TRANSAMERICA

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office: PO Box 219, Cedar Rapids, IA 52406-0219

Multi-Product Application

Residents of CO applying for Critical Illness: THIS IS A LIMITED BENEFIT HEALTH COVERAGE POLICY AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.
ALSO, THESE BENEFITS CANNOT BE COORDINATED WITH BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THEM CAREFULLY TO AVOID DUPLICATION OF COVERAGE.

Residents of NM applying for Critical Illness:
NOTICE TO CONSUMER: This is a limited benefit health plan. The benefits provided are supplemental to, and not a substitute for, major medical coverage, even in combination with other limited benefit plans. To apply for an individual or small-group major medical plan, please visit the website of the New Mexico Health Insurance Exchange at www.bewellnm.com or call 1-833-862-3935 (TTY: 711).

☐ First Application	Changes to existing contract # _____ ☐ Increase Coverage ☐ Add Dependents - Date and Type of Qualifying Event: _____
Group Name	Group Number / Location

Applicant Information

Name	☐ Male ☐ Female	Social Security No.	Date of birth	Cell or home phone
Home address		City	State	Zip code
Email address		Have you used tobacco/nicotine products in the last year? ☐ No ☐ Yes		

Date of hire	Weekly hours worked	Annual salary	Occupation	Applicant ID	Work phone/ext.

Protection against unintended lapse: I understand I have the right to designate at least one person other than myself to receive notice of lapse or termination of this coverage for nonpayment of premium. I understand notice will not be given until thirty days after premium is due and unpaid. ☐ I elect **NOT** to designate any person to receive such notice.

Secondary Addressee Name	Home Address	City	State	Zip code

Kansas Residents: Civil Union/Domestic Partners are not eligible for coverage
Kentucky Residents: Civil Union/Domestic Partners are not eligible for life coverage

Dependent Information

Name Address *(if different from applicant)* *Attach an additional sheet of paper if more room is needed.*	Gender	Relationship to applicant	Date of birth	Social Security Number	Phone Number (if different from applicant	(Age 16+) Used tobacco/nicotine products in the last year? (Age 21+ for PA)
	☐ Male ☐ Female					☐ No ☐ Yes
	☐ Male ☐ Female					☐ No ☐ Yes
	☐ Male ☐ Female					☐ No ☐ Yes
	☐ Male ☐ Female					☐ No ☐ Yes
	☐ Male ☐ Female					☐ No ☐ Yes
	☐ Male ☐ Female					☐ No ☐ Yes

Benefit Selections – Product and Rider Availability Varies by State

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

Critical Illness

☐ **Group Critical Illness (*CI12)***	**Benefit:**	**Plan:**	**Premium**
☐ Applicant ☐ Applicant & Spouse/Partner ☐ Applicant & Children ☐ Applicant, Spouse/Partner & Children			$

Eligibility Questions

1. Are you actively at work on a full-time basis and able to perform the duties of your occupation? ***Residents of NH:*** *Are you currently employed on a full-time basis?* If "no", you and your dependents are not eligible for coverage.	☐ No ☐ Yes
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? ***(Do not answer if resident of AZ, CO, KS, KY, NC, OH, OR, SC, TN or VA)*** If "yes", list names _____, who are not eligible for coverage.	☐ No ☐ Yes
3. **Resident of CA, GA, MA, MN, NJ or VT:** Are all proposed insureds covered under a major medical, hospital, or medical expense insurance plan, an HMO contract, or any other plan that provides "minimum essential coverage" as defined in section 5000A of the Internal Revenue Code? If "no", list names _____, who are not eligible for coverage.	☐ No ☐ Yes

If you answer "no" to question #1, no coverage will be issued.
Anyone listed as ineligible on question 2 or 3 will be automatically excluded from coverage.

Residents of MD and NH *cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions - Please answer the following questions to the best of your knowledge and belief.
Required if applying for more than the Guaranteed Issue Amount or if Late Enrollee.

4. Indicate Height and Weight:	Applicant Spouse/Partner	_____/_____ _____/_____

5. **Critical Illness that includes cancer coverage:** In the past twelve months, has any proposed insured: • Been recommended by a member of the medical profession (licensed physician in FL, KS and KY) for any medical treatment that has not yet been completed; or • Undergone a biopsy or other diagnostic test (or is scheduled for such) to determine whether any form of cancer or malignancy exists (other than a regular Pap Smear, mammogram, Colonoscopy or PSA test)? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes
6. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession (licensed physician in FL, KS and KY) for any of the following? • Acquired Immune Deficiency Syndrome (AIDS) Residents of FL: tested positive for exposure to the HIV infection, been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection • Blood (including Anemia, platelet disorders, Hemochromatosis, Thalassemia or any other abnormality of the spleen, bone marrow or blood or a blood transfusion) • Brain or Nervous System (including Alzheimer's, Dementia, Multiple Sclerosis, Optic Neuritis, Parkinson's, seizures, Vertigo or any other disease or disorder of the brain or nervous system) • Cancer (including Melanoma, Leukemia, Lymphoma or any other cancer or tumor other than non-melanoma skin cancer) • Anxiety, depression, chronic fatigue, suicidal thoughts, or any other psychiatric, emotional, behavioral or mental or nervous disorder? • Digestive (including Barrett's Esophagus, Cirrhosis, Hepatitis, Ulcerative Colitis, Crohn's Disease or any other disease or disorder of the esophagus, stomach, liver, pancreas, intestine or colon) • Glandular (including Diabetes, Addison's, Cushing's, thyroid or any other disease or disorder of the endocrine system) • Heart or Blood Vessels (including Aneurysm, heart attack, stroke, high blood pressure requiring more than two medications to control, or any other disease or disorder of the heart, blood vessels or circulatory system) • Lung (including Asthma, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), Chronic bronchitis, Tuberculosis, Interstitial lung disease or any other disease or disorder of the lungs or airways) • Musculoskeletal (including Fibromyalgia, Lupus, Sjogren's syndrome, Osteoporosis, Muscular Dystrophy, Paralysis, Rheumatoid Arthritis, Autoimmune disorder or any other disease or disorder of the musculoskeletal system) • Renal or Reproductive (including disorders of the breasts, ovaries, prostate, bladder, kidney or any other disease or disorder of the urinary or reproductive organs) If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.

***Residents of MD and NH** cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Residents of CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For further consideration for anyone who fails to qualify for coverage above, provide details of all "yes" answers to questions 5 or 6.. Anyone found to be acceptable will be added to your coverage via an endorsement.		
Question #	Name	Please list: Illness, Injury, Condition, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage. *(**Residents of ME:** exclude HIV related diseases)* (***Residents of MD**: only list details for the past five years)*

Health Outline of Coverage Acknowledgement

Did you receive an Outline of Coverage describing the insurance you are applying for, if required at time of application in your state?

Critical Illness ☐ Yes ☐ No

*Outlines are required for coverage under the jurisdiction of **HI, ID, MA, ME, MT, NH, NJ, OR, SD, WA, or WY**.*

Buyer's Guide to Cancer Insurance Acknowledgement

For residents of ME, NH, UT applying for Critical Illness that includes cancer coverage:

Did you receive a Buyer's Guide to Cancer Insurance? ☐ Yes ☐ No

Fraud Warnings

Standard Fraud Warning for Maine, Pennsylvania and all other states not listed below

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.

Alabama

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas and Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California - For your protection California law requires the following to appear on this form:

Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

District of Columbia, Louisiana and Rhode Island

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.

Florida

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas and Vermont

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 may be guilty of insurance fraud as determined by a court of law.

Kentucky

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.

Massachusetts and Oregon

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.

New Jersey

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. I represent that all statements made on or attached to this application are true and complete to the best of my knowledge and belief.

North Carolina

I understand that any person who knowingly and with intent to injure, defraud, or deceive 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, is guilty of a crime (Class H felony), which may be subject to criminal and civil penalties.

Oklahoma

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.

Tennessee and Washington

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.

Virginia

I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Applicant Statement and Agreement

I have read or had read to me the completed application. **I represent** ***(Residents of MN and VA: I certify)*** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief. **I 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 MA Residents: CAUTION: If your answers on this application are incorrect or untrue, Transamerica Life Insurance Company has the right to deny benefits or rescind your coverage.

I have read the applicable Fraud Warning listed above for my state.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage. **I understand** that coverage will take effect only if this application is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate to which this application is attached.

THE POLICY/CERTIFICATE PROVIDES LIMITED BENEFITS. PLEASE READ YOUR POLICY/CERTIFICATE CAREFULLY.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN ADDITIONAL PAYMENT WITH YOUR TAXES.

For NE Residents: NOTICE TO CONSUMER: THIS IS A LIMITED BENEFIT HEALTH PLAN. THE BENEFITS PROVIDED ARE SUPPLEMENTAL TO, AND NOT A SUBSTITUTE FOR, MAJOR MEDICAL COVERAGE, EVEN IN COMBINATION WITH OTHER LIMITED BENEFIT PLANS.

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. IT IS NOT DESIGNED TO FILL THE "GAPS" OF MEDICARE. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE MEDICARE SUPPLEMENT BUYER'S GUIDE AVAILABLE FROM THE COMPANY.

For NE Residents: THIS IS NOT A MEDICARE SUPPLEMENT POLICY OR CONTRACT. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE GUIDE TO HEALTH INSURANCE FOR PEOPLE WITH MEDICARE AVAILABLE FROM THE COMPANY.

For CT: Any person who is covered by Medicaid should not purchase specified disease coverage.

For NH: A person to be covered for specified disease insurance cannot also be covered by any Title XIX Program (Medicaid).

For UT: I represent that no person to be covered is also covered by any XIX program, designated as Medicaid or any similar name.

I UNDERSTAND THE POLICY/CERTIFICATE MAY CONTAIN A PREEXISTING CONDITION LIMITATION AND THAT PREEXISTING CONDITIONS MAY NOT BE COVERED FOR THE PERIOD STATED IN THE POLICY/CERTIFICATE.

Signed in (City/State) _____ Date: _____

Signatures _____ _____

Applicant Adult Dependents (where required)

For MD Residents: Each signature applies only to the portion of the application completed by you.

Licensed Agent/Representative Statement and Agreement

I 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.

I certify that I have provided any applicable outline of coverage forms.

Name _____ Signature _____

Date _____ Agent # _____ License # _____

The following notices must be left with the applicant.

Abbreviated Notice of Information Practices

Personal information may be collected from persons other than an individual proposed for coverage. This information, as well as other personal or privileged information subsequently collected by Transamerica or its agent, in certain circumstances, may be disclosed to third parties without authorization. A right of access and correction exists with respect to all personal information collected. You will receive a complete Notice of Information Practices with your policy/certificate (and at any other time upon your request) which explains the types of data we collect and typical sources of such information, how we use that data and who we may share it with, your rights to access the data we have collected and how to request corrections, and how we protect the data.

Adverse Underwriting Disclosure

In the event of an adverse underwriting decision, we will send you a written notice with the specific reason for such adverse underwriting decision.

For MO Residents: Notification of acceptance or further delay will be provided within 60 days of home office receipt of this application for an individually underwritten health or accident product.