Decatur County Board of Education

TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 869094
Plano, TX 75086-9817

Interest Sensitive Whole Life Insurance (ISWL) Application

☐ First Application ☐ Add Dependents – Contract # G000045581 ☐ Increase Coverage – Contract # _____

Group Name | Group Number | Location

Applicant (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Date of marriage
Spouse [1] (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week 40	Annual salary	Occupation	Applicant ID

Have you or your spouse used tobacco products in the last year? Applicant ☐ No ☐ Yes Spouse ☐ No ☐ Yes	Home phone	Work phone/ext.

Home address	City	State	Zip code

Life insurance contract owner (Last, First) *(If different than applicant)*	Address	Relationship	Social Security No.

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

Applicant will be the beneficiary for any spouse and/or child(ren) coverage

[1] Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction, or as otherwise agreed upon between the policyholder and the Insurer.

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☑ Monthly ☑ Other_____ Payroll Deduction

I am applying for:	Money Purchase Premium Amt per Mode*
☐ **Applicant ISWL**	
☐ Child Term Rider # of children _____ Add to: ☐ Applicant ☐ Spouse	
☐ **Spouse ISWL**	
☐ **Child(ren) ISWL** (List total premium for all children)	
*For increases, list total Face and Premium Amounts. **Total**	

Spouse and Children may apply for ISWL coverage OR a Term Rider, but not both.

Child(ren) Information		Money Purchase Premium Amt per Mode*
Name *(List all children)*	Date of Birth	

Eligibility Questions

1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage. ☐ Yes ☐ No
2. If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No

Evidence of Insurability Questions – Part 1

3. 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 conditions listed in Question # 6? If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No
4. 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? If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No

Evidence of Insurability Questions – Part 2

5. Indicate height and weight for: **Applicant** / **Spouse** /
6. In the ten years prior to the application date, has any proposed insured 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, neurological, rheumatoid, or other major organ disorders, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)? If "Yes", List Name(s)_____, who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No
7. Do you or any proposed insured have high blood pressure that is controlled by more than two medications? If "Yes", List Name(s)_____ , who will be excluded from coverage, unless included by special endorsement. ☐ Yes ☐ No

Please provide details of all "Yes" answers to questions 2, 3, 4, 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, 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:

Replacement question for residents of AL, AK, AR*, AZ, CO, HI, IA, LA, MD, ME, MS, MT, NE, NC, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI or WV: Do you currently have any other existing life insurance policies or contracts? ☐ Yes ☑ No

If "Yes", complete the replacement form(s) provided by your agent and return with this application.

Replacement question for residents of all other states:

Is the insurance being applied for intended to replace or change any existing life insurance coverage? ☐ Yes ☑ No

If "Yes", list name of company _____ , Policy/certificate # _____ ,
complete the Replacement form(s) provided by your agent and return with this application.

*Residents of AR: Answer both replacement questions. Complete replacement form if answering "Yes" to the second question.

Accelerated Death Benefit Disclosure Acknowledgement: For coverage issued in AL, AR, DC, IL, MI, MS, OH, or TX".

If applying for an Accelerated Death Benefit Rider, did you receive the applicable Disclosure(s) if required in your state
Chronic Condition Rider ☐ Yes ☐ No Critical Care Rider ☐ Yes ☐ No Terminal Illness Rider ☐ Yes ☐ No

Illustration Acknowledgement for all applicants:

I certify that a life insurance illustration showing non-guaranteed values ☐ was ☑ was not used during the sale of the insurance coverage I am applying for on this application. I understand that if my application is approved, an illustration conforming to the policy/certificate as issued will be delivered to me no later than when I receive my policy/certificate. I understand that any non-guaranteed elements contained in any illustration are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgment, and will return a copy of the signed illustration to the Insurer.

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 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; b) I must have satisfied the policyholder waiting period; c) The policyholder 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 month's premium must have been received by the Insurer at its administrative office. **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 Insurer, or its reinsurers, any such information.

I understand the information obtained by use of this Authorization will be used by Insurer to determine eligibility for insurance. Any information obtained will not be released by Insurer 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 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) _____ .

Applicant's Signature _____ Spouse's 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. **I also certify** that this insurance ☐ **does** ☑ **does not** replace or change any existing life insurance coverage. **I further certify** that a life insurance illustration ☐ **was** ☑ **was not** (but a company-provided **Rate Sheet** may have been used and no non-guaranteed values were shown to the applicant) used in connection with this application.

Licensed Representative's Name George E Daniel Jr Agent # CP 036078

Licensed Representative's Signature _____ Date _____

*Information regarding your insurability will be treated as confidential. The Insurer, 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Insurer, 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.

TRANSAMERICA®
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office: PO Box 8063
Little Rock, AR 72203

Beneficiary Information Form

Please complete the form below and send it to us in the enclosed business reply envelope. The information in the form is being requested to assist in identifying and paying claims benefits to the proper beneficiaries, should it become necessary, per your instructions.

PRIMARY INSURED

1. Last Name	First Name	M.I.

2. Address	Apt#	City

State	Zip Code	3. Home Phone ( )	4. Date of Birth	5. Social Security Number

SPOUSE (If applying)

1. Last Name	First Name	M.I.

2. Address	Apt#	City

State	Zip Code	3. Home Phone ( )	4. Date of Birth	5. Social Security Number

PRIMARY BENEFICIARY

Name / Address	DOB	Percent	Relationship	Phone #	SSN / Tax ID#
Total		**100%**			

CONTINGENT BENEFICIARY

Total		**100%**			

SPOUSE'S BENEFICIARY (complete only if spouse coverage was requested)

Name / Address	DOB	Percent	Relationship	Phone #	SSN / Tax ID#
Total		**100%**			

SPOUSE'S CONTINGENT BENEFICIARY(complete only if spouse coverage was requested)

Total		**100%**			

❑ I understand that the company has requested the information on this form be provided to assist in identifying and paying benefits to the proper beneficiaries. After review, I have elected not to provide any information that I did not supply on this form.

Owner/Primary Insured Signature _____ Date _____

Spouse's Signature (if applying) _____ Date _____