ENROLLMENT STEPS

Please complete the following easy steps to enroll in this great new benefit:

STEP 1

Complete, Sign and Date Enrollment form. Be sure to include information on all individuals to be covered.

STEP 2

Complete, Sign and Date the Payment Options Form.

STEP 3

Write a Check made payable to Greater Insurance Service for the first month's premium.

STEP 4

Return the following items to: Greater Insurance Service Corp.
PO Box 8633
Madison, WI 53708-8633

1. Completed Enrollment Form
2. Completed Payment Option Form
3. Check made payable to Greater Insurance Service for one month's premium

If you have any questions on the
enrollment process or payment options, please contact
Greater Insurance Service at
1-877-817-4805

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Administration Provided By:
Key Benefit Administrators
P.O. Box 1279, Fort Mill, SC 29716-1279

Member Enrollment Form

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

Group Name NRLCA Group Number B00075 Location

Member (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	Member

Home address	Work phone/ext.

City	State	Zip code	Home phone

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

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

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

TransChoice® Plus Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA

	First Class Plan	*Monthly Premium*	Express Plan	*Monthly Premium*
Member Only	☐	$ 93.00	☐	$ 138.00
Member plus Spouse	☐	$ 158.00	☐	$ 242.00
Member plus Child(ren)	☐	$ 138.00	☐	$ 218.00
Member plus Family	☐	$ 205.00	☐	$ 323.00

Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? *(Residents of KY or VA- do not answer.)* ☐ Yes ☐ No

If "Yes", List name(s)_____, who will be excluded from coverage.

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.

All states except FL, LA, NJ, or VA- 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 (may be a crime and may subject such person to criminal and civil penalties in OR).

FL- I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.

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.

VA- I understand that any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

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 members; 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, 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 enrollment form in no way implies that I will be accepted for insurance coverage.

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

Member's Signature _____ Spouse's** Signature (if applicable) _____

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

Please send this application, along with your first month's premium, made payable to GIS, to:

Greater Insurance Service
P.O. Box 8633
Madison, WI 53708-86633

**Spouse or equivalent, as defined by governing state law. ***Marriage or equivalent, as defined by governing state law.

Greater Insurance Service Corp. Payment Option Form

Please Complete the Following Information
Please Print
Insured Name:_____ Phone: _____

Address: _____
Street City ST ZIP

Please Select and Check one of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

There is a 4% service fee for this option.

Instructions for Credit Cards

1. Please complete the following account information and return with a check made payable to Greater Insurance Service for one month's premium
2. Credit cards will be charged around the 20th of the month for the next month's premium (*see example at bottom)

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 voided check (no deposit slips) and a check for one month's premium made payable to GIS.
2.-Premium will be deducted around the 15th of each month for the next month's premium (*see example at bottom)

Please Select the Account Type for Withdrawal
WITHDRAWAL AUTHORIZATION

☐ **Checking Account** ☐ **Savings Account**

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

Bank Information _____
(Bank Name, Address and Phone # 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

***An example of deductions is as follows: July's premium will be deducted June 20th for Credit Cards or June 15th for PAIDS. If you have any questions, please call our office at 1-800-747-4472.**

Form: GIS Payment 7-08