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

Group Accident Application

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

Group Name | Group Number | Location

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Date of marriage
Spouse [1] (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

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

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

Child(ren) name	Date of birth	Child(ren) name	Date of birth
_____	_____	_____	_____
_____	_____	_____	_____

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

[1] *Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.*

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

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family ☐ Two-Adult Family	**Premium per Payment Mode***
☐ Basic Accident Coverage (Applicant Only)	$
*If increasing coverage, enter the **TOTAL** Monthly 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? 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.	☐ 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

Please provide details of "Yes" answer to questions 2. 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:

For NH groups only:

Did you receive an Outline of Coverage describing the insurance for which you are applying? ☐ Yes ☐ No

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.

For residents of all states not listed below:
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, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

For residents of DC or LA:
I understand that 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.

For residents of KY:
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, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

For residents of NC or OR:
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, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

For residents of NJ:
I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of OK:
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.

For residents of TN:
It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of VT:
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, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject 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 be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the 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 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.

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

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

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded on 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 # _____

CARE Ancillary Product Payment Form

Insured's Name: _____

Requested Effective Date:_____ (*all actual effective dates will be determined by underwriting)

Monthly Insurance Premium (all plans selected)..… $_____
Monthly CARE Membership Fee ……..+ $ 1.00
Monthly Administration Fee ……..+ $ 4.00
Total Monthly payment ……...…...= $_____

Please Select and Check one of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

**There is a 4% service fee for this option*

1. Please complete the following account information and submit with a check for the first month's premium made payable to Greater Insurance Service
2. Premium will be charged around the 20th of each month for the next month's premium

Account # ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____

Expiration Date: ____/____/____

Name as it appears on the card: _____

Cardholders Signature: _____

☐ Personal Account Insurance Deduction (P.A.I.D.) Arranged by Greater Insurance Service Corp

Instructions for P.A.I. D.

1.-Please submit one month's premium made payable to Greater Insurance Service & voided check (no deposit slips)
2.-Premium will be deducted around the 15th of each month for the next month's premium

Please Select the Account Type for Withdrawal ☐ Checking Account ☐ Savings Account

WITHDRAWAL AUTHORIZATION

Name of Depositor _____
(Print name as shown on Financial Institution Records)

To Financial Institution _____
(Address of Institution or Branch where account is maintained)

TRANSMIT/ROUTING ABA#_____

ACCT. NO. _____

PRE-AUTHORIZED WITHDRAWAL PAYMENT METHOD

As a convenience to me, I hereby request and authorize Greater Insurance Service Corp. to pay and charge to my account, maintained at the above named financial institution, for the payment of premiums due on policies I currently have or may purchase and desire to include under the P.A.I.D. Agreement. The amounts will be drawn on my account by and payable to the order of Greater Insurance Service Corp. provided there are sufficient funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing and until Greater Insurance Service Corp. actually receives such notice. I agree that Greater Insurance Service Corp. shall be fully protected in honoring any withdrawals. I understand that if the withdrawal is presented and not honored for any reason and the amount due is not paid, Greater Insurance Service Corp. assumes no responsibility for a policy lapse or cancellation due to non-payment. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of my rights in respect to each such charge shall be the same as if they were signed personally by me. A customer has the right to stop payment of a debit entry by notification to Financial Institution prior to charging account. After account has been charged the customer has the right to have the amount of an erroneous entry immediately credited to their account by Financial Institution up to 15 days following the issuance of statement or 45 days after posting, whichever occurs first.

_____ _____
Date Signature of Depositor

Form: CARE APP 3-11