MANHATTAN INSURANCE GROUP SM

Out-of-Pocket Protection Plan Webinar

CENTRAL UNITED 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

Why is Hospital Confinement Protection Important?

Many individuals and groups have selected higher deductibles, fewer co-pays and more out-of-pocket costs to make their health insurance premium more affordable.

These out-of-pocket costs may still cause unnecessary burdens to many individuals.

We Can Help!

When a family has a medical condition and has to go to the hospital, they don't need any added financial burden at that time.

Our new Out-of-Pocket Protection Plan is designed to help pay some of the out-of-pocket costs that most families will experience from higher deductible plans with fewer benefits.

How does it work?

- Pays directly to policyholder
- Choose benefits and premium
- Pays in addition to all other insurance
- No deductibles
- No network
- Easy claim filing

Product Highlights

Choose One

Daily Inpatient Hospital Confinement Benefit
Daily benefit (up to 10 days) of either:

- ❑ $100
- ❑ $200

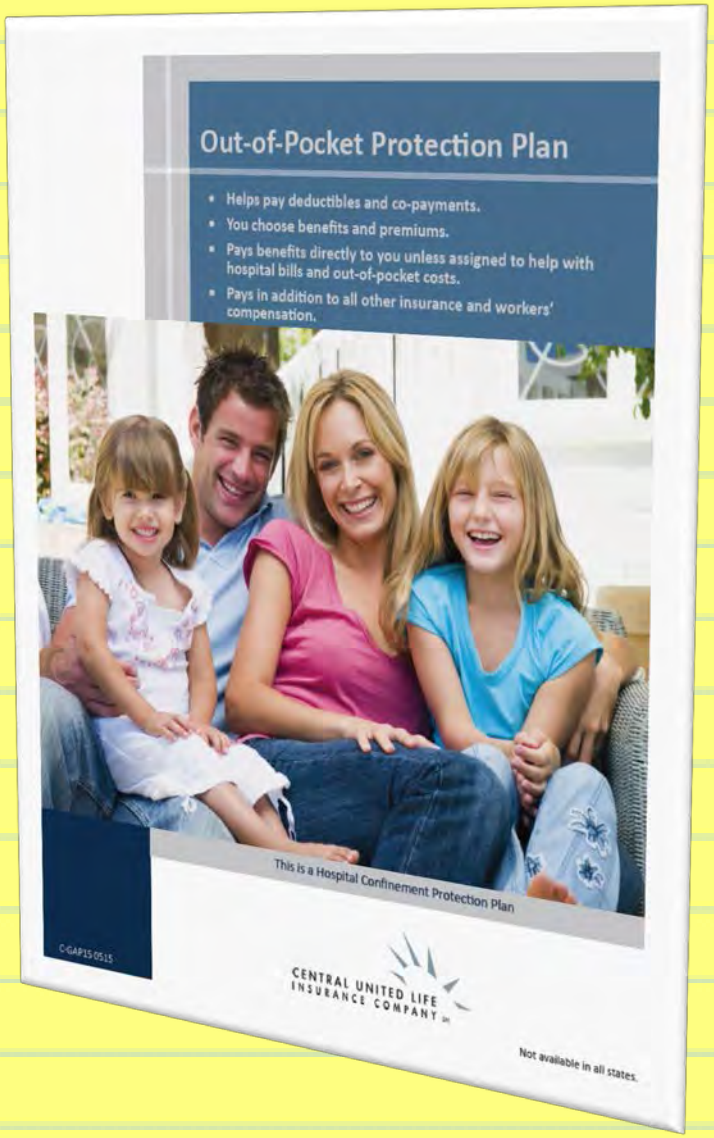
Choose One

First Hospital Admission Benefit Admission benefit of either (1per year):

- ❑ $2,500
- ❑ $5,000
- ❑ $6,350

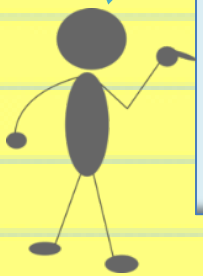
Included

Doctor Office Visit
(2 per year)
$50



Optional Benefits

Choose One



Outpatient Surgery Benefit (2 per year)

- ❑$1,000
- ❑$2,000
- ❑$3,000

Emergency Accident Benefit
(4 per year)
$250 Maximum Benefit

Out-of-Pocket Protection Plan Rates

Individual					
	Issue Age				
	18-34	35-44	45-54	55-69	Child Only
Mandatory Benefits					
Inpatient Hospital					
$100 / day	$0.92	$1.33	$1.83	$2.08	$0.58
$200 / day	$1.83	$2.67	$3.67	$4.17	$1.17
First Hospital Admission					
$2,500	$5.00	$7.08	$9.17	$10.83	$2.92
$5,000	$10.00	$14.17	$18.33	$21.67	$5.83
$6,350	$12.70	$17.99	$23.28	$27.52	$7.41
Office Visit					
$50 up to 2x/year	$8.33	$8.33	$8.33	$8.33	$6.67
Optional Benefits					
Outpatient Surgery					
$1,000	$7.67	$11.00	$14.33	$16.67	$4.33
$2,000	$15.33	$22.00	$28.67	$33.33	$8.67
$3,000	$23.00	$33.00	$43.00	$50.00	$13.00
Emergency Accident					
$250 up to 4x/year	$2.33	$2.33	$2.33	$2.33	$0.92

Refer to form number BB-AGT-TX 0315 for Texas state specific rates

Sample premium – Nan is a 50-year-old female. She chose a $100 per day benefit, a $6,350 hospital admission benefit and the optional emergency accident benefit. The Office Visit is included and not optional. Her total monthly premium is $35.77

Individual & Spouse

	Issue Age			
	18-34	35-44	45-54	55-69
Inpatient Hospital				
$100 / day	$1.67	$2.50	$3.25	$3.75
$200 / day	$3.33	$5.00	$6.50	$7.50
First Hospital Admission				
$2,500	$8.75	$12.50	$16.25	$19.17
$5,000	$17.50	$25.00	$32.50	$38.33
$6,350	$22.23	$31.75	$41.28	$48.68
Office Visit				
$50 up to 2x/year	$15.00	$15.00	$15.00	$15.00
Optional Benefits				
Outpatient Surgery				
$1,000	$13.33	$19.67	$26.00	$30.00
$2,000	$26.67	$39.33	$52.00	$60.00
$3,000	$40.00	$59.00	$78.00	$90.00
Emergency Accident				
$250 up to 4x/year	$4.17	$4.17	$4.17	$4.17

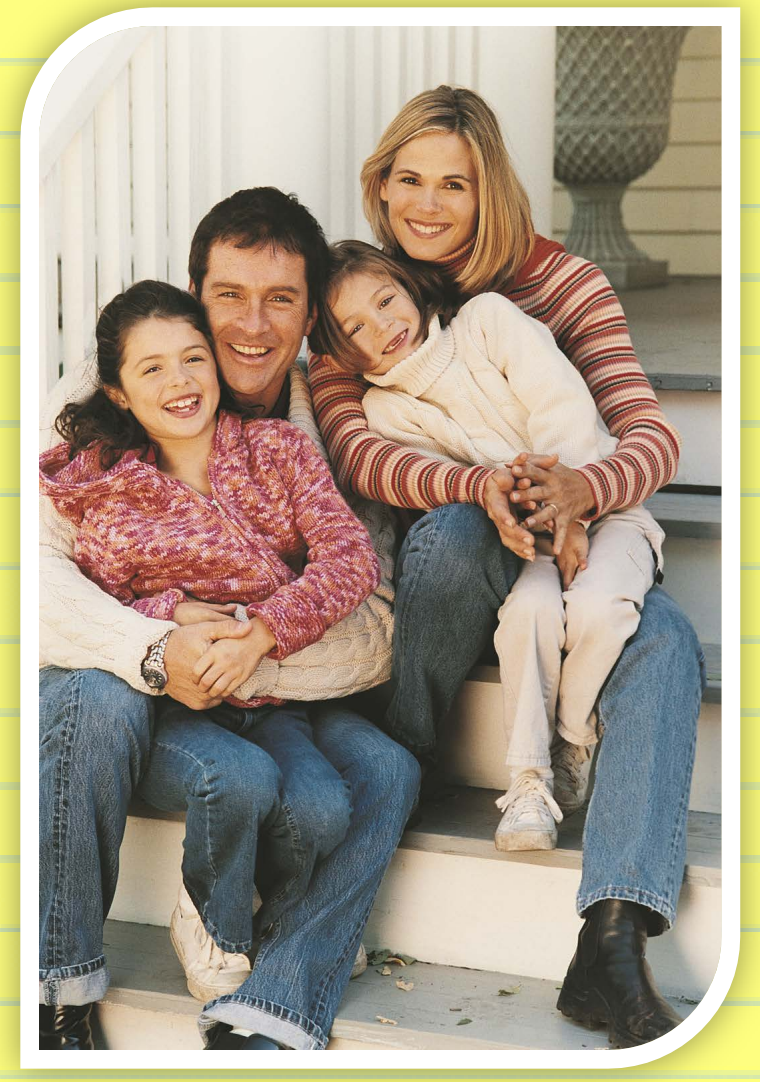
Individual & Family (up to 3 children)

	Issue Age			
	18-34	35-44	45-54	55-69
Inpatient Hospital				
$100 / day	$3.00	$3.83	$4.58	$5.17
$200 / day	$6.00	$7.67	$9.17	$10.33
First Hospital Admission				
$2,500	$15.42	$19.17	$23.33	$25.83
$5,000	$30.83	$38.33	$46.67	$51.67
$6,350	$39.16	$48.68	$59.27	$65.62
Office Visit				
$50 up to 2x/year	$33.33	$33.33	$33.33	$33.33
Optional Benefits				
Outpatient Surgery				
$1,000	$24.33	$30.33	$36.67	$40.67
$2,000	$48.67	$60.67	$73.33	$81.33
$3,000	$73.00	$91.00	$110.00	$122.00
Emergency Accident				
$250 up to 4x/year	$6.42	$6.42	$6.42	$6.42

Turn Bronze or Silver Into Gold

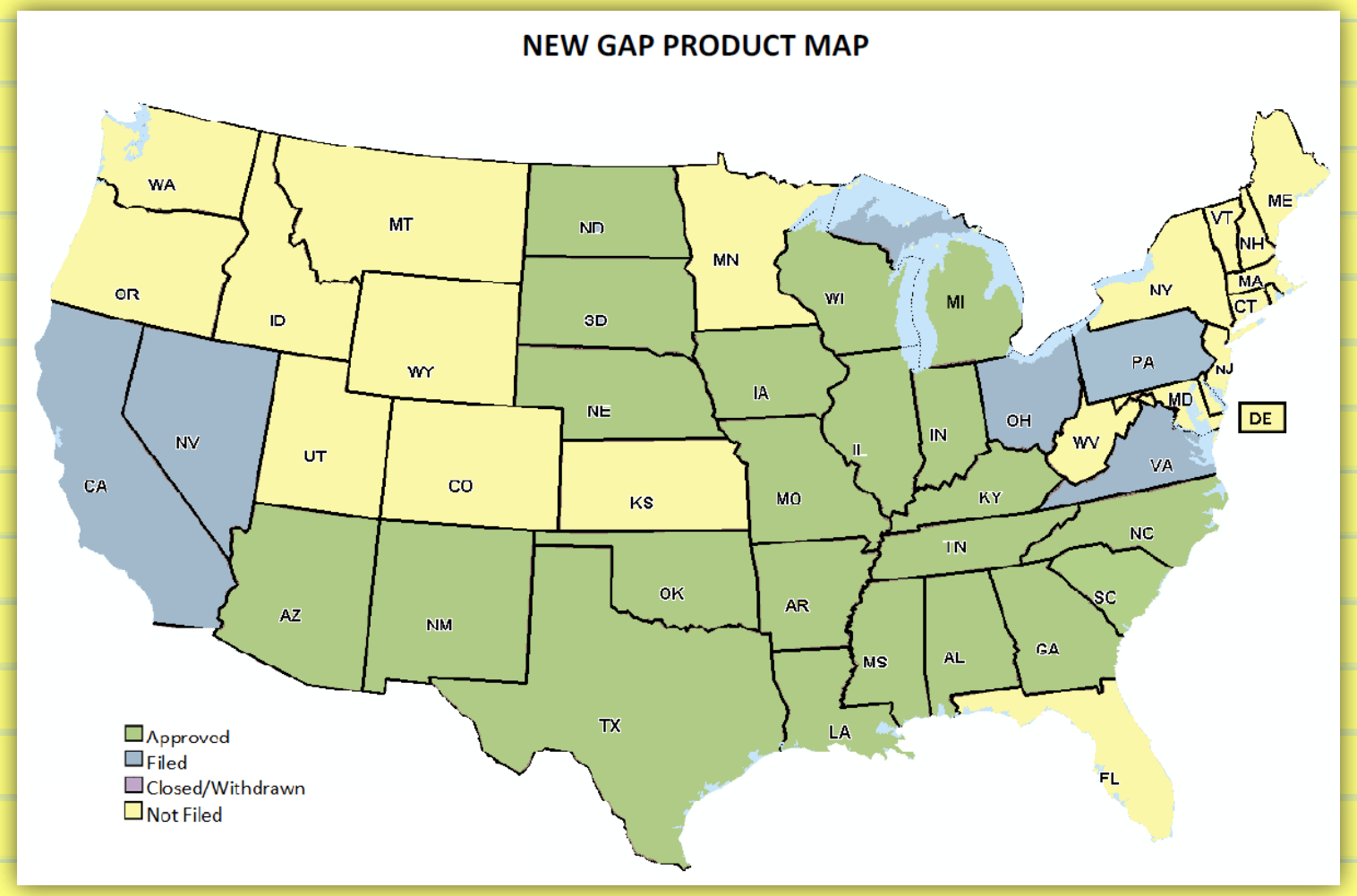
Bronze Plan PPO $6,350 Deductible 100% No Co-Pay & Prescription	Out-of-Pocket Protection $6,350 First Admission, $100 Inpatient, $50 Office Visit, $250 Emergency Accident
$768.58	$63.70
Savings - $205.20	Savings - $141.50
Silver Plan PPO $6,350 Deductible 100% Co-Pays Prescription	
$973.78	

Product Specs



- Issue Ages:
  - 18-69 for individuals
- Rates are unisex

State Availability



Manhattan Direct

MANHATTAN LIFE DIRECT

For assistance, please contact:
Test Worksite
10777 Northwest Frwy.
Houston, TX 77092
☎ 713-529-0045
marketingmail@manhattanlife.com

Out of Pocket Protection Plan

Get a Quote

Products Highlights

- Helps pay deductibles and copayments.
- Your choice of benefits and premiums
- Pays benefits directly to you unless assigned to help with hospital bills and out-of-pocket costs.
- Pays in addition to all other insurance and workers' compensation.

How our plan works?

Once you have met the requirements, fill out the necessary claims form and attach your receipts.

It's that easy!

Benefits are paid in a lump sum directly to you.

Daily Inpatient Hospital Confinement Benefit ** **(per hospital admission)**

You may choose a daily inpatient benefit of either:

- $100 a day
- $200 a day

If you are confined in a hospital as a resident inpatient* We pay the daily inpatient benefit you select up to 10 days per hospital confinement. (In Texas benefit is limited to a maximum benefit period shown in your policy)

First Hospital Admissions **(1 per year)**

You may choose an admission benefit of either:

- $2,500
- $5,000
- $6,350

If you are admitted to a hospital as a resident inpatient* we pay the Hospital Admission Benefit you selected.
This benefit is not payable for the treatment of Mental/Nervous Disorders and Substance Abuse.

Doctor Office Visit **(2 per year):**

- $50

Optional Benefits

MANHATTAN LIFE DIRECT

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marketingmail@manhattanlife.com

Out of Pocket Protection Plan

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

1. *Tell us about you* | **2.** *Get a Quote* | **3.** *Apply Online*

Tell us about you

Applicant: * Please Select **Birth Date:** * MM/DD/YYYY **Year** **Gender:** * Select **Tobacco User?:** * Select

State: * Select **Payment Mode:** * Monthly **Effective Date:** * 08/01/2015

Get a Quote

FAMILY LIFE INSURANCE COMPANY℠

MANHATTAN LIFE DIRECT

For assistance, please contact:

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☎ 713-529-0045

marketingmail@manhattanlife.com

Out of Pocket Protection Plan

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

1. Tell us about you | **2.** *Get a Quote* | *3. Apply Online*

Tell us about you

Applicant: * Self | **Birth Date:** * 01/01/1969 46 **Year** | **Gender:** * Female | **Tobacco User?:** * No

State: * AL - Alabama | **Payment Mode:** * Monthly | **Effective Date:** * 09/01/2015

Daily Inpatient Hospital Confinement Benefit	
◉ $100	$1.83
○ $200	$3.67
First Hospital Admission	
○ $2,500	$9.17
○ $5,000	$18.33
◉ $6,350	$23.28
Doctor's Office Visit	$8.33
☑ Include Outpatient Surgery Benefit	
◉ $1,000	$14.33
○ $2,000	$28.67
○ $3,000	$43.00
☐ Include Emergency Accident Benefit	$2.33
Total Premium:	$47.77

Apply

Applicant's Information

Name: * Last Name * SSN / ITIN : * Gender: * Male Weight: * lb

Height: * Select 0 Marital Status: * Select

Email: * Home Phone: * Work Phone:

Employer's Name: * Occupation/ Duties: *

Hired Date: * Hours Per Week: *

Residential Address

Address 1: * Address 2: City: *

State: * AL - Alabama 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:

Beneficiary

Primary:

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

Relationship: * Select

Add Primary Add Contingent

Billing

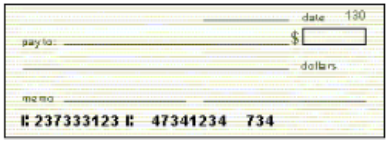
Payment By: * Bank Account

Bank Information

Bank Name: * **Account Name:** *

Account Type: * Checking **Routing Number:** *

Account Number: * **Draft Day:** Select



The account number

The Routing Number is nine digits long and is located at the bottom of your check within the ⑆ symbols

Questions

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:

WILL THIS POLICY REPLACE OR CHANGE ANY: Existing Life or Health Insurance in this or any other company? ○Yes ○No *

If No, which member?:

Has any person had surgery advised by a physician but not yet performed? ○Yes ○No *

If Yes, provide details:

Has any person proposed for insurance been treated, within the last twelve months, by a physician for elevated blood pressure? ○Yes ○No *

If Yes, please list the name(s) of the person(s), types of treatment including medication, date last seen by a physician, last blood pressure reading, and how long blood pressure has been under control and date diagnosed:

Are you or your spouse now pregnant? ○Yes ○No *

If Yes, provide details:

Has any person proposed for insurance been treated (including medication) within the last 12 months by a physician? ○Yes ○No *

If Yes, please list the person(s), types of treatment, including medication and date last seen by a physician:

Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had any of the following conditions? ○ Yes ○ No *

If Yes, check the applicable conditions shown and provide details below:

☐ Addison's disease

☐ AIDS, or tested positive for antibodies to the AIDS virus or HIV virus

☐ Alcoholism, Alcohol, Chemical Dependency or Drug or Alcohol Abuse

☐ Autism Spectrum Disorders, Autism, Asperger's Disorder, Rett's Syndrome, Pervasive Develpmental disorders or Pervasive Developmental Delay

☐ Cancer or Tumor ☐ Cataracts uncorrected ☐ Cerebral Palsy

☐ Liver Disorders, excluding fully recovered Hepatitis A ☐ Coronary Bypass

☐ Crohn's Disease or Ulcerative Colitis

☐ Currently (or within 3 months) hospitalized or confined to any health care institution

☐ Emphysema, Chronic Obstructive Pulmonary Disease, Fibrotic Lung Disease, or Pulmonary Hypertension

☐ Diabetes treated with insulin

☐ Functionally limiting musculoskeletal disease or disorder ☐ Grand Mal Epilepsy

☐ Heart Attack ☐ Heart Disease ☐ Heart abnormality ☐ Hemophilia

☐ Hernia uncorrected ☐ Hepatitis (other than Virus A) ☐ Hodgkin's Disease

☐ Kidney disorders, excluding kidney stones ☐ Leukemia

☐ Mental or Nervous Disorder or disease or disorder of the Central Nervous System

☐ Multiple Sclerosis ☐ Osteomyelitis ☐ Paralysis

☐ Peripheral Vascular Disease or Peripheral Arterial Disease

☐ Rheumatoid Arthritis (requiring 2 or more medications) ☐ Ulcerative Colitis

☐ Sickle cell anemia ☐ Stroke or Brain Aneurysm ☐ Tuberculosis

Has any person proposed for coverage been declined for insurance due to health reasons? ○ Yes ○ No *

If Yes, provide details and dates:

Mail To: * Select

Name: * Address 1: *

Address 2: City: * State: * Select State Zip: *

Special Request:

Email Consent Authorization

◉ I give my written consent to allow the Company to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

Primary Email Address: *

test@test.com

Secondary Email Address:

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.

○ I decline to give consent to the Company to communicate with me by email.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE, AND IT IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Authorization to Obtain and Release Information:

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 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 Central United Life Insurance Company ("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 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.

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, 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 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 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.

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 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 not warranties.

I hereby attest that I am purchasing this Hospital Indemnity policy (sign below for all proposed insured(s)) and/or Dental, Vision, and Hearing policy (sign below only for minor dependent insured(s)) as a supplement or in addition to other major medical health insurance coverage, also known as, “Minimum Essential Coverage.”

By entering your Mother's maiden name you are electronically signing the application thereby giving us authorization to obtain information and process the application. Clicking "Submit" acknowledges that you have read and agree to the Consent and Disclosure to Use Online E-Signatures. [Click to print/download]

Mother's maiden name: *

Submit

FAMILY LIFE INSURANCE COMPANY SM

MANHATTAN LIFE DIRECT

For assistance, please contact:

Test Worksite

10777 Northwest Frwy.
Houston, TX 77092

☎ 713-529-0045

marketingmail@manhattanlife.com

Your application has been submitted successfully!

Thank you very much!

We may contact you for further information.

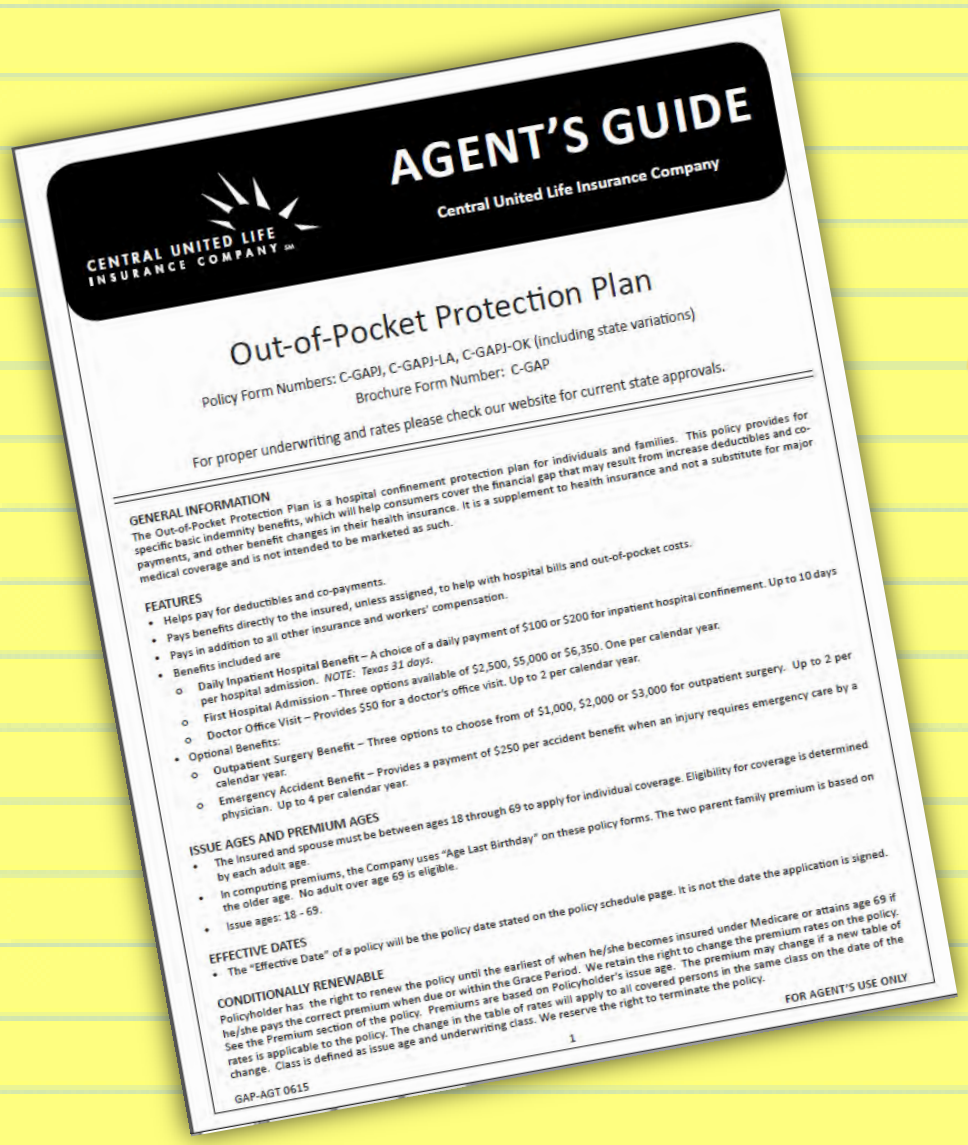
If you have any questions or need assistance, please contact our authorized representative noted above.

View the Application

Submit Another Application | View/Choose Another Product | I am Done

FAMILY LIFE INSURANCE COMPANY SM

Agent's Guide



CENTRAL UNITED LIFE INSURANCE COMPANY℠

AGENT'S GUIDE

Central United Life Insurance Company

Out-of-Pocket Protection Plan

Policy Form Numbers: C-GAPJ, C-GAPJ-LA, C-GAPJ-OK (including state variations)
Brochure Form Number: C-GAP

For proper underwriting and rates please check our website for current state approvals.

GENERAL INFORMATION
The Out-of-Pocket Protection Plan is a hospital confinement protection plan for individuals and families. This policy provides for specific basic indemnity benefits, which will help consumers cover the financial gap that may result from increase deductibles and co-payments, and other benefit changes in their health insurance. It is a supplement to health insurance and not a substitute for major medical coverage and is not intended to be marketed as such.

FEATURES
- Helps pay for deductibles and co-payments.
- Pays benefits directly to the insured, unless assigned, to help with hospital bills and out-of-pocket costs.
- Pays in addition to all other insurance and workers' compensation.
- Benefits included are
  - Daily Inpatient Hospital Benefit – A choice of a daily payment of $100 or $200 for inpatient hospital confinement. Up to 10 days per hospital admission. *NOTE: Texas 31 days.*
  - First Hospital Admission - Three options available of $2,500, $5,000 or $6,350. One per calendar year.
  - Doctor Office Visit – Provides $50 for a doctor's office visit. Up to 2 per calendar year.
- Optional Benefits:
  - Outpatient Surgery Benefit – Three options to choose from of $1,000, $2,000 or $3,000 for outpatient surgery. Up to 2 per calendar year.
  - Emergency Accident Benefit – Provides a payment of $250 per accident benefit when an injury requires emergency care by a physician. Up to 4 per calendar year.

ISSUE AGES AND PREMIUM AGES
- The insured and spouse must be between ages 18 through 69 to apply for individual coverage. Eligibility for coverage is determined by each adult age.
- In computing premiums, the Company uses "Age Last Birthday" on these policy forms. The two parent family premium is based on the older age. No adult over age 69 is eligible.
- Issue ages: 18 - 69.

EFFECTIVE DATES
- The "Effective Date" of a policy will be the policy date stated on the policy schedule page. It is not the date the application is signed.

CONDITIONALLY RENEWABLE
Policyholder has the right to renew the policy until the earliest of when he/she becomes insured under Medicare or attains age 69 if he/she pays the correct premium when due or within the Grace Period. We retain the right to change the premium rates on the policy. See the Premium section of the policy. Premiums are based on Policyholder's issue age. The premium may change if a new table of rates is applicable to the policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. Class is defined as issue age and underwriting class. We reserve the right to terminate the policy.

FOR AGENT'S USE ONLY

GAP-AGT 0615

1

Review our Agent's Guide for detailed underwriting guidelines.

Completing the Application

CENTRAL UNITED LIFE INSURANCE COMPANY
10777 Northwest Freeway, Houston, Texas 77092

Application for Insurance

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. Effective Date: _____

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 ( )
Secondary Address	City	State	Zip	Home Telephone ( )

Payor or Owner if other than Primary Insured	❑ Payor ❑ Owner	Social Security Number	Relationship to Primary Insured
Employer		Occupation	
Date Employed	Hours Worked/Week	Group Number	
Beneficiary (Estate of Primary Insured unless beneficiary named)		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:

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

INSURANCE PLANS

Hospital Indemnity (GAPJ15)	Coverage Applied For: ❑ Individual ❑ Individual/Children ❑ Individual/Spouse ❑ Family			
	Daily Inpatient Hospital Benefit (Choose One) ❑ $100 Per Day ❑ $200 Per Day	Inpatient Hospital Admission (Choose One) ❑ $2,500 ❑ $5,000 ❑ $6,350	Doctors Office Visit ❑ $50	Premium $_____
	Optional Benefits			
	Outpatient Surgery ❑ $1,000 ❑ $2,000 ❑ $3,000		Emergency Accident ❑ $250	Premium $_____
Dental, Vision & Hearing (DVH)	❑ Applicant Only ❑ Family (Family Coverage is up to 5 persons) Policy Year Maximum ❑ $1,000 ❑ $1,500			Premium $ _____

HOSPITAL INDEMNITY COVERAGE QUESTIONS

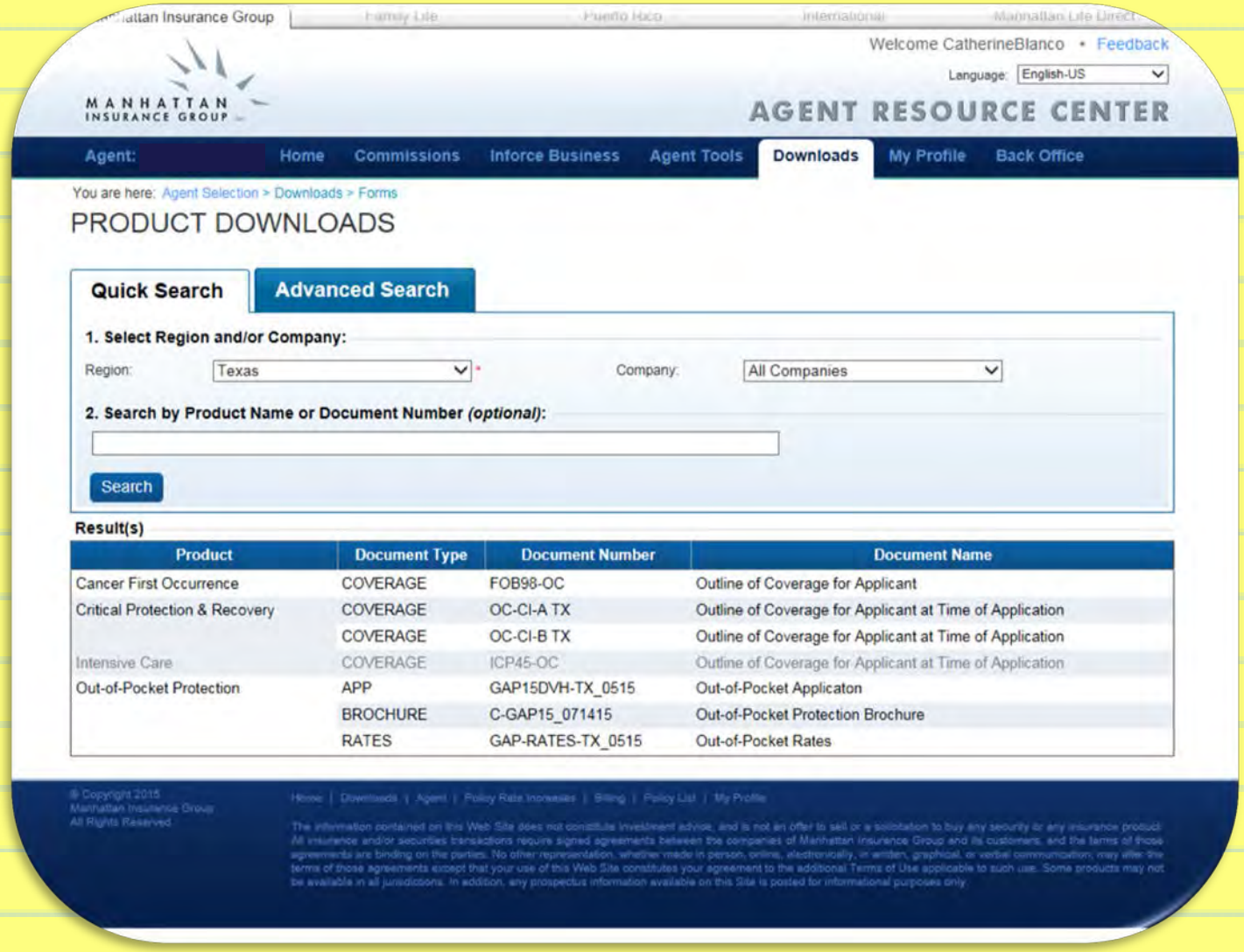
1. Do all the members to be insured reside in the home of the applicant? ❑ YES ❑ NO If "No," which member? _____
   Explain: _____
2. Has any person proposed for coverage been declined for insurance due to health reasons? ❑ YES ❑ NO If "Yes," provide details and dates: _____
3. Has any person had surgery advised by a physician but not yet performed? ❑ YES ❑ NO If "Yes," provide details: _____

GAP15DVH 0515

Page 1

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

Visit Our Website



WWW.MANHATTANLIFE.COM

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.

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

MANHATTAN INSURANCE GROUP

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.

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INSURANCE COMPANY SM