Employee (last, first)		Social Security	Email	
Home Phone	Home address	City	State	Zip Code

Transamerica Programs	Occupation				
Date of Hire	Avg Hrs/wk	______Male ______Female	Date of Birth	Annual Salary	
Dependents to be Covered					
Name	Relationship	Male/Female	Social Security	Date of Birth	Date of Marriage
	Spouse				
	Ch		NA		NA
	Ch		NA		NA
	Ch		NA		NA
	Ch		NA		NA
Primary Beneficiary			Relationship		

I am Applying For THESE ARE WEEKLY

Critical Illness ($20,000 or less)	Benefit Amount		Covg Type	__ Emp, __Emp & Ch, __Fam	
	Weekly Cost		Smoker (Emp only)	Y / N	
Accident	Plan I	___EE $3.57	___EE/Child $4.48	___Emp/Sp $5.57	___Family $6.76
Universal Life - Employee	Face Amount	_____________	Smoker y / n	Weekly Prem	_____________
Universal Life - Spouse	Face Amount	_____________	Smoker y / n	Weekly Prem	_____________
Universal Life - Child	Face Amount	_____________	Smoker y / n	Weekly Prem	_____________
Universal Life - Child	Face Amount	_____________	Smoker y / n	Weekly Prem	_____________

Eligibility Questions	
1. Are you actively at work on a full time basis and able to perform the regular duties of your occupati	Y / N
2. If applying for spouse and/or child(ren) coverage, is any proposed insured currently disa If "Yes" list name ______________________________who will be excluded from covera	Y / N
2A. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes" list name _______________________________________who will be excluded fr	Y / N
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 of the conditions listed; 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)?	Y / N
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?	Y / N

Signature ______________________________ Date

Associated Employee Payroll Deduction Authorization

Employer Name ________________________________

Employee Name ________________________________

Last 4 Social xxx- xx-____________________________

E-Mail ________________________________

Cell Phone ________________________________

		Family Level	Weekly Premium
Accident	Y / N		
Critical Illness	Y / N		
Universal Life	Y / N		

_____I acknowledge receipt of the Outline of Coverage describing some of the most important features of the insurance policy(ies) that I am applying.

_____I choose to enroll in the payroll deduction plan made available on a voluntary basis. I hereby authorize my employer to withhold from my compensation the amounts shown above and remit to the carrier/administrator. I accept that this authority will remain in effect until the administrator has received written notice of termination from me.

_____For any programs that I have waived, I understand that I can apply at a later date; however, any special underwriting concessions will no longer be applicable.

Employee's Signature: ______________________________ Date: ________________