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

Trans Select Application

❒ First Application ❒ Add Dependents – Certificate # _____

Group Name | Group Number | Location

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

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

Applicant will be the owner and beneficiary for any dependent coverage

Payment Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other_____

I am applying for:	Death Benefit	Premium per Mode
☐ Applicant Term Life	$	$
☐ Adult Dependent Term Life	$	$
☐ Child Term Rider: # of children _____ Attach to: ☐ Applicant ☐ 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. ☐ Yes ☐ 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. ☐ Yes ☐ 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. ☐ Yes ☐ 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. ☐ Yes ☐ 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 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. ☐ Yes ☐ 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. ☐ Yes ☐ 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, 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.

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.

For 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 DC, LA, MD or RI: 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 MA, 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 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 OK: 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 TN or WA: 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.

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 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 Insurer, or its reinsurers, any such information.

I understand the information obtained by use of this Authorization will be used by Insurer to determine eligibility for insurance. Any information obtained will not be released by Insurer 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 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) _____ .

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. The Insurer, 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 866-692-6901 (TTY 866-346-3642 for hearing impaired). Insurer, 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.