancel the event if deemed necessary.
14. In accordance with IRS rules and regulations, associates attending our Chairman's Club Conference will receive 1099 earnings for the fair market value of the trip. Please consult your tax advisor if you have any questions concerning your income reporting requirements.
15. Any exceptions to the above guidelines or special requests must be approved by the Director of Marketing of the Company.



It's Simple with Family Life!