TRANSAMERICA LIFE INSURANCE COMPANY

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

# HospitalSelect II Enrollment Form

❒ First Application ❒ Add Dependents – Policy # _____ ❒ Change Coverage – Policy # _____

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 | |

| | | | |
|---|---|---|---|
| Email Address | Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No | Work phone/ext. | Home phone |

| | | | |
|---|---|---|---|
| Date of hire | Avg hours worked per week | Occupation | Applicant ID |

Home address

| | | |
|---|---|---|
| City | State | Zip code |

| Child(ren) name | Social Security No. | Date of birth | Child(ren) name | Social Security No. | Date of birth |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |

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

*Applicant will be the beneficiary for any dependent coverage*

[1] *Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction.*

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other_____

| I Am Applying For: ☐ Employee ☐ Employee Plus Spouse** ☐ Employee Plus Children ☐ Employee Plus Family | | **Premium per pay period*** |
|---|---|---|
| ☑ Hospital Indemnity Coverage | Plan _____ | $ |

**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 dependent 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 |
| 3. | **For residents of all states, except AZ, CO, KS, KY, NC, OR, SC,** or **VA:** Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s) _____, who will be excluded from coverage. | ☐ Yes ☐ No |

**STATEMENTS AND AGREEMENTS:**

**For residents of CA or CO:** Are all proposed insureds covered under one of the following: a major medical, hospital, or medical expense insurance plan; or an HMO contract; or any other plan that provides "minimum essential coverage" as defined in section 5000A of the Internal Revenue Code?
**For residents of MA, MN or VT**: Are all proposed insureds covered under a major medical, hospital or medical expense insurance, or an HMO contract? ☐ Yes ☐ No If "No", list names _____, who will be excluded from coverage.
Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.

**I have** read or had read to me the completed enrollment form. **I represent** ***(Residents of MN and VA:*** **I certify)** that all statements and answers made on or attached to this enrollment form are true to the best of my knowledge and belief. **I 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. **I have read** the Fraud Warning for my state shown on the back of this form.

**For residents of CO: THIS IS A SUPPLEMENTAL POLICY/CERTIFICATE THAT IS NOT INTENDED TO PROVIDE THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU HAVE ANOTHER PLAN (SUCH AS MAJOR MEDICAL COVERAGE) THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE BENEFITS PROVIDED BY THIS POLICY/CERTIFICATE CANNOT BE COORDINATED WITH THE BENEFITS PROVIDED BY OTHER COVERAGE. PLEASE REVIEW THE BENEFITS PROVIDED BY THIS POLICY CAREFULLY TO AVOID A DUPLICATION OF COVERAGE.**

**I understand** that completion of this enrollment form in no way implies that I will be accepted for insurance coverage. **I understand** that coverage will take effect only if this enrollment form is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate. The policy provides limited benefits. Review your certificate carefully.

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 enrollment form all of the information supplied by the enrollee. The enrollee has read or had read to him/her the completed enrollment form.

Licensed Agent/Representative's Name _____ Licensed Agent/Representative's Signature _____ Agent # _____

**Fraud Warning**

**CA: I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.**

***AL, DC, LA, NM, & RI:*** **Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

***FL:*** **I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.**

***KS:*** **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 may be guilty of insurance fraud as determined by a court of law.**

***KY:*** **Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.**

***MA, NC & OR:*** **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, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.**

***MD:*** **Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

***NJ:*** **I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

***OK:*** **Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**

***TN & WA:*** **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.**

***VA:*** **I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.**

***VT:*** **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, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.**

***ME* and all other states**: **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.**