TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

TransAccident® Employee Application

☐ First Application ☐ Add Dependents – Certificate # _____ ☐ Increase Coverage – Certificate # _____

Group Name | Group Number | Location

Employee (Last, First, M.I.) ☐ Male ☐ Female		Social Security No.	Date of birth	Date of marriage
Spouse (Last, First, M.I.) ☐ Male ☐ Female		Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee ID

Home address			Work phone/ext.
City	State	Zip code	Home phone

Child(ren) name	Date of birth	Full time student	Child(ren) name	Date of birth	Full time student
		☐Yes ☐No			☐Yes ☐No
		☐Yes ☐No			☐Yes ☐No

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

Employee will be the beneficiary for any spouse and/or child(ren) coverage

Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other_____

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family ☐ Two-Adult Family

	Premium per pay period*
☐ Off-the Job Accident Basic Coverage	$

ADDITIONAL RIDERS: *(Only available if included in the plan selected by your employer)*

☐ Off-the-Job Accident Disability Rider Monthly Benefit*: ☐ $500 ☐ $1,000	$
☐ Wellness Rider	$

Industry Classification: ☐ A ☐ B ☐ C ☐ D-Disability Riders not available

Total Premium $

*If increasing coverage, enter the TOTAL Monthly Benefit amount and Premium.

Eligibility Questions

1. Is the employee actively at work on a full time basis and able to perform the regular duties of his/her occupation? If "No", you and your dependents are not eligible for coverage.	☐ Yes ☐ No
2. If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)	☐ Yes ☐ No
3. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s)_____ , who will be excluded from coverage.	☐ Yes ☐ No
4. In the past 5 years has any proposed insured had his or her driver's license suspended or revoked? If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)	Not Applicable
5. In the past 12 months have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to an accident? If "Yes", You are not eligible for coverage under this rider, unless included by special endorsement.(Give details below)	☐ Yes ☐ No

Please provide details of all "Yes" answers to questions 2, 4, and 5. Use additional paper if needed.
For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Question #	Name	Please list: Illness, Injury, Condition, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

APPLICANT'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that 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.

I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled (unless included by special endorsement), on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administrative office. Lastly, I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information.

I understand the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau*, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .

Employee's Signature _____ Spouse's Signature (if applicable) _____

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

Licensed Representative's Name _____ Licensed Representative's Signature _____ Agent # _____

*Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, or its reinsurers, may, however, 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. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.