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

AccidentAdvance 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 [1] (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee/Member 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:

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

[1] *Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.*

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

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family ☐ Two-Adult Family

		Premium per Payment Mode*
☐ Basic Accident Coverage (Applicant Only)		$
ADDITIONAL RIDERS: *(Only available if included in the plan selected by the policyholder)*		
☐ Applicant Accident Disability Rider	Monthly Benefit*:	$
☐ Applicant Sickness Disability Rider	Monthly Benefit*:	$
☐ Spouse Off-the Job Accident Disability Rider	Monthly Benefit*:	$
	Total Premium	$

*If increasing coverage, enter the TOTAL Monthly 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. If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? ☐ Yes ☐ No
   If "Yes", List name(s) If Yes Answer, See Medical History Pages, who will be excluded from coverage, unless included by special endorsement.
3. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s) If Yes Answer, See Medical History Pages, who will be excluded from coverage.

The following questions should only be answered if the Sickness Disability Rider is included in the plan selected by the policyholder

4. 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, 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", you are not eligible for coverage under this rider, unless included by special endorsement. ☐ Yes ☐ No
5. Do you have high blood pressure that is controlled by more than two medications? ☐ Yes ☐ No
   If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.
6. In the past 12 months have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any condition in question 4?
   If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement. ☐ Yes ☐ No

Employee Name: _____ SSN: _____

Child(ren) Name	Date of Birth

Please provide details of all "Yes" answers to questions 2, 4, 5, and 6. 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

If Medical Information Has Been Entered It Will Appear on the Following Page(s)

APPLICANT'S STATEMENTS AND AGREEMENTS:

For ID groups only:

Did you receive an Outline of Coverage describing the insurance for which you are applying? ☐ 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.

For residents of all states not listed below:
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.

For residents of DC or 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.

For residents of KY:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of NC or OR:
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 may be a crime and may subject such person to criminal and civil penalties.

For residents of 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.

For residents of OK:
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of TN:
It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of VT:
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, may be committing a fraudulent insurance act which may be a crime subject 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 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 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.

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 on 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 # _____