Submitting Evidence of Insurability (EOI) for Group Term Life, STD, and LTD

Employees who have elected coverage for the following reasons below mustcomplete the attached EOI Form:

- A Late Entrant
- Elected coverage amounts over the Guarantee Issue Amount (GIA)
- An enrollee who requests to increase their coverage by more than the equivalent of 1 X their annual salary during the annual enrollment period

Please note: Coverage subject to EOI is not in effect until the later of the first of the month following approval date or the benefit effective date. You also must not collect premium by payroll deduction for amounts subject to EOI until the later of the first of the month following approval date or the benefit effective date. Please check your policy for specific requirements.

Please have the applicant complete and sign the provided EOI form and deliver to Transamerica using one of thefollowing methods:

For Group Term Life

- **Physical Mail**
  Transamerica
  P.O. Box 219
  Cedar Rapids, IA 52406-0219

- **Email:** shtebpolicyteam@aegonusa.com

- **Fax: 1-866-586-6528**

For Disability

- **Physical Mail**
  Transamerica
  300 Southborough Dr Suite 200
  S Portland, ME 04106

- **Email: TAClientservices@disabilityrms.com**

- **Fax: 1-877-820-5311**

Best Practices

- During the initial enrollment and subsequent annual reenrollments, we recommend sending all EOI forms in one submission to Transamerica with Group Term Life and Disability split to the noted locations above.
- Please ensure all forms include your Group Number to allow for efficient processing.

Should you have any questions, please contact our customer service line at 855-244-8318.

TRANSAMERICA®

Instructions for Completing the Group Term Life Statement of Insurability Form

When to Complete this Form

You are required to complete this form for the following situations (please check the event that applies to you):

☐	This is your Initial Enrollment; you are newly eligible for this coverage.	☐ You are applying for an amount above the Guarantee Issue Limit
☐	This is your Annual Enrollment Period, and:	☐ You did not enroll when you were first eligible, and you are requesting an amount of Employee Paid Term Life insurance in an amount that is more than the equivalent of 1X your annual salary and the Guarantee Issue Limit; or; ☐ You are currently covered for Employee Paid Term Life insurance, and you are requesting an amount of Employee Paid Term Life insurance in an amount of more than the equivalent of 1X your annual salary and the Guarantee Issue Limit; and/or ☐ You are adding Spouse Life insurance coverage for an amount greater than the Dependent Spouse Guarantee Issue Limit. *(Please note that for your Dependent Spouse to be eligible for coverage, you must be covered for Employee Paid Term Life Insurance in at least an equivalent amount.)*
☐	Outside of your Annual Enrollment Period	☐ This application is due to a change in family status. ☐ You are adding Spouse Life insurance coverage for an amount greater than the Dependent Spouse Guarantee Issue Limit. *(Please note that for your Dependent Spouse to be eligible for coverage, you must be covered for Employee Paid Term Life Insurance in at least an equivalent amount.)*

How to Complete the Form- MISSING INFO MAY DELAY THE PROCESSING OF THE APPLICATION

1. Complete questions 1-4 on the following tab for all Proposed Insureds who need underwriting approval.
2. Answer every question entirely and supply additional details to any 'Yes" answers. Please include the total amount of insurance you are applying for in the box asking you for "Amount of Coverage Subject to Insurability".
3. Sign and date your form. **If you are applying for coverage for your spouse, your spouse must also sign the form where we request "Signature of person for whom coverage is being requested"**.
4. Return your signed form to Human Resources to be finalized and return to Transamerica by fax or email as shown below.

Your Benefits Plan Design:

Employer Name: **Employer #:**

Employee Paid Supplemental Term Life Insurance Plan: (need class if applicable) _____
Up to $ _____ in $ _____ increments; Guarantee Issue Limit $ _____
Employee Paid Dependent Supplemental Term Life Insurance Plan:
Spouse – Up to $_____ in increments of $_____ ; Guarantee Issue Limit $_____
Child(ren)- $10,000

Employer Human Resources Department to complete the following:

a. Applicant Annual Salary: _____ b. Applicant Date of Hire: _____
c. Amount of Current Supplemental Life Insurance Applicant is currently covered for: _____

Fax completed form to: 1-866-586-6528; or Scan and Email it to: shtebpolicyteam@aegonusa.com

TRANSAMERICA

Transamerica Life Insurance Company

Home Office: Cedar Rapids, IA
Administrative Office: PO Box 219, Cedar Rapids, IA 52406-0219

Group Basic Term Life Insurance Statement of Insurability Form

Group Name	Group Number	Location

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

Home address	City	State	Zip code

Full Name of person(s) Requiring Underwriting Approval	Relationship to Employee	Date of Birth	Height	Weight	Amount of Coverage Subject to Insurability?	Occupation

1. Is any person listed above currently: (a) hospitalized; (b) confined at home under a physician's care; or (c) receiving or applying to receive disability benefits from any source?	☐ Yes ☐ No
2. In the past six months, has any person listed above been hospitalized (inpatient or outpatient) or missed more than five days of work due to any accident or sickness, except for normal pregnancy?	☐ Yes ☐ No
3. In the past two years, has any person listed above: • Used illegal or habit-forming drugs, except as prescribed by a member of the medical profession (licensed physician in FL), or received medical advice or treatment for drug and/or alcohol abuse; or • Had their driver's license suspended or revoked, been convicted of reckless or drunken driving, or been involved in three or	☐ Yes ☐ No
4. In the past five years, has any person listed above been diagnosed or treated by a member of the medical profession for any of the following? • Acquired Immune Deficiency Syndrome (AIDS) Residents of FL: tested positive for exposure to the HIV infection, been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection • Blood (including Anemia, platelet disorders, Hemochromatosis, Thalassemia or any other abnormality of the spleen, bone marrow or blood or a blood transfusion) • Brain or Nervous System (including Alzheimer's, Dementia, Multiple Sclerosis, Optic Neuritis, Parkinson's, seizures, Vertigo or any other disease or disorder of the brain or nervous system) • Cancer (including Melanoma, Leukemia, Lymphoma or any other cancer or tumor other than non-melanoma skin cancer) • Anxiety, depression, chronic fatigue, suicidal thoughts, or any other psychiatric, emotional, behavioral or mental or nervous disorder? • Digestive (including Barrett's Esophagus, Cirrhosis, Hepatitis, Ulcerative Colitis, Crohn's Disease or any other disease or disorder of the esophagus, stomach, liver, pancreas, intestine or colon) • Glandular (including Diabetes, Addison's, Cushing's, thyroid or any other disease or disorder of the endocrine system) • Heart or Blood Vessels (including Aneurysm, heart attack, stroke, high blood pressure requiring more than two medications to control, or any other disease or disorder of the heart, blood vessels or circulatory system) • Lung (including Asthma, Emphysema, COPD, Chronic bronchitis, Tuberculosis, Interstitial lung disease or any other disease or disorder of the lungs or airways) • Musculoskeletal (including Fibromyalgia, Lupus, Sjogren's syndrome, Osteoporosis, Muscular Dystrophy, Paralysis, Rheumatoid Arthritis, Autoimmune disorder or any other disease or disorder of the musculoskeletal system) • Renal or Reproductive (including disorders of the breasts, ovaries, prostate, bladder, kidney or any other disease or disorder of the urinary or reproductive organs)	☐ Yes ☐ No

Please provide details of all "Yes" answers. 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, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

I have read the completed statement of insurability form and all answers as they pertain to the person(s) listed. All statements and answers made on or attached to this form are true to the best of my knowledge and belief. I understand that the statements and answers will be used by Transamerica Life Insurance Company to determine insurability.

Any person who knowingly presents a false statement in a statement of insurability for insurance may be guilty of a criminal offense and subject to penalties under state law.

North Dakota and South Dakota residents: 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.

California residents: The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Florida residents: 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.

I also understand that coverage will become effective only if underwriting is approved by Transamerica Life Insurance Company.

For purposes of determining insurability, I hereby authorize any licensed physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, prescription drug service, health maintenance organization or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request. This authorization will be valid for 24 months, but I understand that I may revoke it at any time by giving written notice to Transamerica Life Insurance Company.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .

Employee's Signature _____

Signature of person for whom coverage is being requested _____
(or legal representative if such person is under the age of majority or is incapacitated)

Administrative Office Use Only: Request has been reviewed by the Administrative Office and is: ☐ Approved ☐ Declined Date: _____

Reviewer Name: _____ Reviewer Signature: _____

NOTICE TO APPLICANT

Information regarding your insurability will be treated as confidential. Transamerica Life insurance Company, or its reinsurers, may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.