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

TRANSAMERICA® SurvivorPlan Enrollment Form

☑ First Application ☐ Add Dependents – Policy or Certificate # ________ ☐ Increase Coverage – Policy or Certificate # ________

Group Name	COASTAL TRANSPORT	Group Number		Location	San Antonio, TX

Employee (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	Employee ID
Spouse (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Occupation	Home phone	Work phone/ext.

Home address	City	State	Zip code

Child(ren) name	Date of birth	Child(ren) name	Date of birth
________	________	________	________
________	________	________	________

I Am Applying For **Cancer and Wellness Insurance:**

Deduction taken: ☑ Pre-tax

Cancer and Wellness Insurance **Basic Plan**	☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	☐ Individual $______	☐ Single Parent Family $_______	☐ Family $_______
Enhanced Plan	☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly	☐ Individual $______	☐ Single Parent Family $_______	☐ Family $_______

I Am Applying For **Group Critical Illness Insurance Benefit Amount**

Deduction taken: ☑ Post-tax
☐ Non-Tobacco ☐ Tobacco User

☐ Individual	☐ $10,000	☐ Weekly $________
☐ 1 Parent Family	☐ $20,000	☐ Bi-Weekly $________
☐ 2 Parent Family		☐ Semi-Monthly $________

TLSP-EF-01-CoastalTrans-071712

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. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s)____ , who will be excluded from coverage.	☐ Yes ☐ 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 (may be a crime and may subject such person to criminal and civil penalties in NC or OR).

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 of employees; b) I must have satisfied the employer waiting period; c) the 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 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.

I understand that completion of this enrollment form in no way implies that I will be accepted for insurance coverage.

I understand that the insurance I am applying for contains a Pre-Existing Condition Limitation and that pre-existing conditions will not be covered for the period stated in the policy/certificate.

Signed in (City/State) ________________________ This ________ Day of (Month/Year) __________________ .

Employee's Signature ____

Licensed Representative's Name __________________ Licensed Representative's Signature __________________ Agent # ________