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 – 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 (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

		Benefit Amount*	Premium Per Pay Mode*
Critical Illness Insurance	Plan (if applicable)	$	$
		TOTAL PREMIUM	$

*If increasing coverage, enter the **TOTAL** Benefit Amount and 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 will be excluded from coverage.

Evidence of Insurability Questions

3. Indicate height and weight for : **Employee** / **Spouse** /
4. 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? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement.
5. In the ten years prior to the application date, has any proposed insured been treated for, been diagnosed as having, or had any indication, sign, or symptom of having any heart (including heart attack), lung, brain, circulatory, respiratory, blood, vascular (including stroke), neurological, kidney, liver, pancreas, 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)_____ , who will be excluded from coverage, unless included by special endorsement.
6. Does any proposed insured have high blood pressure that is controlled by more than two medications? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement.

Only answer if the coverage you are applying for includes the Cancer Rider

7. In the ten 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? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No

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)_____, who will be excluded from coverage, unless included by special endorsement.

APPLICANT'S STATEMENTS AND AGREEMENTS:

For residents of CA, MA, and MN only:

Are all proposed insureds covered under major medical, hospital, or medical expense insurance, or an HMO contract? ☐ Yes ☐ No

If "No", list names _____, who will be excluded from coverage.

Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.

For residents of MA, NH, NJ, and OR only:

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

I have read or had read to me the completed application. **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; 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 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. **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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, 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.

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