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

Life and Health Group Application and Agreement

Multi-State Version

Name of Group (*"you, your"*):		Tax ID Number:	SIC Code:	Website Address:
Street Address:		City:	State:	ZIP Code:
Contact Name:	Email Address:		Phone #:	Fax #:
Nature of Group:		# of Employees/Members:	# Eligible for Coverage:	# of Years in Existence:
Billing Address: *(if different)*		City:	State:	ZIP Code:
Billing Contact Name: *(if different)*	Email Address:		Phone #:	Fax #:
Billing Address is For: ☐ Group Policyholder ☐ Third Party Administrator ☐ Premium Collection Agency *(Requires a Premium Collection Agreement)*				

You hereby authorize Transamerica Life Insurance Company, our authorized agents or our enrollers (collectively referred to as we, us, or our) to offer each of your eligible employees/members the opportunity to purchase insurance coverage as described in this form. This authorization is based upon the following agreements:

1. We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
2. The initial enrollment shall take place from __________ to __________. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
3. Unless otherwise agreed upon by you and us, you will collect premium contributions from your participating employees/members and forward to us when due. We customarily bill you each month. You will forward the premiums due to us within 15 days of the receipt of the monthly bill. You will maintain records of all premium contributions from your employees/members while this agreement remains in force and for two years after it terminates. These records will remain open to inspection and audit by us during normal business hours during this time.
4. In the event of any misappropriation by you, your employees or your agents, of funds owed to us, you will reimburse us for our entire loss including attorney fees and expenses incurred in collection, and any benefits we would not have had to pay but for such misappropriation.
5. Do benefit selections vary by class? ☐ No ☐ Yes *(define classes below)*

Definition of Class 1:	
Definition of Class 2:	
Definition of Class 3:	
Definition of Class 4:	

6. Eligibility for insurance:
   a. Employer Groups - eligible employees are defined as those who work at least [ ] hours per week for you, and have been so employed for at least [ ] days.

	Class 1	Class 2	Class 3	Class 4	
Employer Groups - eligible employees are defined as those who work at least					hours per week for you,
and have been so employed for at least					days.

   b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws, who are not currently disabled and are able to perform the normal activities of a person of like age and gender.
7. Is dependent coverage being offered? ☐ Yes ☐ No
   If yes, do you include same-sex partners? ☐ No ☐ Yes, state mandate *(Not applicable in TX)* ☐ Yes, corporate decision *(attach eligibility requirements)*

Billing Information

Pay periods per year:	Payments will be remitted: ☐ After each deduction ☐ Monthly ☐ Other ______________________
Payroll deductions per year:	Premium amount on bill should reflect: ☐ Levelized amount over 12 months ☐ Actual amount of deductions occurring each month
First payroll deduction date:	Preferred billing sequence: ☐ Alphabetical ☐ Social Security Number ☐ Employee/Member ID ☐Other ________
First bill due date:	Preferred Billing Method: ☐ Paper ☐ Electronic *(via website)* ☐ Self-Bill / Multiple Billing Locations: ☐ No ☐ Yes *(attach listing)*

Name of Section 125 Plan Administrator *(if applicable)*	Plan Start Date	Plan Anniversary Date

Fraud Warning

District of Columbia, Louisiana, Maryland, 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.

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, North Carolina 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 to or attached to this application are true and complete to the best of my knowledge and belief.

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.

Puerto Rico
Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

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.

Vermont
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.

For Maine and All other states
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 and agree that this application will be made part of each group master policy issued as a result of this application. The Group listed above will be named as the Policyholder for each group master policy. I agree that no insurance will be effective until approved by us at our administrative office.

Signed in (City/State) ____________________ This ________ Day of (Month/Year) ______________, ________.

____
Signature of Officer | Email Address

____
Print Name and Title of Officer

____
Signature of Licensed Agent/Producer | Email Address

____
Print Name of Licensed Agent/Producer | Agent/Producer Number | License Number

Insurance Selections

(Product and Rider availability subject to state approval)

☐ **Limited Benefit Indemnity – TransConnect** *Product not available in CT, FL, GU, MN, NH, NJ, PR and WA.* ***Large Employer Group Only (51+) in MA.***	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **TransConnect** ☐ **HealthPak**

Do you continuously maintain a medical plan? ☐ Yes ☐ No *(Product only available while you continuously maintain an underlying medical plan)*

How many plans are in force? _____ *(Attach a copy or plan summary of each plan and the most recent billing statement)*

	Class 1	Class 2	Class 3	Class 4
Hospital Inpatient Benefit Amount				
Underlying Medical Plan Deductible				

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* ________________________

☐ **Group Accident Insurance – AccidentAdvance** *Product not available in CA, CO, FL, KY, MN, NH, PR, VT, WA.*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **24-Hour Coverage** ☐ **Off-the-Job Only Coverage** ☐ **HealthPak AccidentAdvance** *(No Sickness DI Rider)*

			Plan 1	Plan 2	Plan 3
Module 1 – Accident Emergency Treatment Benefits			Units	Units	Units
Module 2 – Follow-Up Visits and Physical Therapy Benefits			Units	Units	Units
Module 3 – Initial Accident Hospitalization			Units	Units	Units
Accept	**Decline**	**Optional Riders**			
☐	☐	Accidental Death and Dismemberment Rider	Units	Units	Units
☐	☐	Accident Hospital & ICU Income Rider	Units	Units	Units
☐	☐	Expanded Benefits Rider	Units	Units	Units
☐	☐	Wellness Benefit Rider *(Not available in CT, DC or MA)*	Units	Units	Units
☐	☐	Accident Only Disability Income Rider Elimination Period-0 Days Benefit Period: ☐ 6 ☐ 12 Months			
☐	☐	Sickness Only Disability Income Rider Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months			
☐	☐	Spouse Off-the-Job Accident Only Disability Income Rider Elimination Period-0 Days Benefit Period: 6 Months			

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* ________________________

Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ **Group Off-the-Job Accident – TransAccident** *Product not available in FL, GU, ID, MN, NH, NM, PA, PR, VT, WA.*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **Total Plan** ☐ **Select Plan** ☐ **Custom Plan** *(Attach Plan Design)* ☐ **HealthPak TransAccident** *(No Sickness DI Rider)*

Accept	Decline	
☐	☐	Accident Only Disability Income Rider Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months
☐	☐	Sickness Only Disability Income Rider *(N/A in MD)* Elimination Period-14 Days Benefit Period: ☐ 6 ☐ 12 Months
☐	☐	Wellness Rider *(Not available in CT, IN or MA)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* ________________________

Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ **Individual Accident Insurance – AccidentSelect** **Accident AnswerSelect in MN and OR** *Product not available in CT, FL, GU, MA, NJ, VT, WV.*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **Plan I** ☐ **Plan II**

Accept	Decline	
☐	☐	Accident Only Disability Income Rider *(Not available in PA)*
☐	☐	Sickness Only Disability Income Rider *(Not available in MD, SC or VA) (Accident & Sickness Disability Rider in MN and OR)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* ________________________

Workers' Compensation: Are all employees/members covered under Workers' Compensation? ☐ Yes ☐ No *(explain below)*

☐ **Group CI Insurance – CriticalAssistance Select** *Product not available in CT, GU, ID, MA, MN, NH, PR or WA.* *Available as an Individual policy in FL and MD.*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **With Benefit Reduction** ☐ **Without Benefit Reduction** ☐ **HealthPak CI** ☐ **LIVESTRONG CI** *(Only available in GA)*

☐ Option A – Cancer, Heart Attack, Stroke, End Stage Renal Failure, and Major Organ Transplant
☐ Option B – Heart Attack and Stroke Only *(Not available in GA)*
☐ Option C – Cancer Only *(Not available in GA)*
☐ Option B and C – Heart Attack, Stroke, and Cancer Only *(Not available in GA)*

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Section 125 ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* ________________________

☐ **Group Interest Sensitive Whole Life – Trans$ure** *Product not available in CA or PR.* *Available as an Individual policy in VT.*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **Money Purchase** ☐ **Defined Benefit** *****Attach a copy of the Rate Sheet*****

Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.

Waiver of Premium for Layoff included in all states except MA, MN, VT, and WA.

Accept	Decline	
☐	☐	Accelerated Death Benefit for Critical Care: ☐ 25% ☐ 50% ☐ 75% ☐ 100% *(Not available in CT, FL, MA, or NJ)*
☐	☐	Accelerated Death Benefit for Long-Term Care *(Not available in MA, UT or VT) (Only available to large group (51+) in FL)*
☐	☐	Extension of Benefits Rider *(Not available in CT, FL, MA, NC, NJ, PA, TX, UT or VT)*
☐	☐	Accidental Death & Dismemberment *(Not available in MN or VT)*
☐	☐	Child Level Term Insurance Rider *(Not available in VA)*
☐	☐	Waiver of Premium for Total Disability

Replacement: Are you replacing existing coverage? ☐ No ☐ Yes

IRS Type: ☐ Welfare Benefit Plan ☐ ERISA ☐ 5500 Required ☐ Other *(please explain)* ________________________

Make a photocopy for your records.