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

CriticalAssistance Plus Employee Application

❒ First Application ❒ Add Dependents – Policy # _____ ❒ Increase Coverage – Policy # _____

Group Name | Group Number | Location

Applicant (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	Applicant ID

Have you or your spouse used tobacco products in the last year? Applicant ☐ No ☐ Yes Spouse ☐ No ☐ Yes	Home phone	Work phone/ext.

Home address	City	State	Zip code

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:

Applicant 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

		Premium Per Pay Mode*
Critical Illness Insurance	Benefit Amount: $	$
☐ Cancer Benefit Rider		
☐ Occupational HIV Benefit Rider (only available to healthcare industry employees)		
☐ Quality of Life Benefit Rider		
☐ Cancer Screening Wellness Benefit Rider	Benefit Amount: ☐ $50 ☐ $100	
*If increasing coverage, enter the TOTAL Benefit Amount and Premium.	TOTAL PREMIUM	$

Eligibility Questions

1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? ☐ Yes ☐ No
   If "No", you and your dependents are not eligible for coverage.
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who are not eligible for coverage.

Evidence of Insurability Questions

3. Indicate height and weight for : Employee / Spouse /
4. In the seven years prior to the application date, has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease? If "Yes", List name(s)_____ ☐ Yes ☐ No
5. In the seven years prior to the application date, has any proposed insured been treated for, been diagnosed as having, or had any known indication, sign, or known symptom of having any heart (including heart attack), lung, brain, circulatory, respiratory, blood, vascular (including stroke), neurological, kidney, liver, pancrease, rheumatoid, or reproductive disorders, diabetes, optic neuritis, fibromyalgia, or chronic fatigue syndrome, had any medical or surgical procedures recommended (including major organ transplant) or advised by a physician but not done at this time, or, in the two years prior to the application date, been treated or counseled for alcohol or drug abuse? ☐ Yes ☐ No
   If "Yes", List name(s)_____
6. Does any proposed insured have high blood pressure that is controlled by more than two medications? ☐ Yes ☐ No
   If "Yes", List name(s)_____

Only answer if you are applying for the Cancer Benefit Rider

7. In the seven years prior to the application date, has any proposed insured been diagnosed as having or been treated for any form of internal cancer, or malignancy (excluding basal cell skin cancer) which includes leukemia, Hodgkin's Disease, carcinoma, sarcoma, lymphoma, or malignant tumors? ☐ Yes ☐ No
   If "Yes", List name(s) _____
8. In the past 12 months, has any proposed insured been recommended for any medical treatment that has not yet been completed, undergone a biopsy or other diagnostic test, or is now scheduled for such to determine whether any form of cancer or malignancy exists, other than a regular Pap Smear, Mammogram, Colonoscopy, or PSA test? ☐ Yes ☐ No
   If "Yes", List name(s)_____

APPLICANT'S STATEMENTS AND AGREEMENTS:

Is the insurance being applied for intended to replace any existing health or accident and sickness insurance coverage? ☐ Yes ☐ No
If "Yes", list name of company _____ , Policy/certificate # _____ , complete the replacement form(s) provided by your agent and return with this application.

I have read or had read to me the completed application. I represent that all statements and answers I have 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 understand that coverage will become effective only after all of the following conditions have been met: a) I must satisfactorily answer all questions on this form; and b) the first month's premium must have been received by the underwriting company at its administrative office.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

I understand that the insurance I am applying for contains a Pre-Existing Condition Limitation and that pre-existing conditions will not be covered for the period stated in the policy.

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. I also certify that this insurance ☐ does ☐ does not replace any existing health, accident and sickness, or disability insurance coverage.

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.