MANHATTAN LIFE INSURANCE COMPANY
FAMILY LIFE INSURANCE COMPANY
CENTRAL UNITED LIFE INSURANCE COMPANY

10777 Northwest Freeway, Houston, Texas 77092
1-800-669-9030 or 713-529-0045

PREMIUM PAYMENT AGREEMENT

This premium payment agreement is between _____ and _____ .
(thereafter referred to as the Company) (Group Name)

1. The program is voluntary and may be terminated on written notice of not less than thirty (30) days to The Company, P.O. Box 925989, Houston, TX 77292-5989.
2. The minimum requirements to establish and maintain is three lives.
3. Eligible employees may purchase insurance on their dependents subject to the terms and conditions of the policy.
4. The Company will send or E-mail an itemized statement at a date specified by the employer showing premiums due.
5. Premiums will be sent to The Company within 14 days of the receipt of the billing.
6. Premiums will be deducted Weekly____, Monthly____, Bi-Monthly (every 15 days)____, Bi-weekly ____, Other(specify)_____.
9. Premiums will be remitted to The Company _____ Monthly (12 times per year), _____ 13 Pay (13 times per year), _____ 26 Pay (26 times per year), or_____(other).
10. Number of full-time employees (30 hours per week) _____

Please **circle** the single **day** of the month you would like to have as the policy effective date and premium due date:
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28

Requested Group Effective date:_____
Are the premiums to be sheltered under a Cafeteria Plan?
YES [ ] NO [ ]
If yes, plan date:_____
Select desired sequence of your billings. (Circle only one of these four):
A - Alpha by Insured's Name S - Social Security Number
E - Numeric by Employee Number

For Home Office Use **ONLY**
Group Number Assigned

[ ][ ] [ ][ ][ ][ ][ ][ ][ ] [ ][ ]
Bill Day Group Number Due Day

Company or Group Name_____

Contact Person_____

Address_____

Address_____

_____ _____ _____
City State Zip Code

Phone_____ Fax _____ E-mail_____

_____
(Authorized Signature) (Title) (Date)

_____
(Agent's Signature) (Number) (Date)

Original To **MANHATTAN LIFE/FAMILY LIFE/CENTRAL UNITED/INVESTORS CONSOLIDATED**
Photocopy or Second Original To **EMPLOYER**

ManhattanLife Since 1850

CAFETERIA PLAN (SECTION 125) INFORMATION SHEET

Please answer the following questions so we may properly set your account up and not cause any delays in processing.

1. Does your company currently have a Section 125 Cafeteria Plan in place?

   Yes No (Circle One) (If "no", proceed to Number 4.)

2. Our Company's 125 plan year is _____through _____.

3. Our open enrollment period is held during the month of _____.

4. Signature of Officer: _____

Title: _____Date: _____

Company Name: _____

City: _____State: _____

Voluntary Group Insurance provided by . . . . . .
MANHATTAN LIFE INSURANCE COMPANY
FAMILY LIFE INSURANCE COMPANY
CENTRAL UNITED LIFE INSURANCE
INVESTORS CONSOLIDATED

ManhattanLife℠
Since 1850