TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 869094
Plano, TX 75086-9817

Group Term Life Employee Application

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

Group Name _____ Group Number _____ Location _____

Group Term Life Plan of Insurance: ☐ VTL ☐ TAC$-Advantage® Additional Rider Coverage: ☐ Critical Illness Rider ☐ AD&D Rider

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

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

Home address	City	State	Zip code

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:	Face Amount*	Premium per pay period*
☐ Employee	$	$
☐ Spouse**	$	$
☐ Child(ren); Number of Children _____	$	$
*If increasing coverage, enter the **TOTAL** Face Amount and Premium.	**TOTAL 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. In the six months prior to the application date, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to accident or illness, except for normal pregnancy? (Give details on Page 2)	☐ Yes ☐ No

Evidence of Insurability Questions

	Employee /	Spouse** /
4. Indicate height and weight for :		

5. 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)_____, who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)	☐ Yes ☐ No
6. 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, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, reproductive, rheumatoid or neurological disorders, high blood pressure, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form? If "Yes", List name(s)_____, who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)	☐ Yes ☐ No
7. Has any proposed insured been recommended for any medical treatment that has not yet been completed? If "Yes", List name(s)_____, who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)	☐ Yes ☐ No

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

The following question should only be answered when the employer selected plan includes the Critical Illness Rider

8. Has any proposed insured ever been recommended for an organ transplant, including bone marrow, or undergone a biopsy or other diagnostic test within the last 30 days? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. (Give details below)

Please provide details of all "Yes" answers to questions 2, 3, 5, 6, 7, and 8. 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 residents of AL, AK, AR*, AZ, CO, HI, IA, LA, MD, ME, MS, MT, NE, NC, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI or WV:
Do you currently have any other existing life insurance policies or contracts? ☐ Yes ☐ No
If "Yes", complete the replacement form(s) provided by your agent and return with this application.
For residents of all other states:
Is the insurance being applied for intended to replace or change any existing life 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.
*Residents of AR: Answer both replacement questions. Complete replacement form if answering "Yes" to the second question.

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) 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. **I also certify** that this insurance ☐ does ☐ does not replace or change any existing life 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 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.

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