

# Florida

## APPLICATION KIT

### **Index Universal Life**

- Freedom Global IUL II<sup>SM</sup>
- Freedom Index Universal Life II<sup>SM</sup>

### **Universal Life**

- Accumulation UL

# Transamerica Life Insurance Company New Business Cover Sheet

Fax to: 866.297.3607

Date: \_\_\_\_\_ Number of pages including this cover sheet: \_\_\_\_\_

Agent # \_\_\_\_\_ Agent Name \_\_\_\_\_

Agent Phone # \_\_\_\_\_ Agent Fax # \_\_\_\_\_

Proposed Insured's Name \_\_\_\_\_

Best time of day / evening to call: \_\_\_\_\_ Special language needs? \_\_\_\_\_

If this is a companion policy, write companion name: \_\_\_\_\_

## Forms Checklist

### For All Products

- | Primary Insured          | Additional Insured       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Application   |
| <input type="checkbox"/> | <input type="checkbox"/> | HIPAA Authorization Form  |
| <input type="checkbox"/> | <input type="checkbox"/> | Terminal Illness Form, <b>if applicable</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | Initial Premium or Pre-authorization Form   |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV Consent Form, <b>if applicable</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | Replacement Form, <b>if applicable</b><br>Form must be dated same as, or earlier than the application                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Illustration, <b>if applicable</b><br>All pages are required in NAIC states for Universal Life                            |
| <input type="checkbox"/> | <input type="checkbox"/> | IUL Only- Statement of Understanding<br><u>AND</u> IUL Supplemental App   |
| <input type="checkbox"/> | <input type="checkbox"/> | Transfer or 1035 Exchange Form <b>if applicable</b><br>Mail original 1035 form, within 5 working days of the fax          |
| <input type="checkbox"/> | <input type="checkbox"/> | Health Questionnaire (list type), <b>if applicable</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical Requirements, <b>if applicable</b><br>Order all necessary Medical Requirements, indicate orders on Agent's Report |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this an Internal Replacement / or Conversion?<br>If yes, Policy number _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (please explain) _____  |

**TransACE®  
TransACE CV®  
TransTerm®**

**Office ID# 14610**

For illustration software go to [www.agentnetinfo.com](http://www.agentnetinfo.com), Software Downloads, TransWare

When completing the APA40 app be sure to indicate:

- Underwriting Class** being applied for exactly as it appears on the illustration.
- Kind Code** - also found on the quote page of the illustration.
- RAP** (Required Annual Premium). This amount is found in the upper left corner of the Producer Quote page of the illustration.

#### Company Scheduled to do Paramed

- |                               |                                     |                                |
|-------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> APPS | <input type="checkbox"/> ExamOne    | <input type="checkbox"/> Other |
| <input type="checkbox"/> EMSI | <input type="checkbox"/> Portamedic |                                |

Lab Slip/Bar Code #: \_\_\_\_\_ Date Taken: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

**Tip!** To speed processing...

- Submit initial application and forms **ONLY ONCE**, either via fax or mail
- Retain your original copy of this fax, as we reserve the right to request a re-fax of the original if we are unable to read the fax. Do NOT mail original application and forms unless requested.
- Print legibly, in English, and use black ink
- Do NOT use white-out
- Make sure all necessary supplemental forms are included

Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

**PROPOSED INSURED INFORMATION**

1. Name (First, M.I., Last)			2. Mailing Address (Cannot be a P.O. Box) City, State, Zip			
3. Home Telephone No. ( )		4. Work Telephone No. ( )		5. Birth Date	Age	6. Birth State / Country
7. Height	8. Weight	9. Marital Status		10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	11. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No	12. If no, give immigration status/type of visa:
13. Occupation & Duties			14. Annual Income Current Year _____ Annual Income Previous Year _____ Net Worth _____			15. Social Security No. or Tax I.D. No.
						16. Drivers License No./ State
						17. E-mail Address

18. Have you used any tobacco or nicotine products within the last 5 years?  Yes  No If yes, list type and when used last

**BENEFICIARY AND OWNER DESIGNATION** (Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed Insured.)

19. Primary		Relationship		Primary		Relationship	
Primary		Relationship		20. Contingent		Relationship	

**OWNER** (Unless otherwise noted, the Owner will be the Insured. For Florida applicants, you may name a secondary addressee to receive notice of possible lapse in coverage - complete the Additional Information section.)

21. Name			a. Relationship to Proposed Insured		b. Social Security Number	
c. Address (Cannot be a P.O. Box)				d. Birth Date		e. Phone ( )
f. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ <input type="checkbox"/> Type of VISA _____						

**POLICY INFORMATION**

22. Plan: UL _____		Term _____		23. Amount of Insurance		24. Planned Premium	
<input type="checkbox"/> Level <input type="checkbox"/> Increasing		Guarantee Period _____		\$		\$	

25. Mode of Payment (for bank draft, complete authorization, and collect initial payment.)  
 Monthly Bank Draft  Quarterly  Semiannually  Annually  Other \_\_\_\_\_

**26. ADDITIONAL BENEFITS and AMOUNTS**

<input type="checkbox"/> Additional Insured Rider (AIR) \$ _____	<input type="checkbox"/> ROP \$ _____
<input type="checkbox"/> Base Insured Rider (BIR) \$ _____	<input type="checkbox"/> Critical Illness Accelerated Death Benefit Rider \$ _____
<input type="checkbox"/> Children's Benefit Rider \$ _____	<input type="checkbox"/> Waiver of Premium Benefit Rider (WP)
<input type="checkbox"/> Accidental Death Benefit Rider (ADB) \$ _____	<input type="checkbox"/> Waiver of Monthly Deduction
<input type="checkbox"/> Monthly Disability Income Rider Monthly Payout \$ _____	<input type="checkbox"/> Guaranteed Death Benefit No Lapse Rider
<input type="checkbox"/> Guaranteed Insurability Rider (GIR) \$ _____	

27. Name of Proposed Additional Insured(s) including any children applying	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last.
								<input type="checkbox"/> No <input type="checkbox"/> Yes _____
								<input type="checkbox"/> No <input type="checkbox"/> Yes _____
								<input type="checkbox"/> No <input type="checkbox"/> Yes _____
								<input type="checkbox"/> No <input type="checkbox"/> Yes _____

**28. LIFE INSURANCE IN FORCE** If none check this box

Insured's Name	Company (only need if replacing)	Policy Number (only need if replacing)	Face Amount
			\$
			\$
			\$

**29. DISABILITY INCOME - INSURANCE IN FORCE** If none check this box  Complete only if applying for Disability Rider.

Insured's Name	Company	Policy Number	Monthly Amount	Benefit Period	Elimination Period

**30. GENERAL QUESTIONS** Complete the following. For YES answers, give full details in the space provided in Section 52.

31. Will the insurance applied for replace or change any existing insurance or annuity? .....  Yes  No
- Have you or any proposed Additional Insured (including any children applying),**
32. Had any health, disability or life insurance pending or contemplated with another company?.....  Yes  No
33. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? .....  Yes  No
34. Within the past 5 years,
- a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? .....  Yes  No  
(If yes, provide state and drivers license number.)
- b. Been or is now fully or partially disabled? .....  Yes  No
- c. Been charged with or convicted of any felony or been on probation?.....  Yes  No
35. Within the past 2 years, (any yes answer to 35a or 35b, complete the Aviation and Avocation Questionnaire)
- a. Taken part in any type of motor vehicle racing, mountain climbing, underwater or sky diving, hang gliding or plan to within the next 2 years?...  Yes  No
- b. Flown other than as a passenger, or plan to within the next 2 years? .....  Yes  No
- c. Foreign residence or travel contemplated? .....  Yes  No
36. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? .....  Yes  No
37. Family History: To the best of the applicant's knowledge is there a history of cardiovascular disease (including coronary artery disease, stroke or transient ischemic attack), internal cancer or melanoma in parents/siblings prior to age 60? If yes, please provide details including, type of cancer (if applicable) and if there was a death due to this condition.....  Yes  No
38. Have you or any proposed Additional Insured sought protection from creditors within the past 5 years? .....  Yes  No
39. Do you or any proposed Additional Insured currently or within the past two years consume six or more alcoholic beverages per week? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions.....  Yes  No
40. Have you or any proposed Additional Insured had any weight change of 10 or more pounds in the past year? .....  Yes  No

**41. MEDICAL QUESTIONS** Each question must be individually asked and answered. For YES answers, give full details in the space provided in Section 52.

42. Have you or any proposed Additional Insured (including any children applying) EVER been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?.....  Yes  No
- (Questions 43 to 49) Within the past 10 years, have you or any proposed Additional Insured (including any children applying) been treated or diagnosed by a licensed member of the medical profession as having any disease or disorder (an abnormal physical or mental condition) of the:**
43. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? .....  Yes  No
44. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)?.....  Yes  No
45. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)?.....  Yes  No
46. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder?.....  Yes  No
47. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? .....  Yes  No
48. Endocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)?.....  Yes  No
49. Cancer, tumor, polyps, melanoma or other malignancy? .....  Yes  No
50. Have you or any proposed Additional Insured (including any children applying) had or been advised by a licensed member of the medical profession to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? .....  Yes  No
51. Are you or any proposed Additional Insured (including any children applying) currently under the observation of a physician or taking medication? .  Yes  No

**52. ADDITIONAL INFORMATION** Explain all "yes" answers below. If additional space required, use Supplemental Form SA-ADINFO.

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations) Medical Facilities & Physicians Names, Addresses, Phone Numbers

**53. PERSONAL PHYSICIAN(S)** If additional space required, use Supplemental Form SA-ADINFO.

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

**SECTION 54. ILLUSTRATION CERTIFICATION** The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application. (Universal Life only)

The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

**Applicant's/Owner's statement:** By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

**ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S)** –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Transamerica Life Insurance Company, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, 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 may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

**I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, (3) Notice of Insurance Information Practices, and (4) Disclosure for Accelerated Terminal Illness Benefit, if required. I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.**

**I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.**

Please make checks payable to Transamerica Life Insurance Company. Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with application: \$ \_\_\_\_\_ **Best time for a personal history interview:** \_\_\_\_\_ a.m. / p.m. **Okay to contact at work?**  Yes  No

**FRAUD WARNING:** 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.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
 City State Month Year

\_\_\_\_\_  
 Signature of proposed Insured (if age 15 or over)

\_\_\_\_\_  
 Signature of proposed Owner (if other than proposed Insured)

\_\_\_\_\_  
 Signature of Parent or Legal Guardian (if proposed Insured is under 18 and Parent/Guardian has not signed as Owner)

\_\_\_\_\_  
 Signature of Additional Insured

**SECTION 55. TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER CERTIFICATION**

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

**FRAUD WARNING:** 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.

**Signature of Proposed Owner** \_\_\_\_\_ **Date** \_\_\_\_\_

**SECTION 56. AGENT INFORMATION & SIGNATURE**

Signature of Agent ( )	(Print First and Last Name) ( )	Agent # and Florida License Identification # _____
Telephone Number _____	Agent Fax # _____	Agent E-mail Address _____
Split Agent Signature (If Applicable) ( )	(Print First and Last Name) ( )	Agent # and Florida License Identification # _____
Telephone Number _____	Agent Fax # _____	Agent E-mail Address _____
<ul style="list-style-type: none"> <li>• Did you ask all questions on the application in the presence of all proposed Insureds, record the answers as given, and witness all signatures? <input type="checkbox"/> Yes <input type="checkbox"/> No If not, please provide details. _____</li> <li>• Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, submit the state required forms.)</li> </ul>		

# CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

## PLEASE READ THIS CAREFULLY

**No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the Conditional Receipt.**

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from \_\_\_\_\_, the sum of \$\_\_\_\_\_ for the insurance application dated \_\_\_\_\_, with \_\_\_\_\_ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

**The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or \$500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.**

### Authorization (Signatures Required)

**I certify that I have read and reviewed the Conditional Receipt and the acknowledgment of the applicant and proposed Insured in the application. The terms and conditions of the conditional receipt have been explained to me fully by the agent and I understand them.**

**FRAUD WARNING:** 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.

Dated at \_\_\_\_\_ on \_\_\_\_\_  
City State Date Signature of Agent or Authorized Company Rep

\_\_\_\_\_  
Signature of proposed Insured Signature of Applicant (if other than proposed Insured)

## DETACH AND LEAVE THIS PAGE WITH APPLICANT

### NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

**Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.**

### MIB GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured: Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may, upon request, supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

### NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Transamerica Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

**PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.**

## AGENT'S REPORT

How well do you know proposed Insured? \_\_\_\_\_

Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance? Yes    No

*(If "yes," explain in Remarks Section)*

Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?)

*(If "yes," explain relationship \_\_\_\_\_)*

Did you see all of those to be insured on the date the application was written? *(If "no," explain in Remarks Section)*

Class of Risk Quoted:

Term

- Preferred Plus
- Preferred Nontobacco
- Standard Plus
- Standard Nontobacco
- Preferred Tobacco
- Standard Tobacco

UL & IUL

- Preferred Elite
- Preferred Plus
- Preferred
- Non-Tobacco
- Preferred Tobacco
- Tobacco

1. Agent's Name	Agent No.	% if Split
2. Agent's Name	Agent No.	% if Split

**COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED**  
 What is the relationship of the Owner to the primary Insured (please explain)?  
 \_\_\_\_\_  
 What is the relationship of the Payor to the primary Insured (please explain)?  
 \_\_\_\_\_

ADDITIONAL REMARKS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed Insured not fully set forth herein. I will not deliver the policy if the health of the Insured has changed.

\_\_\_\_\_  
Signature of Writing Agent

## PRE-AUTHORIZED WITHDRAWAL PLAN

I/we, the undersigned, hereby authorize and request \_\_\_\_\_ to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my/our account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I/we request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I/we agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I/we understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This Authorization may be terminated by either party by giving written notice to the other.

### INITIAL PAYMENT (MUST CHECK ONE BOX)

- CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.
- AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

**Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.**

### ACCOUNT INFORMATION

<b>TAPE VOIDED CHECK HERE</b> <b>(Place tape along TOP of check)</b>			
<b>If not attaching void check or if withdrawing from Savings Account, complete the following information</b>			
_____			
Bank Name, Office or Branch			
_____			
Bank Address	City	State	Zip Code
_____	_____	_____	_____
Payor Name(s)		Check one: <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
_____	_____		
Transit Routing Number	Account Number		
_____	_____		

### COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

<b>Premium to Withdraw</b> \$ _____	<input type="checkbox"/> Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
	<input type="checkbox"/> Withdraw on a different day of the month; choose a day between 1 and 28 _____

### SIGNATURE

<b>Payor Signature(s)</b> – as on financial institution's records. A copy is as valid as the original.	
X _____	<b>Date:</b> _____



**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Signature of Primary Proposed Insured/Patient or Personal Representative	Date
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

Parent       Legal guardian       Power of Attorney       Other (please describe): \_\_\_\_\_

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): \_\_\_\_\_

**A copy of this authorization will be considered as valid as the original.**

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

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1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
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- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
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Parent       Legal guardian       Power of Attorney       Other (please describe): \_\_\_\_\_

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): \_\_\_\_\_

**A copy of this authorization will be considered as valid as the original.**

**Monumental Life Insurance Company**

**Transamerica Life Insurance Company**

**Stonebridge Life Insurance Company**

**Western Reserve Life Assurance Co. of Ohio**

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499. Telephone: (319) 355-8511

### **NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE**

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

YES

NO

**DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.**

I have read this notice and received a copy of it.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's Name (Printed or Typed)

\_\_\_\_\_  
Agent's Address (Printed or Typed)

\_\_\_\_\_  
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name

Policy Number

Name of Insured

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Monumental Life Insurance Company**

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Florida regulations give you the right to receive a written Comparative Information form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

YES

NO

**DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.**

I have read this notice and received a copy of it.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent's Name (Printed or Typed)

\_\_\_\_\_  
Agent's Address (Printed or Typed)

\_\_\_\_\_  
Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name

Policy Number

Name of Insured

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# Exhibit B

## COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

\_\_\_\_\_  
(Proposed Insured)

\_\_\_\_\_  
(Insurer's Address)

\_\_\_\_\_  
(Replacing Agent's Name)

### APPLICANT INFORMATION

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone (\_\_\_\_) \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

### POLICY INFORMATION

Policy Generic Name \_\_\_\_\_  
 Policy Number \_\_\_\_\_  
 Date of Issue \_\_\_\_\_ Issue Age \_\_\_\_\_  
 Contestable Period Expires \_\_\_\_\_  
 Suicide Period Expires \_\_\_\_\_  
 Policy Loan Rate \_\_\_\_\_

### POLICY/RIDER DESCRIPTION

POLICY/ RIDER NAME	INITIAL/ CONTINUING BENEFIT	(Age) BENEFIT FROM TO	INITIAL/ RENEWAL ANNUAL PREMIUM	(Age) PAYABLE FROM TO
-----------------------	-----------------------------------	--------------------------	---------------------------------------	--------------------------

TOTAL INITIAL ANNUAL PREMIUM \$ \_\_\_\_\_ MODE OF PYMT. \_\_\_\_\_ AMT. \$ \_\_\_\_\_

TOTAL RENEWAL ANNUAL PREMIUM \$ \_\_\_\_\_ AMT. \$ \_\_\_\_\_

#### COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

Yr Age	GUARANTEES				PROJECTIONS*			
	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
55								
60								
65								
75								
85								
95								

\*Projections include dividends and current interest rates which are not guaranteed.

**IMPORTANT NOTICE:**

The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implications.

REMARKS:\*\*

\*\* This space may be used for information regarding newly developed or unusual type products or other comments an agent might want to convey to his prospect.

## INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM

1. In the disclosure of values premiums shall be shown only if they increase the cash value or death benefits for the primary insured.
2. Any benefits for secondary insureds shall be shown on a supplementary exhibit.
3. Values will be shown for each year in which either an initial change in face value or premium payment occurs.

# Exhibit B COMPARATIVE INFORMATION FORM FOR PROPOSED INSURANCE

\_\_\_\_\_  
(Proposed Insured)

\_\_\_\_\_  
(Insurer's Address)

\_\_\_\_\_  
(Replacing Agent's Name)

## APPLICANT INFORMATION

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone (\_\_\_\_) \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

## POLICY INFORMATION

Policy Generic Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Date of Issue \_\_\_\_\_ Issue Age \_\_\_\_\_  
Contestable Period Expires \_\_\_\_\_  
Suicide Period Expires \_\_\_\_\_  
Policy Loan Rate \_\_\_\_\_

## POLICY/RIDER DESCRIPTION

POLICY/ RIDER NAME	INITIAL/ CONTINUING BENEFIT	(Age) BENEFIT FROM TO	INITIAL/ RENEWAL ANNUAL PREMIUM	(Age) PAYABLE FROM TO

TOTAL INITIAL ANNUAL PREMIUM \$ \_\_\_\_\_ MODE OF PYMT. \_\_\_\_\_ AMT. \$ \_\_\_\_\_

TOTAL RENEWAL ANNUAL PREMIUM \$ \_\_\_\_\_ AMT. \$ \_\_\_\_\_

### COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED

Yr Age	GUARANTEES				PROJECTIONS*			
	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMLTV PREMIUM	CASH VALUE	DEATH BENEFIT
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- Monumental Life Insurance Company
- Stonebridge Life Insurance Company
- Transamerica Life Insurance Company
- Western Reserve Life Assurance Co. of Ohio

4333 Edgewood Road NE, Cedar Rapids, IA 52499

**Notice and Consent for  
HIV-Related Testing  
FLORIDA**

To evaluate your insurability, the Insurer designated above (“the Insurer”) has requested that you provide a sample of your bodily fluid(s) for testing and analysis. This is to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

**Pre-Testing Considerations**

Many public health organizations have recommended that before taking an HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

**Meaning of a Positive Test Result**

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

**Confidentiality of Test Results**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law; or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer; or may be disclosed to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results may be reported to an insurance medical information exchange under procedures that are designed to assure confidentiality. This might include the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS. Information might also be reported for the preparation of statistical reports that do not disclose the identity of any particular person.

**Notification of Test Results**

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health. A trained person should deliver that information so that you can understand clearly what the test result means. Please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name and address of physician for reporting a positive test result:

Name	Address
Phone Number	City, State, Zip Code

**Consent**

**I have read and I understand this *Notice and Consent for HIV-Related Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing*. I voluntarily consent to providing a sample of bodily fluid(s), the testing of my bodily fluid(s) and the disclosure of the test results as described above.**

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Please Print)	Date of Birth
Signature of Proposed Insured or Parent/Guardian	State of Residence
Date	

- Monumental Life Insurance Company
- Stonebridge Life Insurance Company
- Transamerica Life Insurance Company
- Western Reserve Life Assurance Co. of Ohio

4333 Edgewood Road NE, Cedar Rapids, IA 52499

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FLORIDA**

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Name	Address
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I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured (Please Print)	Date of Birth
Signature of Proposed Insured or Parent/Guardian	State of Residence
Date	

## AGENT REPLACEMENT GUIDE

The following are guidelines on how to submit life insurance business to the company under the Replacement Regulation. Please take time and review the below information carefully, so we can continue to process your business quickly and efficiently. Thanks for your help and cooperation.

### **EVEN IF YOUR CUSTOMER IS NOT REPLACING HIS OR HER POLICY, YOU MAY BE REQUIRED TO LEAVE A REPLACEMENT NOTICE.**

#### **Situation #1: YOUR CUSTOMER DOES NOT HAVE EXISTING LIFE INSURANCE**

- When your customer does not have existing life insurance or only has life insurance purchased by his or her employer **you are only required to ask the replacement questions in the application.**

#### **Situation #2: YOUR CUSTOMER DOES HAVE EXISTING LIFE INSURANCE, BUT IS NOT REPLACING**

- You must read the Replacement Notice (Notice) aloud to your customer (There is a box for the customer to opt out of having the Notice read to them; it must be marked if the customer opted out.)
- You and your customer must sign and date the Notice
- A copy of the Notice must be left with your customer
- You must send in the Notice with the application

#### **Situation #3: YOUR CUSTOMER IS REPLACING LIFE INSURANCE**

- You must read the Notice aloud to your customer (There is a box for the customer to opt out of have the Notice read to them, it must be marked if the customer opted out.)
- You must complete the Notice -Please use the below examples of acceptable replacements as a guide
  1. Change in family status-divorce/death/dependants
  2. Higher guaranteed cash value
  3. Higher death benefit for the same premium
  4. Lower premium for the same death benefit
  5. Termination of a substantial existing policy loan
  6. Poor performance of existing policy in relation to expectations
  7. Improved underwriting class
  8. Significantly better financial rating than existing company
  9. Policy owner wants/does not want a separate account
  10. Unresolvable ownership or beneficiary problem
  11. Agent relationship issue
  12. Need or want for permanent insurance
  13. Changing insurance needs or objectives
- You and your customer must sign and date the Notice
- A copy of the Notice must be left with your customer
- You must send in the Notice with the application

**In addition, you must:**

- Leave all the sales materials as defined below with the customer (sales illustrations may be given at policy delivery)
- You must sign a statement provided by the company that you have used only approved sales material in the solicitation
- The above statement must be sent in with the application

**Below are the definitions that are important to you.**

**Financed purchase-** the purchase of a new policy involving the use of funds obtained by the withdrawal or surrender of or by borrowing from values of an existing policy to pay all or part of any premium due on a new policy.

**Replacement-** an internal or external transaction in which a new policy or contract is to be purchased, and it is known or should be known to the agent, that by reason of the transaction, an existing policy or contract has been or is to be:

1. Lapsed, forfeited, surrendered or partially surrendered, assigned to the replacing insurer or otherwise terminated
2. Converted to reduced paid-up insurance, continued as extended term insurance, or otherwise reduced in value by the use of nonforfeiture benefits or other policy values
3. Amended so as to effect either a reduction in benefits or in the term for which coverage would otherwise remain in force or for which benefits would be paid
4. Reissued with any reduction of cash value or;
5. Is a financed purchase.

**Sales material-** Includes illustrations for the product purchased and any material created or provided by the company or agent related to the policy or contract which is purchased. (i.e.: a brochure which describes the product)

If your customers are replacing their policy, they will receive an additional letter with their policy. This letter will inform them to keep all their sales material and give them a number to call if the sales material is not left behind.

**In addition,** for claims on policies that replaced coverage with the same or an AEGON-affiliated company, the company will credit the period of time that elapsed under the replaced policy's incontestable and suicide period up to the face amount of the replaced policy.



Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA

APPLICATION AMENDMENT

Life Insured: @@@@...

The Application for Policy/Certificate ("Policy") No. @@@@...is amended as follows:

REQUEST TO BACKDATE POLICY TO "SAVE AGE"

I request that Transamerica Life Insurance Company ("Transamerica") date the life insurance Policy for which I am applying in the application so as to "save age." I understand that dating to "save age" means that each of the regular premium payments I make on the Policy will be lower in dollar amounts than if I did not date to "save age." I also recognize that dating to save age means part of my first premium payment will be for a period of time during which insurance coverage will not be in effect. The precise length of that period will depend on a number of factors, such as:

- (a) how far back in weeks or months the Policy needs to be dated in order to qualify for the younger insurance age,
(b) how long it takes to process my application, which includes how quickly I respond to any requests for information from Transamerica, and
(c) how quickly I am able to obtain delivery of the Policy and make the first premium payment, which in most cases is when coverage commences.

I further understand that I may have the option of making an initial estimated premium payment with my application and that doing so may eliminate or reduce the period of time for which I would be paying premiums without coverage.

I/We declare that I/we have, in an identical manner, completed and signed the copy of this amendment that is attached to and made part of the Policy issued by the Company.

It is agreed that this amendment shall be part of the application for the Policy.

Signed at \_\_\_\_\_ on \_\_\_\_\_ Date

Witness to all signatures (Licensed Resident Agent, as required)

Policyowner

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Agent#

Florida License ID#

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Page  
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Intentionally