

Kansas

APPLICATION KIT

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

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Office ID# 14610

For illustration software go to
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

- APPS ExamOne Other
 EMSI 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



Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499

GA # _____
**Individual Life Insurance
Application For One Life
Part 1**

Proposed Insured: _____
First Middle Last Suffix Mr./Mrs./Ms./Dr.

Birthdate: _____ Age _____ Birth Place: _____ Male Female
Mo. Day Yr.

Soc. Sec. No.: _____ U.S. Citizen Yes No If no, complete Residency & Travel Questionnaire

Employer: _____ Area Code & Work Phone _____

Occupation: _____

Annual Income \$ _____ Net Worth \$ _____

Residence: _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Area Code & Home Phone

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

Address: _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen Yes No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: _____

Address: _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Date of Trust, if Applicable

1. Plan Applied For: _____ Kind Code: _____

2. Risk Classification: Preferred Plus/Select Preferred Standard Plus Standard
Extra Rating of _____ Other _____

3. Nicotine Classification: Nicotine Non-Nicotine

4. Amount Applied For \$ _____

5. Additional Benefits by Rider: Waiver of Premium/Waiver Provision Accident Indemnity \$ _____ Other _____ \$ _____

6. Premium Payment Mode: Annual Semi-Annual Quarterly Monthly Other _____
 PAC Direct Bill

7. Complete for Flexible Premium Plans:
Required Premium Per Year (RAP) \$ _____
Planned Periodic Premium \$ _____
+ Initial Lump Sum \$ _____
= Total Initial Premium \$ _____

8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? Yes No (APL will be in effect unless no is checked.)

9. Do you have any existing life insurance or annuities? If none, check this box . If yes, please list the policies below.

a. Do you have any knowledge or reason to believe that the insurance application will replace or change any existing life insurance policy or annuity? Please indicate yes or no in the chart.

Type of Coverage (Personal / Business / Employer Provided / Group)	Company/Policy Number	Face Amount	Replacement?
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Total Accidental Death insurance in force with all companies: \$ _____

APPLICATION (NB)

continued on next page

Rev 12/08



* D T O O 8 *

10. Is any application for life insurance pending with any other company? Yes No
If yes, give company name, amount applied for and total amount to be placed. _____
11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? Yes No If yes, give insurance company name, owner's name, and amount of insurance of each policy.

12. Mail Additional Premium Notices To: _____
Address: _____
No. & Street City State Zip Country

Yes No "You" means any person proposed to be insured.

13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
15. Have you used nicotine at any time? Date Last Used
- Cigarettes _____
- Cigar/Pipe/Chewing Tobacco _____
- Other _____
16. Driver's License #: _____ State: _____
In the past five years, have you been convicted of or pleaded guilty to:
- a. Moving violations? If yes, give dates and type. _____
- b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
- c. Reckless driving? If yes, give dates. _____
17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Remarks: Give details for any questions answered yes

I, the Proposed Insured, and I, the Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/we agree:** (1) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (2) except as otherwise provided in the conditional receipt, if issued, with the same Proposed Insured as on this application, any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/we understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application.



FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: 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.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: 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.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: 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 civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: 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.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars (\$5000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to you under Section 101(j) of the Internal Revenue Code to the extent it exceeds the premiums and other considerations paid by you for the policy unless the written Notice and Consent is obtained **prior to policy issue** and certain other requirements of such section are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc., consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc., 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.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for one year from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. Yes No

PLEASE MAKE CHECKS PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.

Amount paid with this Application \$ _____ Check # _____ Credit Card (Complete Credit Card Order Confirmation Form)

Signed at _____ on _____, _____
City-State Date

X _____ X _____
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at _____ on _____, _____
City-State Date

X _____ X _____
Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner, give corporate title and full name of corporation below.

X
Signature of Licensed Producer

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____ CASE MANAGER: _____

PRODUCER 1: _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 2: _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 3: _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

Indicate City/County Code as required in AL, GA, KY, LA, & SC _____

What is the purpose for insurance? _____

Are you related to the Proposed Insured? Yes No Relationship _____

How long have you known the Proposed Insured? _____

Proposed Insured is: Single Married Divorced Widowed

Yes No To the best of your knowledge, does the applicant have any existing life insurance or annuities?

Yes No To the best of your knowledge, could replacement be involved?

X _____
Signature of Producer

PRE-AUTHORIZED CHECK/WITHDRAWAL PLAN ("PAC")

Unless a Conditional Receipt was issued along with this authorization, I/we agree this authorization shall not become effective for payment of the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

- | | | |
|-------------------------------------------------------------------------------------|--------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> MONTHLY (This will be elected if no box is checked) | <input type="checkbox"/> PREMIUM | <input type="checkbox"/> NEW AUTHORIZATION |
| <input type="checkbox"/> QUARTERLY | <input type="checkbox"/> LOAN REPAY | <input type="checkbox"/> BANK CHANGE |
| <input type="checkbox"/> SEMI-ANNUAL | <input type="checkbox"/> SAVINGS | <input type="checkbox"/> ADD TO EXISTING POLICY |
| <input type="checkbox"/> ANNUAL | <input type="checkbox"/> CHECKING | <input type="checkbox"/> OTHER _____ |

PICK A DATE TO DRAFT (1-28) _____

NAME OF FINANCIAL INSTITUTION: _____
PHONE #: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
ACCOUNT NUMBER: _____
NAME(S) ON BANK ACCOUNT: _____
ROUTING#: _____

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements or riders), or as agreed to by me, and for such other payments as I may authorize the Company to make. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on the earliest due date. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this authorization in no way affects the terms of the policy, other than the mode of payment, and I understand that if the premiums are not paid within the grace period allowed by a policy, as in the event any such withdrawal being dishonored, or for any reason, then the policy shall terminate subject to any nonforfeiture provisions in the policy.

AUTHORIZATION TO HONOR PAC WITHDRAWALS

As a convenience to me, I hereby request the financial institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company and/or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these authorizations.

_____ **BANK SIGNATURE(S) OF DEPOSITOR(S)** _____ **DATE** _____ **SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR**



NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

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 seek 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, MA 02184-8734, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice to Persons Applying for Insurance: Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499.

INSTRUCTIONS FOR CONDITIONAL RECEIPT

DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

1. any Proposed Insured has been treated for or experienced, within the last 12 months, any disorder of the heart, stroke, or other vascular disease, cancer, or HIV infection, or
2. any Proposed Insured is under the age of 16 or over the age of 75, or
3. the amount applied for under the attached application exceeds \$2,000,000.

IF ANY PROPOSED INSURED IS NOT DISQUALIFIED BY ONE OR MORE OF THE FACTORS LISTED IN 1 - 3 ABOVE, YOU MAY COLLECT MONEY AT THE TIME THE APPLICATION PART 1 IS COMPLETED.

Make all checks payable to Transamerica Life Insurance Company. Do not make checks payable to the insurance producer or leave the payee blank, otherwise this Receipt cannot become effective. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application (2 months' premium for Monthly Pre-Authorized Withdrawal Plan). For credit card payments, complete a Credit Card Order Confirmation Form.

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). Subject to conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for will become effective as of the date an application and the full initial premium for that application have been received by the Company or an agent acting on its behalf (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, subject to the following restrictions:

1. There is no coverage if the proposed Insured commits suicide.
2. Coverage is void if the application contains any material misrepresentation and/or has been fraudulently completed.
3. The amount of conditional coverage provided under this Receipt, if any, shall be limited to the lesser of the amount(s) applied for or \$50,000 of life insurance.
4. Coverage is void if a check or draft received in payment of the premium is not honored for payment when presented.
5. There is no conditional coverage for riders or any additional benefits if any, for which you have applied.

Any conditional coverage provided by this Receipt will terminate on the date the Company or its agent has notified the applicant of an adverse underwriting decision and returned any unearned premium.

Any ambiguities in this Receipt shall be construed so as to comply with K.S.A. 40-451.

Authorization (Signatures Required)

I certify that I have read and reviewed the Conditional Receipt and the Authorization to Obtain and Disclose Information in the application. The terms and conditions of the Conditional Receipt have been explained to me fully by the agent and I understand them.

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)



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.)

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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)

1. Proposed Insured: <i>(Print Full Name)</i> _____	2. Date of Birth: Month _____ Day _____ Year _____	3. Social Security # _____
------------------------------------------------------------	--------------------------------------------------------------	-----------------------------------

4. Name/Address/Phone of primary care physician:

Name: _____ Address: _____

Phone: _____ City/St/Zip: _____

Date and reason for last visit: _____

5. Height: _____ **Weight:** _____

Give complete details of all yes answers to questions 6 - 9, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

6. HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:

	Yes	No
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	<input type="checkbox"/>	<input type="checkbox"/>
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	<input type="checkbox"/>	<input type="checkbox"/>
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	<input type="checkbox"/>	<input type="checkbox"/>
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	<input type="checkbox"/>	<input type="checkbox"/>
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	<input type="checkbox"/>	<input type="checkbox"/>
i. Cancer, tumor, polyp or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
j. Any physical deformity or amputation?	<input type="checkbox"/>	<input type="checkbox"/>
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	<input type="checkbox"/>	<input type="checkbox"/>
l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test?	<input type="checkbox"/>	<input type="checkbox"/>

Details: _____

7.

	Yes	No
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	<input type="checkbox"/>	<input type="checkbox"/>

8. OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:

	Yes	No
a. Consulted, been examined or been treated by any physician or practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	<input type="checkbox"/>	<input type="checkbox"/>
c. Had observation or treatment at a clinic, hospital or other medical facility?	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have a surgical procedure?	<input type="checkbox"/>	<input type="checkbox"/>
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	<input type="checkbox"/>	<input type="checkbox"/>
f. Had any injury requiring treatment?	<input type="checkbox"/>	<input type="checkbox"/>



* D T 0 3 8 *

- | | | | |
|----|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| | | Yes | No |
| 9. | | | |
| a. | Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Has your weight changed by more than 15 pounds in the past year? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. | Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |

10. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** Yes No *If yes, list all and indicate why.*

11. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers # _____				
Sisters # _____				

12. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** Yes No *If yes, indicate type, frequency and date last used.*

13. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** Yes No *If no, provide complete details.*

14. Do you participate in regular weekly exercise?..... Yes No
15. Do you participate in athletics (*Team or Individual*)?..... Yes No
16. Have you ever used any tobacco products?
17. Do you get regular examinations by your health care provider?
18. Do you get regular annual dental checkups?
19. Do you clean your house or do yard work?.....
20. Do you have a pet?.....
21. Are you a member of a social group or volunteer for charity work?.....

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) _____ on _____, _____

AGENT'S STATEMENT: I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Insured.

Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

Print name of Proposed Insured

NON-MEDICAL

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)

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.**
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- 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.
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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.

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

IMPORTANT NOTICE REGARDING REPLACEMENT OF LIFE INSURANCE

Our agent is recommending that you purchase a life insurance policy from us. In connection with this purchase, you have indicated either as a result of his recommendation or at your own initiative, that you may terminate or change your existing policy issued by our company or that you may obtain a loan from our company against your existing policy to pay premiums on the proposed policy. Any of these actions is a replacement of life insurance. This notice must be given to you, along with a Comparative Information Form which includes preliminary information comparing the proposed policy with your existing policy to be replaced. Please read this notice and the Comparative Information Form carefully.

Whether it is to your advantage to replace your existing insurance coverage, only you can decide. It is in your best interest, however, to have adequate information before a decision to replace your present coverage becomes final so that you may understand the essential features of the proposed policy and of your existing insurance coverage.

To this end, we are required to give you a Policy Summary including complete information on the proposed policy no later than when the policy is delivered to you. In addition, we will, at your request, furnish you additional information concerning your existing policy. You may want to discuss your purchase with other advisors. The information you receive will be of value to you in reaching a final decision.

If either the proposed policy or the existing insurance you intend to replace is a participating policy, you should be aware that dividends may materially reduce the cost of insurance and are an important factor to consider. Dividends, however, are not guaranteed.

You should also recognize that a policy which has been in existence for a period of time may have certain advantages to you over a new policy. If the policy coverages are basically similar, the premiums for a new policy may be higher because rates increase as your age increases. Under your existing policy, the period of time during which our issuing company could contest the policy because of a material misstatement or omission on your application, or deny coverage for death caused by suicide, may have expired or may expire earlier than it will under the proposed policy. Your existing policy may have options which are not available under the policy being proposed to you or may not come into effect under the proposed policy until a later time during your life. Also, your proposed policy's cash values and dividends, if any, may grow slower initially because the company will incur the cost of issuing your new policy. On the other hand, the proposed policy may offer advantages which are more important to you.

If you are considering borrowing against your existing policy to pay the premiums on the proposed policy, you should understand that in the event of your death, the amount of any unpaid loan, including unpaid interest, will be deducted from the benefits of your existing policy thereby reducing your total insurance coverage.

After we have received your application and notified the other insurance company you will have twenty days from the date the proposed policy is delivered to you to cancel the policy issued on your application and receive back all payments you made to us.

CAUTION

If, after studying the information made available to you, you do decide to replace the existing life insurance with our company with a new life insurance policy issued by our company, you are urged not to take action to terminate or alter your existing life insurance coverage until after you have been issued the new policy, examined it and have found it to be acceptable to you. If you should terminate or otherwise materially alter your existing coverage and fail to qualify for the life insurance for which you have applied, you may find yourself unable to purchase other life insurance or able to purchase it only at substantially higher rates.

I have received and read a copy of this Replacement Notice.

(Signed) _____

Date _____

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I have received and read a copy of this Replacement Notice.

(Signed) _____

Date _____

COMPARATIVE INFORMATION FORM

Name of Proposed Insured				Address				
City and State				Date of Birth				
General Information		Existing Life Insurance			Proposed Life Insurance			
Name of Company								
Policy Number								
Basic Policy Generic Name								
Name of Basic Policy								
Rider 1; Generic Name								
Rider 2; Generic Name								
Rider 3; Generic Name								
Issue Age								
Date of Issue								
Contestable Period								
Suicide Clause Expires								
Premium Data/Death Benefits	Premium Mode: Amount	Age Payable to	Death Benefit	Age Benefit Ceases	Premium Mode: amount	Age Payable to	Death Benefit	Age Benefit Ceases
Basic Policy	\$		\$		\$		\$	
Rider 1	\$		\$		\$		\$	
Rider 2	\$		\$		\$		\$	
Rider 3	\$		\$		\$		\$	
Accidental Death Benefit	\$		\$		\$		\$	
Option to Purchase Additional Insurance	\$		\$		\$		\$	
			Option Ages:				Option Ages:	
Waiver of Premium Benefit	\$		\$xxx		\$		\$xxx	
Disability Income Benefit	\$		\$xxx Monthly Income:		\$		\$xxx Monthly Income:	
Total Current Premium	\$				\$			
Cash Values/Dividends	Guaranteed Cash Value*		Dividends*		Guaranteed Cash Value*		Dividends*	
Currently Last policy anniversary	\$		\$		\$		\$	
1 Year Hence	\$		\$		\$		\$	
5 Years Hence	\$		\$		\$		\$	
10 Years Hence	\$		\$		\$		\$	
At Age 65	\$		\$		\$		\$	
	Current Death Benefit of Dividend Additions*				\$			
	Current Cash Value of Dividend Additions*				\$			
	Current Accumulated Dividends*				\$			
	Current Policy Loan*				\$			
	Existing				Proposed			
	Maximum Policy Loan Interest Rate %				Maximum Policy Loan Interest Rate %			
	Existing Dividends are based on current (19)				Proposed Dividends are based on current (19)			
	Scale*				Scale*			

*Dividends, policy loan and certain guaranteed cash value information concerning your existing insurance may not be known to our agent. Dividends are not guaranteed. However, they may materially reduce the cost of insurance and are an important factor to consider. Thus, if dividends or other figures have been omitted from this Comparative Information Form, you should not reach a final decision to replace your existing insurance until you have them. You may obtain the omitted figures from the company that issued your existing policy.

COMPARATIVE INFORMATION FORM

Name of Proposed Insured				Address				
City and State				Date of Birth				
General Information		Existing Life Insurance			Proposed Life Insurance			
Name of Company								
Policy Number								
Basic Policy Generic Name								
Name of Basic Policy								
Rider 1; Generic Name								
Rider 2; Generic Name								
Rider 3; Generic Name								
Issue Age								
Date of Issue								
Contestable Period								
Suicide Clause Expires								
Premium Data/Death Benefits	Premium Mode: Amount	Age Payable to	Death Benefit	Age Benefit Ceases	Premium Mode: amount	Age Payable to	Death Benefit	Age Benefit Ceases
Basic Policy	\$		\$		\$		\$	
Rider 1	\$		\$		\$		\$	
Rider 2	\$		\$		\$		\$	
Rider 3	\$		\$		\$		\$	
Accidental Death Benefit	\$		\$		\$		\$	
Option to Purchase Additional Insurance	\$		\$		\$		\$	
			Option Ages:				Option Ages:	
Waiver of Premium Benefit	\$		\$xxx		\$		\$xxx	
Disability Income Benefit	\$		\$xxx Monthly Income:		\$		\$xxx Monthly Income:	
Total Current Premium	\$				\$			
Cash Values/Dividends	Guaranteed Cash Value*		Dividends*		Guaranteed Cash Value*		Dividends*	
Currently Last policy anniversary	\$		\$		\$		\$	
1 Year Hence	\$		\$		\$		\$	
5 Years Hence	\$		\$		\$		\$	
10 Years Hence	\$		\$		\$		\$	
At Age 65	\$		\$		\$		\$	
	Current Death Benefit of Dividend Additions*				\$			
	Current Cash Value of Dividend Additions*				\$			
	Current Accumulated Dividends*				\$			
	Current Policy Loan*				\$			
	Existing				Proposed			
	Maximum Policy Loan Interest Rate %				Maximum Policy Loan Interest Rate %			
	Existing Dividends are based on current (19)				Proposed Dividends are based on current (19)			
	Scale*				Scale*			

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Western Reserve Life Assurance Co. of Ohio

Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy to not more than 12 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE AND YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.

By signing below, you agree that you have read the above and received a copy of this disclosure form.

Date

Owner's (Applicant's) Signature

Agent's Signature

IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

Terminal Illness Accelerated Death Benefit Disclosure Form

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Owner's (Applicant's) Signature

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Transamerica Life Insurance Company
 Home Office: 4333 Edgewood Road NE
 Cedar Rapids, IA 52499

**Application Supplement
 for Children's Insurance Rider**
 File # _____

1. Child(ren) proposed for coverage under the Children's Insurance Rider

Name: First, Middle Initial, Last	Age	Date of Birth	Sex	Height	Weight

2. Yes No Are all the children being covered U.S. Citizens? If no, give details in Remarks.
3. Yes No Is coverage under the Children's Insurance Rider being requested for all minor children of the Proposed Insured?
If no, give details in Remarks.
4. Yes No Are any children proposed for coverage not living with the Proposed Insured?
If yes, give details in Remarks.
5. Give details to all yes answers in Remarks, including all dates and diagnoses.

Yes	No	Has any child proposed for coverage been diagnosed with:
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Abnormalities, Heart Disorder, Epilepsy, Cancer, Malignancy, Blood Disorder, Leukemia, Diabetes, Cystic Fibrosis, Kidney Disease, Brain or Neurological Disorder?
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or other lung disease or injury or illness requiring hospitalization?

Remarks

It is represented that the statements and answers given in this supplement are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application for life insurance for _____ as Proposed Insured.

Signed at _____
 (city-state)

Date: _____

 Signature of Proposed Insured

 Witness of Proposed Insured Signature

Signed at _____
 (city-state)

 (date)

 Signature of Owner (if other than Proposed Insured)

 Witness of Owner Signature





Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499

Illustration Notice

To be completed by the Applicant:

I understand the following concerning the application for the life insurance policy accompanying this form: *(check the appropriate box)*

- 1. No illustration has been presented to me prior to the application for this policy.
- 2. An illustration was presented to me, but it differs from the coverage I have applied for.

If a policy is issued, an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery. I will review the illustration and sign the acknowledgment to that effect when I receive it and return a copy of the signed illustration to the Company's representative.

Signature of Applicant

Date

To be completed by the Sales Representative

This is to certify that: *(check the appropriate box)*

- 1. No illustration was presented at the time of the sale of the life insurance policy applied for on the accompanying application.

Or

- 2. An illustration was presented to the Applicant at the time of the sale of the life insurance policy with state regulations and company requirements. However, the illustration differs from the life insurance policy applied for on the accompanying application.

Signature of Sales Representative

Date





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



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") backdate the life insurance Policy for which I am applying in the attached application so as to "save age".

I understand that backdating means that this application is amended to be "dated back" to the time specified in this amendment. I also understand that the Policy I am purchasing is the Policy then available for sale as of the date specified on this amendment.

I understand dating to "save age" means that each of the required Policy premiums I make on the Policy will be lower in dollar amounts than if I did not date to "save age". I realize that backdating means my required fixed premium will be due and payable from my "dated back to save age" date. **I recognize and understand my monthly deductions taken from my premium payments will start from the same date and will be for a period of time during which life insurance will not be in effect.** Likewise, the Surrender Charge period of my Policy will begin from that same date. Interest will not begin to accrue until either the Policy issue date or the premium payment is received in our Administrative Offices, whichever is later. The precise length of that period in which interest will not accrue depends 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 applied for plan,
- 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 begins.

I further understand that I may have the option of making an initial estimated premium payment with my application and that in so doing 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 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.

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