

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



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)		/ /	<input type="radio"/> Male <input type="radio"/> Female
Dependent Name (First/Last)		/ /	<input type="radio"/> Male <input type="radio"/> Female
Dependent Name (First/Last)		/ /	<input type="radio"/> Male <input type="radio"/> 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.

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

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

Signature of Spouse X _____ **Date** _____

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.
CA4000GAM.CA (Rev. 6-07)

5. 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 coinsurance 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.

Please complete this form and return to
ASCE Plan Administrator:

