TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 219
Cedar Rapids, IA 52406-0219

Life and Health Group Application and Agreement

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:

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 premiums from your participating employees/members. You will forward the premiums to us within 15 days after you receive the monthly bill. You will maintain records of all premiums collected from your employees/members while this agreement remains in force and for two years after it terminates. During this period, you will make these records available for inspection and audit by us during normal business hours. If premium contributions collected by you, your employees, or your vendors are misappropriated, you will reimburse us for our entire loss, including attorney fees and expenses incurred in collection, to the extent permitted by the laws of your state.
4. 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:	

5. Eligibility for insurance:
   a. Employer Groups - eligible employees are defined as those who work at least 20 hours per week for you, and have been so employed for at least 0 days.

Class 1	Class 2	Class 3	Class 4
20			
0			

   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.
6. Is dependent coverage being offered? ☒ Yes ☐ No
7. Is coverage being offered through a Section 125 plan? ☐ Yes ☒ No
   If "yes", which product(s): _____ Plan Start Date: _____ Plan Anniversary Date _____
8. Is coverage being offered replacing existing coverage? ☐ Yes ☒ No
   If "yes", which products? _____

I have read the Fraud Warning for my state shown on Page 3 of this form.

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

licensing@connexioninsurance.com

Signature of Licensed Agent/Producer — Email Address

LV036372 — 41620

Print Name of Licensed Agent/Producer — Agent/Producer Number — License Number

Billing Information

Billing Name (if other than group name) Benefitfocus			
Billing Address: 1 Investors Way	City: Norwood	State: MA	ZIP Code: 02062
Billing Contact Name:	Email Address:	Phone #:	Fax #:
Billing Address is: ☒ Group Policyholder ☐ Third Party Administrator ☐ Premium Collection Agency *(Requires a Premium Collection Agreement)*			

Pay periods per year: 12
Payroll deductions per year: 12
First payroll deduction date: 5th of month of effective date
First bill due date: 1st of month following eff date

Payments will be remitted: ☐ After each deduction ☒ Monthly ☐ Other _____	
Premium amount on bill should reflect: ☒ Levelized amount over 12 months ☐ Actual amount of deductions	
Preferred billing sequence: ☒ Alphabetical ☐ Social Security Number ☐ Employee/Member ID	
Preferred Billing Method: ☐ Paper ☐ Website ☒ Self-Bill	Multiple Billing Locations: ☒ No ☐ Yes *(attach listing)*

Insurance Selections

Participation Requirement: Each group master policy requires a minimum of 2 covered lives or the state minimum, whichever is greater in order to be issued and remain in force. Any group master that falls below this requirement may be terminated, subject to the notice requirements in the master policy. Special underwriting offers may require higher participation in order to continue receiving the special underwriting offer for new insureds.

Master Contract Delivery: ☒ Electronic Delivery or ☐ Paper (US Mail) Delivery

☐ **Group Universal Life Insurance – TransElite**	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☒ **High Face Amount** *****Attach a copy of the Rate Sheet*****
Age Band Rates: ☒ Yes ☐ No

ACCEPT	DECLINE	
☒	☐	ADB for Chronic Condition Rider (Living Benefit Rider)
☒	☐	Extension of Benefits Rider
☒	☐	Child Level Term Insurance Rider

☐ **Individual Accident Insurance – AccidentSelect**	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☒ **Plan I w/wellness rider**

☐ **Group Cancer Insurance – CancerSelect Plus**	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:

			Plan 1
Module 1 – Hospital Benefits			2 Units
Module 2 – Surgery Benefits			2 Units
Module 3 – Radiation and Chemotherapy Benefits			2 Units
Module 4 – Wellness and Miscellaneous Benefits			1 Units
Module 5 – Drug-Related Expense Benefits			1 Units
Accept	**Decline**	**Optional Riders**	
☒	☐	First Occurrence Rider *(Lump Sum Diagnosis Rider in SD)*	2 Units

Insurance Selections

☐ **Group CI Insurance – CriticalEvents**	**Group Contribution?** ☐ Yes ☒ No	**Requested Effective Date:**

	Plan 1
Dependent Coverage	☒ 50%
Rate Structure	☒ Issue Age
First Occurrence	☒ First after Effective Date
☒ Cancer Benefit Rider	☒ Yes ☐ No
☒ Recurrent Critical Illness Benefit Rider	50 %
☒ Wellness Benefit Rider	$ 50

☐ **Hospital Indemnity – HospitalSelect III HSA Plan**	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:**

Do you offer a medical plan with at least a $1,000 deductible? ☒ Yes

Coverage: (Attach Plan Design)	**Class 1**
Base: Daily In-Hospital Indemnity Benefit	$ 100
Maximum (choose one): 31 Days per Confinement	☒ 31 Days
☒ Hospital Confinement Indemnity Benefit Rider	$ 500
Maximum of 1 Day per Confinement. Calendar Year Maximum	1 Days
☒ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$ 100
Calendar Year Maximum	30 Days
☒ Pre-existing Conditions & Limitations Rider	☐ Yes ☒ No

Fraud Warning - 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.

Please complete, sign and date this application and return to us at the address listed above.
Make a photocopy for your records.