TRANSAMERICA® LIFE INSURANCE COMPANY

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

# AccidentSelect® Employee Application

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

Group Name | Group Number | Location

| | | | | |
|---|---|---|---|---|
| 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 |

| | | | |
|---|---|---|---|
| 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: |

*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: ☐ Individual ☐ Single Parent Family ☐ Family ☐ Two-Adult Family

| | Premium per pay period* |
|---|---|
| ☐ Accident Plan 1 | $ |
| ☐ Accident Plan 2 | $ |
| ☐ | $ |

OPTIONAL RIDERS:

| | | | |
|---|---|---|---|
| ☐ Off-the-Job Accident Disability Rider | Monthly Benefit*: $ | Benefit Period: | $ |
| ☐ Sickness Disability Rider | Monthly Benefit*: $ | Benefit Period: | $ |

Industry Classification: ☐ A ☐ B ☐ C ☐ D-Disability Riders not available

Total Premium $

*If increasing coverage, enter the TOTAL Monthly Benefit amount and 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. 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 |
| 4. In the past 5 years has any proposed insured had his or her driver's license suspended or revoked? If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2) | Not Applicable |

## The following questions should only be answered by the employee when applying for the Sickness Disability Rider

| | |
|---|---|
| 5. Indicate height and weight for : | Employee / |
| 6. In the ten years prior to the application date, have you 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", You are not eligible for coverage under this rider, unless included by special endorsement. (Give details on Page 2) | ☐ Yes ☐ No |

| | |
|---|---|
| 7. Have you been recommended to seek: 1) medical advice; 2) treatment; 3) care; and/or 4) counseling that has not yet been completed?<br>If "Yes", You are not eligible for coverage under this rider, unless included by special endorsement. (Give details below) | ☐ Yes ☐ No |
| 8. In the past 12 months have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to accident or illness, except for normal pregnancy?<br>If "Yes", You are not eligible for coverage under this rider, unless included by special endorsement. (Give details below) | ☐ Yes ☐ No |

Please provide details of all "Yes" answers to questions 2, 4, 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 |
|---|---|---|
| | | |
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## APPLICANT'S STATEMENTS AND AGREEMENTS:

Is the insurance being applied for intended to replace any existing health, accident and sickness, or disability 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.

**For Georgia, Idaho, Montana, Nevada, New Hampshire, or Texas residents only:** Did you receive an Outline of Coverage describing the insurance you are applying for, which is required? ☐ 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. **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) I must satisfactorily answer all questions on this form; d) 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 e) 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.

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 # _____