

First Application       Add Dependents – Certificate # \_\_\_\_\_       Increase Coverage – Certificate # \_\_\_\_\_

Group Name **Arcadia Services, Inc.**      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	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F	Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Child(ren) name	Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> F	Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
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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*

**TransChoice® Plus** Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA

	Plan I	Weekly Premium	Plan II	Weekly Premium	Plan III	Weekly Premium	Add Group Term Life with AD&D Rider*	Add Short-Term Disability (Employee Only)
 Employee Only	<input type="checkbox"/>	\$ 13.86	<input type="checkbox"/>	\$ 22.36	<input type="checkbox"/>	\$ 29.68	<input type="checkbox"/>	\$ 2.12
Employee plus Spouse	<input type="checkbox"/>	\$ 23.99	<input type="checkbox"/>	\$ 39.97	<input type="checkbox"/>	\$ 53.68	<input type="checkbox"/>	\$ 3.12
Employee plus Child(ren)	<input type="checkbox"/>	\$ 24.18	<input type="checkbox"/>	\$ 40.51	<input type="checkbox"/>	\$ 53.62	<input type="checkbox"/>	\$ 2.32
Employee plus Family	<input type="checkbox"/>	\$ 34.42	<input type="checkbox"/>	\$ 58.27	<input type="checkbox"/>	\$ 77.85	<input type="checkbox"/>	\$ 3.31

STD not available in: CA, NJ, NY, PR, or RI  
 \*AD&D not available for children

**Dental** Underwritten by BNLAC      **Vision** Underwritten by BNLAC

	Weekly Premium		Weekly Premium
 Employee Only	<input type="checkbox"/> \$ 5.22	 Employee Only	<input type="checkbox"/> \$ 1.88
Employee plus Spouse	<input type="checkbox"/> \$ 10.32	Employee plus Spouse	<input type="checkbox"/> \$ 2.98
Employee plus Child(ren)	<input type="checkbox"/> \$ 12.62	Employee plus Child(ren)	<input type="checkbox"/> \$ 3.04
Employee plus Family	<input type="checkbox"/> \$ 17.97	Employee plus Family	<input type="checkbox"/> \$ 4.83

Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? *(Residents of KY or VA- do not answer.)*  Yes  No  
 If "Yes", List name(s) \_\_\_\_\_, who will be excluded from coverage.

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

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.

**All states except FL, LA, NJ, or VA-** 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 (may be a crime and may subject such person to criminal and civil penalties in OR).

**FL-** 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.

**LA-** I understand that any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NJ-** I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**VA-** I understand that any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

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, 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 enrollment form in no way implies that I will be accepted for insurance coverage.

My signature below authorizes my employer to reduce my wages by the amounts required to pay for my elections. This agreement is subject to the terms of the Premium Conversion Section 125 Plan (as may be amended) and revokes any prior election and compensation reduction agreement relating to the Premium Conversion Plan.

Signed in (City/State) \_\_\_\_\_ This \_\_\_\_\_ Day of (Month/Year) \_\_\_\_\_

Employee's Signature \_\_\_\_\_ Spouse's\*\* Signature (if applicable) \_\_\_\_\_

Licensed Representative's Name \_\_\_\_\_ Licensed Representative's Signature \_\_\_\_\_ Agent # \_\_\_\_\_