ManhattanLife Limited Benefit Supplemental Outpatient Prescription Drug Member Claim Form

Underwritten by: ManhattanLife Insurance Company
Administered by: Bay Bridge Administrators, LLC

Please include your certificate number on your claim. If you need assistance locating your certificate number, please contact our Claims Department at 800-845-7519.

To avoid delays in processing, please fill out the sections and pages which apply to your claim. You may mail, email, submit via online portal, or fax your completed claim form to:

Bay Bridge Administrators, LLC
P.O. Box 161690
Austin, TX 78716

Email: claims@bbadmin.com
Portal: portal.bbadmin.com
Fax: 512-275-9350

Please read the following instructions and complete this form carefully.

A prescription receipt or pharmacy printout from the dispensing pharmacy is required for each prescription for which a claim is being submitted.

The drugs for which you are requesting payment must be clearly identified on the receipt or history and include the following information: Dispense Date, 11-digit National Drug Code (NDC), Medication Name, Strength, Dose, Quantity, Days' Supply, Amount Paid, Prescriber's Name, the Prescriber's National Provider Information (NPI) Number, and the Total Cost of the prescription.

- Please submit your receipts **TAPED** to a separate piece of paper with this form.
- Fill out Step 1: Member Information
- Fill out Step 2: Authorization for Release of Health-Related Information
- Fill out Step 3 ONLY if information is missing from your receipt OR Step 3 can be completed by your pharmacist or physician IF you do not have a receipt
- Fill out Step 4: Member Signature

Please submit your claim via mail, email, online portal, or fax provided on this form.

STEP 1: MEMBER INFORMATION (*To be completed by member)*		
Cardholder ID #:	Group Number:	
Cardholder's Name (*Last, First MI)*		
Mailing Address:		Apt. #:
City:	State:	Zip Code:

STEP 2: AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO BAY BRIDGE ADMINISTRATORS, LLC

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, Pharmacy Benefit Manager (PBM), medical facility, or other health care provider that has provided payment, treatment or services on behalf of the Insured named below within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning the Insured named below to Bay Bridge Administrators. LLC and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Bay Bridge Administrators. LLC may:

1) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 2) administer coverage; and 3) conduct other legally permissible activities that relate to any coverage the Insured named below has with Bay Bridge Administrators. LLC.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that: (A) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in, Arizona, Georgia, Illinois, Minnesota, New Jersey, New Mexico, North Carolina, Ohio or Virginia, this Authorization shall not remain valid for longer than: (1) the term of coverage of the policy if the claim is for a health insurance benefit; or (2) the duration of the claim if the claim is not for a health insurance benefit; and, (B) as to HIV-related information only, if the Insured resides/resided in Arizona, this Authorization shall remain valid for 180 days; and, (C) if the Insured resides in, or in the case of a death claim, was a resident at the time of death in Wisconsin, this Authorization shall remain valid for the policy term or the pendency of a claim for benefits under the policy, whichever is longer. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Bay Bridge Administrators. LLC at P.O. Box 161690, Austin, TX 78716, Attention: Claims Department. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Bay Bridge Administrators. LLC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record of the Insured named below, Bay Bridge Administrators. LLC may not be able to make any benefit payments. I understand that the Insured or Insured's authorized representative may request a copy of this Authorization.

_____

Name of Insured or covered Dependent if over 18 (please print)

X _____ _____

Signature of Insured or Dependent if over 18 — Date

_____

Description of Personal Representative's Authority

STEP 3: ENTER INFORMATION FOR PRESCRIPTION DRUGS
(*Complete only if information is missing from the receipt or you do not have a receipt)*

Drug Name & Strength	NDC (National Drug Code)	Quantity Dispensed	Ingredient Cost	Day's Supply	Vaccine Administration Fee or Dispensing Fee	Total Cost

Pharmacy Name: _____

Pharmacy NPI Number: _____

Prescribing Physician Name: _____

Prescribing Physician NPI Number: _____

If you do not have a receipt this section must be completed and signed by a pharmacist or physician.

Pharmacist or Physician Signature: _____

FRAUD WARNING

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Oregon: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

Kentucky: 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 commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

STEP 4: MEMBER SIGNATURE

Claim payments are subject to satisfaction of any applicable Outpatient Prescription Drug Deductible and Policy Deductible. Total benefits payable during a Plan Year may not exceed the Outpatient Prescription Drug Maximum Benefit per Plan Year per Covered Person or per Family, as applicable.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

By signing, you acknowledge that the above information is true to the best of your knowledge and belief.

Signature: _____ Date: _____

BAY BRIDGE ADMINISTRATORS

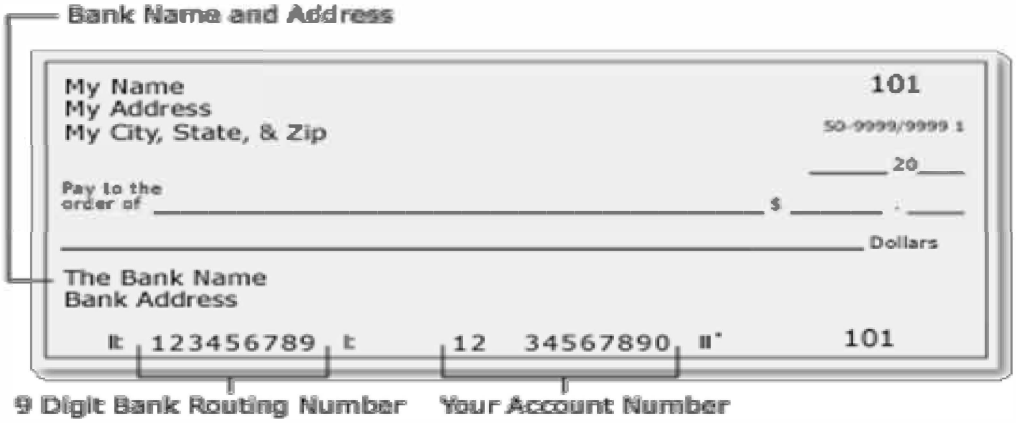
We are pleased to offer electronic ACH (Automated Clearing House) payments for your supplemental coverage benefit payments. ACH payments provide an alternative to paper checks, affording you the following advantages:

- Better cash management forecasting - accelerated funds availability – certainty of delivery
- Establishment of excellent payment and credit records
- Being part of "Going Green" by reducing paper

Enrolling means payment will deposit into your bank account, eliminating use of paper checks and mail delays. We will continue to send you the corresponding Explanation of Benefits via regular mail.

Frequently Asked Questions

How do I get started? Complete and sign the Direct Deposit Authorization Agreement Form. Below reflects where you find the bank routing/bank account numbers that need to be included.



What is the process of enrolling in ACH? Once we receive your completed form, the form is sent to the team that builds the ACH set up.

How long does the ACH enrollment process take? It could take up to 3 business days for the ACH to become effective.

What needs to happen if we change account numbers or financial institutions? If you want to change your ACH electronic authorization, please complete another Direct Deposit Authorization Agreement Form and submit it. Include a note on the form indicating this is for a change in information.

How long does the ACH authorization remain in effect? Your authorization will remain in effect until we receive notification form you that you prefer receiving a check in the mail.

Indemnity Policy Benefit Payment
Direct Deposit Authorization Agreement

First Name | MI | Last Name | SSN

Street Address | City | State | ZIP Code

Phone | Email

Bank Name | Account No. | Routing/Transit No. | Account type: ○ Checking ○ Savings

Bank Address: Street, City, State, Zip | Name(s) on Bank Account

Please Attach Voided Check Here

I (we) hereby authorize Bay Bridge Administrators, LLC hereinafter call "Company" to initiate credit entries to my (our) account indicated above at the depository financial institution named above, hereinafter called "Bank," and to credit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

This authorization is to remain in full force and effect until Company has received written notification from me (or either of us) of its termination in such time and in such manner as to afford Company and Bank a reasonable opportunity to act on it.

Authorized Signature | Date

(Signature must match signature card on account)

Bay Bridge Administrators, LLC.
P.O. Box 161690, Austin, TX 78716
Phone: (800) 845-7519 Fax: (512) 275-9350
Email: underwriting@bbadmin.com
Website: www.bbadmin.com

BAY BRIDGE ADMINISTRATORS