TRANSAMERICA®
Employee Benefits

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Employer Name _____ Effective Date _____

Critical Illness and Accident Enrollment Form **Today's Date**:_____

Employee Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/ Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Social Security Number: _____

Date of Birth: _____ Date of Hire _____ Gender ☐ Male ☐ Female Tobacco User? ☐ Yes ☐ No

For Residents of CA, MA or MN Only: Are all proposed insured's covered under major medical, hospital or medical expense insurance, or an HMO contract? ☐Yes ☐No
Is anyone proposed for coverage covered by any Title XiX program (e.g. Medicaid)? ☐Yes ☐No

Critical Illness Enrollment Information

NEW ENROLLMENT ☐ CHANGE EXISTING ENROLLMENT ☐ COVERAGE EFFECTIVE DATE _____

Employee coverage amount requested:

☐ $ 10,000 ☐ $ 15,000 ☐ $20,000

Primary Beneficiary _____ _____ _____
(First Name) *(Last Name)* *(Relationship to employee)*

Who do you wish to cover?

☐ Employee Only ☐ Single Parent Family ☐ Two Adult Family

Enter the applicable monthly _____ premium amount from the rate grid: $ _____

☐ I ELECT this coverage. ☐ I DECLINE this coverage.

Accidental Injury Enrollment Information

NEW ENROLLMENT ☐ CHANGE EXISTING ENROLLMENT ☐ COVERAGE EFFECTIVE DATE _____

Employee coverage level requested:

Plan 1: Premium Amount (Payroll Cycle)	☐	Individual $	☐	Single parent family $	☐	Two adult family $	☐	Family $
Plan 2: Premium Amount (Payroll Cycle)	☐	Individual $	☐	Single parent family $	☐	Two adult family $	☐	Family $

☐ I ELECT this coverage. ☐ I DECLINE this coverage.

I elect to have premiums paid via pretax according to IRS Section 125? ☐**Yes** ☐**No**

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Employee Authorization

☐ **I elect to enroll.** *My signature below acknowledges that I am an employee in an eligible class of the indicated employer. I authorize my employer to deduct the premium indicated from my paycheck until I have instructed them in writing to stop the deduction.*

☐ **I elect to WAIVE coverage.** *I understand that I may be waiving benefits and benefit features that may not be available to me again.*

Do you agree to receive correspondence about your coverage electronically? ☐Yes ☐No

If yes, please provide email _____

Did you receive an Outline of Coverage describing the insurance you are applying for, if required in your state? ☐ Yes ☐ No

_____ _____

Employee Signature Date

**Employee and spouse are eligible for coverage if 64 years old or younger as of the effective date of coverage.*

***Dependent children are eligible for coverage up to age 26, regardless of student status.*

****For residents of CA, products are not available to anyone age 65 or older.*

Information on Covered Dependents

Employee Name | **Employer**

Full Name	Gender	Date of Birth	Beneficiary	Beneficiary relationship?
Spouse	☐ Male ☐ Female			
Tobacco User? ☐ **Yes** ☐ **No**		**Spouse Social Security #**		
Child	☐ Male ☐ Female			
Child	☐ Male ☐ Female			
Child	☐ Male ☐ Female			
Child	☐ Male ☐ Female			
Child	☐ Male ☐ Female			