



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

**CoPower Basic Term  
 Life Simplified Issue  
 Employee Application**

First Application     Add Dependents \_\_\_\_\_ (only available to groups that offer dependent coverage)

Group Name	Group Number	Location
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Employee (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	Date of marriage
Spouse/Domestic Partner (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee ID
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Home address	Work phone/ext.
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City	State	Zip code	Home phone
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Primary Beneficiary: (Last, First, M.I.)	Relationship:
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Contingent Beneficiary: (Last, First, M.I.)	Relationship:
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*Employee will be the beneficiary for any spouse/domestic partner and/or child(ren) coverage*

I am applying for:    Employee    Face Amount: \_\_\_\_\_  
 Dependents (only available to groups that offer dependent coverage)

**Eligibility Questions**

1. Is the employee actively at work on a full time basis and able to perform the regular duties of his/her occupation? If "No", you and your dependents are not eligible for coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If applying for dependent coverage, is any proposed insured currently disabled? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Evidence of Insurability Questions**  
 Complete only if applying for more than \$50,000

3. Indicate height and weight:	/
4. In the six months prior to the application date, have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to accident or illness, except for normal pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Have you 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", coverage will be limited to a maximum of \$50,000.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the ten years prior to the application date, have you been treated for, been diagnosed as having, or had any indication, sign or symptom of having any heart, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, reproductive, rheumatoid or neurological disorders, high blood pressure, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form? If "Yes", coverage will be limited to a maximum of \$50,000.	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you been recommended for any medical treatment that has not yet been completed? If "Yes", coverage will be limited to a maximum of \$50,000	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide details of all "Yes" answers to questions 2, 4, 5, 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:**

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 also 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 of employees; b) I must have satisfied the employer waiting period; c) employer 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 for my dependents, they must not be disabled (unless included by special endorsement), on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administrative office. Lastly, 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 Transamerica Life Insurance Company, or its reinsurers, any such information.

I understand the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company 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, claim, 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) \_\_\_\_\_  
Employee's Signature \_\_\_\_\_ Spouse/Domestic Partner 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.

Licensed Representative's Name \_\_\_\_\_ Licensed Representative's Signature \_\_\_\_\_ Agent # \_\_\_\_\_

\*Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Transamerica Life Insurance Company, 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.