# CARA TransAmerica
## Employer Application

**Employer Group Information**

| Effective Date : | | |
|---|---|---|
| Group Name : | | |
| Address : | | |
| City : | State : | Zip Code : |
| Contact Person : | | |
| Phone : | Fax : | |
| Email : | | |

| **CARA TransAmerica** | | **Number of Employees** |
|---|---|---|
| TransAccident (Off-the-Job Accident Plan) | | |
| | Total Premiums Due | $ |
| ☐ ACH ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually | Administration Fee * | $ |
| Note: ACH groups – Please complete the ACH form. | Grand Total | $ |

**Please make check payable to "CARA"**

* Please refer to ***AIS Administration Fee Schedule*** for your choice of billing option.

**Broker Information**

| Broker Name : | | |
|---|---|---|
| Firm Name : | | |
| Address : | | |
| City : | State : | Zip Code : |
| Phone : | Fax : | |
| Email : | | |
| Tax ID # or SSN # : | | |

**General Agent Information**

| GA Name : |
|---|
| GA Firm Name : |

**Please mail to: AIS * One Kaiser Plaza, Suite 1333 * Oakland, CA 94612 * Attn: New Business**

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

# TransAccident® Employee Application

☐ First Application ☐ Add Dependents – Certificate # ______ ☐ Increase Coverage – Certificate # ______

| Group Name | Group Number | Location |
|---|---|---|
| | | |

| Employee (Last, First, M.I.) | ☐ Male ☐ Female | Social Security No. | Date of birth | Date of marriage*** |
|---|---|---|---|---|
| Spouse** (Last, First, M.I.) | ☐ Male ☐ Female | Social Security No. | Date of birth | |

| Date of hire | Avg hours worked per week | Annual salary | Occupation | Employee ID |
|---|---|---|---|---|
| | | | | |

| Home address | Work phone/ext. |
|---|---|
| | |

| City | State | Zip code | Home phone |
|---|---|---|---|
| | | | |

| Child(ren) name | Date of birth | Full time student | Child(ren) name | Date of birth | Full time student |
|---|---|---|---|---|---|
| ______ | ______ | ☐Yes ☐No | ______ | ______ | ☐Yes ☐No |
| ______ | ______ | ☐Yes ☐No | ______ | ______ | ☐Yes ☐No |

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

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

Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other______

I Am Applying For: ☐ Individual ☐ Single Parent Family ☐ Family ☐ Two-Adult Family

| | | Premium per pay period* |
|---|---|---|
| ☐ Off-the Job Accident Basic Coverage | | $ |
| **ADDITIONAL RIDERS:** ***(Only available if included in the plan selected by your employer)*** | | |
| ☐ Off-the-Job Accident Disability Rider | Monthly Benefit*: ☐ $500 ☐ $1,000 | $ |
| ☐ Sickness Disability Rider | Monthly Benefit*: ☐ $500 ☐ $1,000 | $ |
| ☐ Wellness Rider | | $ |
| Industry Classification: ☐ A ☐ B ☐ C ☐ D-Disability Riders not available | Total Premium | $ |

*If increasing coverage, enter the **TOTAL** Monthly Benefit amount and Premium.

## Eligibility Questions

1. Is the employee actively at work on a full time basis and able to perform the regular duties of his/her occupation? ☐ Yes ☐ No
   If "No", you and your dependents are not eligible for coverage.
2. If applying for spouse** and/or child(ren) coverage, is any proposed insured currently disabled? ☐ Yes ☐ No
   If "Yes", List name(s)______, who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)
3. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s)______, who will be excluded from coverage.
4. In the past 5 years has any proposed insured had his or her driver's license suspended or revoked? Not Applicable
   If "Yes", List name(s)______, who will be excluded from coverage, unless included by special endorsement. (Give details on Page 2)

**The following questions should only be answered by the employee if the Sickness Disability Rider is included in the employer selected plan**

5. Indicate height and weight: **Employee** /
6. In the ten years prior to the application date, have you 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, reproductive, rheumatoid or neurological disorders, high blood pressure, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form? ☐ Yes ☐ No
   If "Yes", You are not eligible for coverage under this rider, unless included by special endorsement. (Give details on Page 2)

** Spouse or equivalent as defined by governing state law *** Marriage or equivalent as defined by governing state law

| | |
|---|---|
| 7. Have you been recommended to seek: 1) medical advice; 2) treatment; 3) care; and/or 4) counseling that has not yet been completed?<br>If "Yes", You are not eligible for coverage under this rider, unless included by special endorsement. (Give details below) | ☐ Yes ☐ No |
| 8. In the past 12 months have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to accident or illness, except for normal pregnancy?<br>If "Yes", You are not eligible for coverage under this rider, unless included by special endorsement.(Give details below) | ☐ Yes ☐ No |

Please provide details of all "Yes" answers to questions 2, 4, 6, 7, and 8. 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## APPLICANT'S STATEMENTS AND AGREEMENTS:

**For MA, NH and NJ residents only:** Did you receive an Outline of Coverage Form, which is required? ☐ Yes ☐ No

**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 also 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, 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 months premium must have been received by the underwriting company at its administrative office. **Lastly, 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 Transamerica Life Insurance Company, or its reinsurers, any such information.

**I understand** the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company 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, claim, 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) ____________________ .

Employee'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.

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

*Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Transamerica Life Insurance Company, 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.

** Spouse or equivalent as defined by governing state law *** Marriage or equivalent as defined by governing state law

# CARA Membership Application

The undersigned, whose address and telephone number are shown below, hereby makes application for membership in CARA, an unincorporated association, upon the terms and conditions herein provided.

Upon payment of the membership application fee in the amount of $15.00 and acceptance by CARA, the undersigned shall be entitled to all privileges and benefits as a CARA member, including participation in all CARA sponsored insurance programs for which such member shall be qualified and accepted.

In order to sustain membership in CARA, the member shall pay to CARA each year on or before the anniversary date of enrollment shown below, the annual dues established by the CARA Board of Directors. Said association dues shall be used by CARA solely for and in consideration of membership in the association.

The undersigned agrees to abide by the association's laws and such other membership rules as may be promulgated by the CARA Board of Directors from time to time.

Group Name: ______________________________________________

Address: ______________________________________________

Telephone Number: ______________________

Signature: ______________________

Title: ______________________

Date: ______________________

For internal use:

Accepted by CARA ______________________
Signature

# AIS

(In Nevada, also known as EWC Insurance Services, Inc.)

# Administration Fee Schedule

| Monthly | ACH (Auto Bank Draft) [1] | By Mail |
|---|---|---|
| 1 to 4 Employees | $ 3.50 | $ 10.00 |
| 5 > Employees | $ 3.50 | $ 20.00 |
| CARA Annual Fee [2] | Waived | $ 15.00 |

**Other Billing Options:**

| By Mail | Quarterly | Semi-Annually [3] | Annually |
|---|---|---|---|
| 1 to 4 Employees | $ 20.00 | $ 25.00 | $ 25.00 |
| 5 > Employees | $ 30.00 | $ 25.00 | $ 25.00 |
| CARA Annual Fee [2] | $ 15.00 | $ 15.00 | $ 15.00 |

**Please make check payable to "CARA".**

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1 ACH groups will not receive any monthly statements.

2 CARA Annual Fee is due on anniversary month.

3 SINGLE employee groups requesting "Mail Billing" are required to pay semi-annually.

## AUTHORIZATION AGREEMENT FOR DIRECT PAYMENTS (ACH DEBITS)

**E.W.C. INSURANCE SERVICES, INC. DBA AIS**

**I (we) hereby authorize E.W.C. Insurance Services, Inc. DBA AIS, hereinafter called COMPANY, to initiate *debit entries* to my/our CHECKING account indicated below at the Depository Financial Institution named below, hereinafter called DEPOSITORY, and to debit the same to such account on the ☐ 5th or ☐ 20th of each month (select one). I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.**

**DEPOSITORY NAME ______________________________ BRANCH__________**

**CITY____________________STATE ______________ZIP CODE__________**

**ROUTING#____________________ACCOUNT#____________________**

**This authorization is to remain in full force and effect until COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.**

**NAME(S)______________________________ CLIENT #________________**
FOR INTERNAL USE ONLY

**DATE____________SIGNED X______________________________**

***NOTE: All written debit authorization MUST provide that the receiver may revoke the authorization only by notifying the originator in the manner specified in the authorization within 30 days. This form is to be submitted along with 1st month's premium and/or a copy of 'VOID' check.***

sample check

Any Name
1234 Any Street
City, State Zip Code

2345

DATE____________

Pay to the order of ______________________________

______________________________ *Dollars*

Depository Name

**Bank Name**

Branch

Main Branch
1234 Any Street
City, State Zip Code
(800) 555-1234

______________________

⑆123456789⑆ 2345 ⑈1234567890

Routing Number    Account Number