NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

ASCE | MEMBER ADVANTAGES

TRANSAMERICA PREMIER LIFE INSURANCE COMPANY
Admin. Office: 100 Light Street, Baltimore, Maryland 21202

APPLICATION

1. YES, ENROLL ME IN THE GROUP $3,500 FIRST DIAGNOSIS

Member's Name (Last, First)

Street Address | City | State | ZIP

Email Address | Daytime Phone | Work Phone

2. COMPLETE YOUR MEMBER INFORMATION

MONTHLY Premiums: Please check one

Member Only: ❍ $12.95 (per month) **Family:** ❍ $19.95 (per month)

❍ **OPTION 1:** DIRECT BILLING: Following your initial billing, you will be billed (Choose one): ❍ Semiannually ❍ Quarterly

❍ **OPTION 2:** ELECTRONIC FUNDS TRANSFER: I request and authorize the ASCE Group Insurance Program to make monthly withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group First Diagnosis Cancer Insurance Plan. (Enclose a VOIDED check or deposit slip, as applicable.) To terminate automatic withdrawal, please contact the plan administrator at 800.650.2723.

X

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT **DATE**

❍ **OPTION 3:** CREDIT CARD: I authorize premium contributions to be charged to my credit card monthly:

Credit Card: ❍ MasterCard ❍ Visa ❍ Discover ❍ American Express

Credit Card #: _____ Exp. Date _____

X

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT **DATE**

3. IF, IN ADDITION TO YOURSELF, YOU ARE APPLYING FOR FAMILY COVERAGE, COMPLETE BELOW AS APPLICABLE.

	Name	Date of Birth	Sex
Dependent Name (First/Last)		/ /	❍ Male ❍ Female
Dependent Name (First/Last)		/ /	❍ Male ❍ Female
Dependent Name (First/Last)		/ /	❍ Male ❍ Female

4. PLEASE READ, SIGN AND DATE:

I hereby represent that to the best of my knowledge, no person to be insured under this policy has been diagnosed with Cancer or received treatment* for Cancer excluding Skin Cancer, Leukemia and Hodgkin's Disease with the last 6 months.

(Treatment means medical and surgical care by a licensed provider to detect or cure cancer. This includes examination, diagnostic procedures, surgery (including pre-and post-operative care), prescribed medication, and the application of remedies and therapy. It does not include any diagnostic procedures or examinations performed to monitor a previous removal or remedy of cancer, provided there is no positive diagnosis of cancer or of a recurrence of cancer.)

If you answered "Yes," please indicate the name(s) of the person(s) and their corresponding medical condition(s): _____

_____

_____

It is understood that any person listed above will not be eligible for coverage except any person listed with skin cancer. Any person listed with skin cancer will be eligible for coverage. Benefits, however, will not be payable for skin cancer. It is understood that no benefits will be payable for expenses incurred during the first 12 months of coverage for any cancer diagnosed or treated within the first 45 days after the insured person's effective date of coverage **(NOT APPLICABLE TO RESIDENTS OF AZ, MO, TX, & WI.)**

Your coverage will be effective on the first day of the month following acceptance of your application, provided your first premium is paid and you are not hospital-confined on that date.

Are you or any dependents eligible for Medicare? ❍ Yes ❍ No

Notice to Consumer:
THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. ALSO, THE BENEFITS PROVIDED BY THIS POLICY 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.

NOTICE: This policy may only be issued if you have minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code, or you are treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States pursuant to Code section 5000A(f)(4)(B). If you have employer-sponsored coverage, COBRA coverage, insurance purchased from DC Health Link, Medicare, or other similar insurance, you likely have minimum essential coverage. If your minimum essential coverage is terminated for any reason, you should notify the company immediately.

Questions (1), (2), and (3) below are not required for applicants age 65 or older.

(1) Do you have comprehensive medical coverage including the minimum essential coverage required by the Affordable Care Act (ACA) or are you treated as having minimum essential coverage due to your status as a bona fide resident of any possession of the United States? ❍ Yes ❍ No

If you answered NO to question 1, you are not eligible for this policy, in the form of hospital or fixed indemnity insurance.

(2) Do you understand most supplemental only policies may not pay full benefits if your ACA compliant minimum essential coverage plan is not in force? ❍ Yes ❍ No

(3) Do you understand that the benefits provided under this policy may be limited? ❍ Yes ❍ No

Signature of Member X	**Date**
(Please sign and date in ink)	
Signature of Spouse X	**Date**

DC and OH Residents: 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 crime and may be subject to fines or confinement in prison.

CA4000GAM R1015

Please complete this form and return to
ASCE Plan Administrator:

PEARL INSURANCE®
1200 E. Glen Ave., Peoria Heights, IL 61616-5348
Questions, please call 800.650.2723

6. IMPORTANT NOTICE TO PERSONS ON MEDICARE

THIS POLICY OR CERTIFICATE DUPLICATES SOME MEDICARE BENEFITS. **THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY.** This policy or certificate provides limited benefits, if you meet the policy conditions, for hospital and medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy or certificate. It does not pay you medicare deductibles or coninsurance and is not a substitute for a Medicare supplement insurance policy.

This policy or certificate duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy.
- Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services, regardless of the reason you need them. These include:

- Hospitalization • Physician services • Hospice • Other approved items and services

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.