



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
 Enrollment Form**

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

Group Name _____ Group Number _____ Location _____

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

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.

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 # _____