

First Application Add Dependents – Certificate # _____

Group Name	Group Number	Location
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Applicant <i>(Last, First, M.I.)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth	Home phone
Adult Dependent <i>(Last, First, M.I.)</i>	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security Number	Date of Birth	Date of marriage or union
<input type="checkbox"/> Spouse <input type="checkbox"/> Civil Union/Domestic Partner <input type="checkbox"/> Common Law				
Applicant's Email Address		Do you agree to receive correspondence about your coverage electronically? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you used tobacco products in the last year? Applicant <input type="checkbox"/> No <input type="checkbox"/> Yes Dependent <input type="checkbox"/> No <input type="checkbox"/> Yes
Date of hire/membership	Avg hours worked per week	Annual salary	Occupation	Applicant ID
Home address		City	State	Zip code

Primary Beneficiary: <i>(Last, First, M.I.)</i>	Relationship:
Contingent Beneficiary: <i>(Last, First, M.I.)</i>	Relationship:
<i>Applicant will be the owner and beneficiary for any dependent coverage</i>	

Payment Mode: Weekly Bi-Weekly Semi-Monthly Monthly Other _____

I am applying for:	Death Benefit	Premium per Mode
<input type="checkbox"/> Applicant Term Life	\$ _____	\$ _____
<input type="checkbox"/> Adult Dependent Term Life	\$ _____	\$ _____
<input type="checkbox"/> Child Term Rider: # of children _____ Attach to: <input type="checkbox"/> Applicant <input type="checkbox"/> Adult Dependent	\$ _____ per child	\$ _____
Total Premium per Mode		\$ _____

The following Eligibility and Evidence of Insurability questions do not apply to the Child Term Rider.

Eligibility Questions	
1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? Are you a member in good standing and able to perform the activities of a person of like age and gender? If "No", you and your dependents are not eligible for coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If applying for dependent coverage, is any proposed insured dependent currently disabled? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Evidence of Insurability Questions – Part 1	
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 any of the conditions listed in Question #6? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No
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? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Evidence of Insurability Questions – Part 2				
5. Indicate height and weight for:	Applicant	/	Adult Dependent	/
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, neurological, rheumatoid, or other major organ disorders, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No			
7. Does any proposed insured have high blood pressure that is controlled by more than two medications? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No			

Please provide details of all "Yes" answers to questions 2, 3, 4, 6 and 7. 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:

Replacement question 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.

Replacement question 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.

Accelerated Death Benefit Disclosure Acknowledgement:

If applying for an Accelerated Death Benefit Rider, did you receive the applicable Disclosure(s) if required in your state?

Long Term Care Rider Yes No Critical Care Condition Rider Yes No Terminal Illness Rider 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 and complete 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, 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.

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 any proposed insured dependent 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.

I hereby authorize any licensed physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, health maintenance organization or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), employer, consumer reporting agency, or government body that has any personal information or record of my health, to give personal information to Transamerica Life Insurance Company, or its reinsurers. Personal information means health records (including mental health records, except Psychotherapy notes), criminal and driving records, prescription drug records, alcohol or drug use records, insurance claim and application records and financial and employment records. **I authorize** Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request. This authorization will be valid for 24 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim.

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 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 Agent/Producer's Name _____ Agent # _____ License # _____

Licensed Agent/Producer's Signature _____ Date _____

Information regarding your insurability will be treated as confidential. Transamerica Life insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.