Transamerica Life Insurance Company (*"insurer"*)
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

TransConnect®
With Critical Illness
Enrollment Form

☐ First Application ☐ Add Dependents – Certificate # ________ ☐ Increase Coverage – Certificate # ________

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	Gender	Full time student	Child(ren) name	Date of birth	Gender	Full time student
________	________	☐M ☐F	☐Yes ☐No	________	________	☐M ☐F	☐Yes ☐No
________	________	☐M ☐F	☐Yes ☐No	________	________	☐M ☐F	☐Yes ☐No

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:	Employer Paid Benefit Amount	Voluntary Benefit Amount [1]	Premium per pay period*
☐ TransConnect Basic Coverage ☐ Employee ☐ Employee Plus Spouse** ☐ Employee Plus Children ☐ Employee Plus Family	$	$	$
ADDITIONAL COVERAGE: *(If included in the plan selected by your employer)(Only available to family members covered by TransConnect)*			
☐ CriticalAssistance Select Plan A with Benefit Reduction — Benefit Amount: $ ☐ Employee ☐ Employee Plus Spouse** ☐ Employee Plus Children ☐ Employee Plus Family			$
☐ Accident Advance Plan_____ ☐ Employee ☐ Employee Plus Spouse** ☐ Employee Plus Children ☐ Employee Plus Family			$
		Total Premium	$

[1] Voluntary benefit will only be issued when the required participation is met.
*If increasing coverage, enter the **TOTAL** Benefit and/or Coverage Amount and Premium.

1. Do all proposed insureds participate in the employer's (or Another) major medical or comprehensive health insurance coverage*? ☐ Yes ☐ No
   If "No", List name(s)________________________, who will be excluded from coverage.
   *Note: All family members must participate in the same plan"
2. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s)________________________, who will be excluded from coverage.

APPLICANT'S STATEMENTS AND AGREEMENTS:

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 understand that I must be actively at work for the required number of hours specified in the group policy and/or my employer's application in order to maintain coverage. I currently participate in my employer's (or Another) major medical or comprehensive health insurance coverage, and understand that the TransConnect insurance coverage provides supplemental benefits to the major medical or comprehensive health insurance benefits.

I authorize the required payroll deductions associated with my elected coverage (and the coverage of my dependents, if any). I reserve the right to revoke this deduction at any time with written notification to the insurer and my employer.

Signed in (City/State) ________________ This ________ Day of (Month/Year) ________________ .

Employee's Signature ________________ Spouse's** Signature (if applicable) ________________

Licensed Representative's Name ________________ Licensed Representative's Signature ________________ Agent # ________

**Spouse or equivalent, as defined by governing state law. ***Marriage or equivalent, as defined by governing state law.