

Massachusetts

APPLICATION KIT

Index Universal Life

- Freedom Global IUL IISM
- Freedom Index Universal Life IISM

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, 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) _____ |

TransACE®
TransACE CV®
TransTerm®

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

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 _____			15. Social Security No. or Tax I.D. No.	
			Annual Income Previous Year _____			16. Drivers License No./ State	
			Net Worth _____			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.)

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: <input type="checkbox"/> 10 Yr <input type="checkbox"/> 15 Yr <input type="checkbox"/> 20 Yr <input type="checkbox"/> 30 Yr			23. Amount of Insurance \$		24. Planned Premium \$
25. Mode of Payment (for bank draft, complete authorization, and collect initial payment.) <input type="checkbox"/> Monthly Bank Draft <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannually <input type="checkbox"/> Annually <input type="checkbox"/> Other _____					

26. ADDITIONAL BENEFITS and AMOUNTS

<input type="checkbox"/> Waiver of Premium Benefit (WP) _____				<input type="checkbox"/> ROP _____	
<input type="checkbox"/> Children's Benefit Rider _____					
<input type="checkbox"/> Additional Insured Rider (AIR) _____					

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
 If the answer to this question is "yes", you must complete a separate replacement notice. In addition, the agent is required to leave with you the original or a copy of written or printed communications used for presentation to you. We also are required to submit to the replacing insurer a copy of the replacement notice along with the application.
- 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 racing, mountain climbing, underwater or sky diving, hang gliding or plan to? Yes No
- b. Flown other than as a passenger, or plan to? Yes No
- c. Foreign residence or travel contemplated? **The answer to the foreign travel question may result in higher rates or coverage may be declined.** 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: 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 diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? 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 health care professional as having any disease or disorder 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 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 (Universal Life only) The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.

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 to the best of my knowledge and belief. 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.

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

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

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.

Signature of Proposed Owner _____ **Date** _____

SECTION 56. AGENT INFORMATION & SIGNATURE

Signature of Agent ()	(Print First and Last Name) ()	Agent #
Telephone Number	Agent Fax #	Agent E-mail Address
Split Agent Signature (If Applicable) ()	(Print First and Last Name) ()	Agent #
Telephone Number	Agent Fax #	Agent E-mail Address
<ul style="list-style-type: none"> • 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. _____ • 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.) _____ 		

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.

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; telephone number 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

TAPE VOIDED CHECK HERE (Place tape along TOP of check)			
If not attaching void check or if withdrawing from Savings Account, complete the following information			

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

Premium to Withdraw \$ _____	<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

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

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.**
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.

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 REQUIRED BY THE COMMISSIONER OF INSURANCE READ CAREFULLY BEFORE PROCEEDING

This notice is required by the Commissioner of Insurance because you have indicated that you are buying a new life insurance policy or annuity and discontinuing or changing an existing one. Such a decision could be a good one, or a mistake. You will not know for sure until you make a careful comparison of your existing policy and the proposed replacement policy. Premiums alone are not determinative of low cost. Take the time to obtain and understand the facts.

We are required by law to notify your existing company that you may be replacing their policy.

Consider both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

Cash Value Insurance: To make a comparison of cash value policies (policies with loan or surrender values in addition to death protection), Consideration must be given to each policy's cash values, premiums, coverage amounts and dividends, if any, over the life of the policy.

To simplify this task, you may wish to request from your existing insurance company and the company issuing the replacement policy yield index figures for five, ten and twenty years. The yield index is a percentage that represents an estimate of the interest rate the insurer projects you will earn on the savings portion of the cash value policy. The policy with the higher yield index will generally be the better buy.

The Yield Index Committee of the National Association of Insurance Commissioners in 1986 devised a method for calculating a yield index. In order to request this yield index information, merely check the box below and your request will be forwarded to both insurance companies.

You can also compare the cash values and/or surrender values listed in the replacing company's policy summary for the first five policy years with those in your current policy for the next five years. Low cash values or surrender values in early policy years are often the result of high expenses associated with issuing a new policy. If the replacement policy has low values in its early years, it will usually take longer for it to provide you with benefits that equal or exceed the benefits of your existing policy. In some cases, the replacement policy may never provide benefits equal to those in your present policy.

Term Insurance: If you are replacing your present insurance policy with term insurance (policies that provide death protection only), it makes sense to shop for a low cost policy. Costs for term insurance vary widely and substantial savings may be realized by comparison shopping. Premiums alone are not always determinative of low cost since some policies pay dividends and others do not. You may wish to request interest-adjusted cost indices for five, ten and twenty years from several insurance companies including your existing insurer to help you compare term insurance premiums. The policy with the lower index numbers is usually the better buy.

Please list below the identification of the policies which are involved in the replacement. Your existing insurer will be notified that you may be replacing their policy.

() Check box to request yield indices for cash value policies.

Applicant's Signature

Date

Agent's Signature

Company/Contract No.

Company/Contract No.

Company/Contract No.

- 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 MASSACHUSETTS

**NOTICE OF AIDS VIRUS ANTIBODY TESTING AND AUTHORIZATION
FOR TESTING AND DISCLOSURE**

This document contains important information concerning the AIDS virus antibody test that we require you undergo to apply for insurance with us. It also contains information about who will have access to the information we obtain.

READ THIS NOTICE VERY CAREFULLY. DO NOT SIGN IT UNLESS IT IS COMPLETELY FILLED OUT AND YOU HAVE READ AND UNDERSTOOD IT.

You have up to 21 days from the date you receive this form to decide whether to sign this authorization.

AUTHORIZATION FOR TESTING AND DISCLOSURE

In connection with your insurance, a sample of your bodily fluid(s) will be tested for the presence of the AIDS virus (HIV) antibody. Before consenting to this test, you are urged to read the following information about AIDS, the nature of the test and our policy concerning confidentiality of test and other HIV-related information. After you read this material, you will find a request for your written authorization to be tested for the AIDS virus and for subsequent disclosure of test results. You should be aware that a positive test result may result in the denial of your insurance application.

Information About Aids

AIDS is a condition caused by the human immunodeficiency virus (HIV). In some individuals the virus reduces the body's normal defense mechanisms against certain diseases or infections. As a result, such people often develop such unusual conditions as severe pneumonia or a rare skin cancer. The symptoms of AIDS may include the following, although other causes of these symptoms are more likely: unexplained weight loss; persistent night sweats, cough, shortness of breath, diarrhea and white spots evidencing fungal infection; fever and swollen lymph nodes lasting more than one month; and raised purple spots on or under the skin or on mucous membranes.

From medical studies, it is clear that the following groups are at a high risk of contracting AIDS:

- Past or present users of intravenous drugs;
- Males who have had sex with more than one male since the late 1970's;
- Recipients of blood or blood products infected by the HIV virus; and
- Sexual partners of individuals belonging to any of the above categories.

Hiv Antibody Test

The HIV antibody test is actually a series of tests designed to detect the presence of antibodies to the AIDS virus rather than detect the virus itself. Antibodies to the AIDS virus are found in most people with AIDS, and can be found in people who do not have AIDS but have been exposed to the virus.

Your sample will first be subjected to a test known as ELISA (enzyme-linked immunosorbent assay). If the result of this test is positive, the ELISA test will be repeated. If this repeat ELISA test is also positive, your sample will then be subjected to another, more specific technique called the Western blot test, for confirmation. Your test result is considered positive only after positive results are obtained on two ELISA tests and a Western blot test.

Positive Test Results. In general, if you receive such a positive test result, there is a high probability that you have HIV antibodies. However, there is a risk that a person who has not been exposed to the virus will be incorrectly classified by the test as having a positive test result. This is called a "false positive" result. People who are not in one of the "high risk" groups listed above who get a positive test result are much more likely to receive a "false positive" than those who are in a high risk group.

A positive test result does not mean that you have AIDS. The diagnosis of AIDS is established using a patient's history, symptoms and physical examination. A positive test result does mean, however, that you are at risk of developing AIDS. It also means that, without taking precautions, you may transmit the virus to other people. Therefore, the following steps are recommended to limit the spread of AIDS: (1) stop donating blood; (2) limit sexual contacts and follow "safe sex" practices; (3) inform your sexual partners; (4) notify your doctor; and (5) if you are considering having a child, carefully evaluate the risks to the fetus.

If your test result is positive, the test result will be sent to the doctor you designate on this form, or if you prefer, we will mail the result directly to you no later than 45 days after your sample is taken. It is strongly recommended that you consult a physician or obtain counseling to learn more about the meaning of such a result.

Negative Test Results. If your test result is not positive, you most likely have not been infected by the virus. However, it is possible to have been infected with the virus within the past year and not yet have developed antibodies that cause a positive test result. It is possible to receive a "false negative" result.

Counseling And Alternative Test Sites

You may experience increased anxiety as a result of having this test performed or receiving a positive test result. Many public health organizations recommend that before a person takes an HIV-related test, he or she obtain counseling about the test and about AIDS. A source of information about AIDS and counseling is the AIDS Action Line, (617) 536-7733 or 1-800-235-2331 (toll-free). In addition, the Massachusetts Department of Public Health offers free anonymous HIV antibody testing, with pre-test and post-test counseling at its Alternative Test Sites. For additional information regarding AIDS, AIDS testing or counseling, or to obtain a free, anonymous test, individuals in the high risk categories listed above are encouraged to contact the Massachusetts Department of Public Health, Alternative Test Sites at (617) 624-5300 for an appointment. Confidential and/or anonymous HIV antibody testing (not blood donation) and counseling is also available at various locations in Massachusetts for a fee of \$35 by appointment with the American Red Cross.

If you wait up to 21 days from the date you receive this form to decide whether to be tested, unless other circumstances relating to your eligibility change, this delay will not affect our decision to offer you insurance.

Confidentiality

Under Massachusetts law we must treat all HIV-related information (including test results) as highly confidential. We have established safeguards within our company that will protect the privacy of any HIV-related information that is in your files. We have designated employees who are responsible for keeping this information confidential. We have designated certain personnel who will have access to HIV-related information if they need the information in connection with an insurance transaction. Other personnel are aware that they are not permitted access to such information. We will make sure that HIV-related information that is stored in a computer data bank or other files is protected by reasonable security safeguards.

To handle your insurance business, we may need to disclose your test results or other HIV-related information to employees, reinsurers, contractors or attorneys who need HIV-related information for underwriting, claims or another necessary business purpose in connection with your insurance transaction. These persons and entities have been informed of their clear legal obligation to maintain the confidentiality of all HIV-related information, including test results. Similar privacy safeguards have also been adopted by the laboratory that will perform tests on your sample, and by any contractor, reinsurer or attorney to whom we might grant access to HIV-related information. If we need to disclose to anyone else information about you and AIDS, we must again ask you to provide prior written consent to such disclosure. However, HIV-related information could be disclosed without your consent in response to a subpoena or as required by law. If you believe that your right to the confidentiality of any HIV-related information about you has been violated, you should contact the Division of Insurance at (617) 727-7794, or by writing to the Division's Consumer Services Section, One South Station, Boston, MA 02110-2208.

Medical Information Bureau (MIB). If your test result is positive, we will make a report indicating a nonspecific abnormal test result to the Medical Information Bureau, Inc. (MIB). The nature of the test will not be reported; there will be no record with the MIB that you had a positive HIV antibody test. The MIB is a nonprofit organization of life insurance companies which operates an information exchange for its members. Our decision on whether or not to issue you a policy will not be sent to the MIB. If you later apply to another MIB member company for life or health insurance or submit a claim for life or disability insurance benefits, the MIB will, upon request, provide that company with information in its file, including information we have furnished. Otherwise, the MIB will observe confidentiality safeguards similar to our own stated above. Upon your request, the MIB will arrange for disclosure to you of any information it has in your file. If you feel the information in the MIB's file is not correct, you may contact the MIB and seek a correction in accordance with the procedures outlined in the Federal Fair Credit Reporting Act. The address of the MIB's information office is: MIB Inc., P.O. Box 105, Essex Station, Boston, MA 02112. The MIB telephone number is (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Disclosure And Access To Information

If we disclose any HIV-related information to a person or entity who is not our employee, reinsurer, attorney, or contractor as described above, or the MIB, or other entity as required by law, we will notify you in writing unless we are prohibited from doing so by law or court order. Upon your written request, we will provide you, either directly, or at your option, through a physician designated by you, with copies of any information relating to you and AIDS in our files, for the reasonable cost of photocopying those documents. If you believe any of the information in our files is incorrect, you may write to us to request that it be corrected.

AUTHORIZATION

I have read and I understand this *Notice and Consent for HIV-Related Testing* which may include AIDS Virus (HIV) Antibody/Antigen testing. I understand that: if I test positive I may be denied the insurance for which I have applied; I may experience increased anxiety as a result of having this test; the people and entities described above will or may have access to the results of my test as stated above for the purposes identified on this form; I will be given a copy of this form; and this authorization is valid for ninety (90) days from the date of my signature below.

I authorize the collection and testing of my bodily fluid(s) for HIV antibodies and the disclosure of the test results as stated on this form.

NOTIFICATION OF POSITIVE TEST RESULT

In the event of a positive test result:

Please send the result to me at:

Street

City, State, Zip Code

I authorize the Insurer to send the result to my physician and understand that such results may become part of my physician's permanent medical records concerning me:

Name of Health Care Provider

Street

Phone Number

City, State, Zip Code

Name of Proposed Insured

Date of Birth

Name of Insurance Producer

Signature of Insured

Date

Address of Insurance Producer

Name of Laboratory or Paramedical Company

Address of Laboratory or Paramedical Company

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

**SUMMARY AND DISCLOSURE STATEMENT FOR
TERMINAL ILLNESS ACCELERATED DEATH BENEFIT
(REQUIRED AT TIME OF APPLICATION)**

Limitations of the Accelerated Death Benefit:

The accelerated death benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays you may not be enough to cover your medical, nursing home or other bills. **Unlike conventional life insurance proceeds, accelerated death benefits payable under this product rider COULD BE TAXABLE IN SOME CIRCUMSTANCES.** We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated death benefit product.

A. Consequences of This Benefit:

Receipt of accelerated death benefits MAY AFFECT MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that you own a policy with an accelerated death benefit may affect your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

B. Medical Condition(s) enabling accelerating of life benefit:

Terminal illness which means a condition that a physician certifies will reasonably be expected to result in death in 24 months or less.

C. Option(s):

___ 100% of total Death Benefit as a LUMP SUM

D. Premium for Accelerated Benefit: None

E. Administrative Expense Charge: None

By signing below, you agree that you have read and received a copy of this summary and disclosure statement at the time of application.

Date

Owner's (Applicant's) Signature

Date

Agent's Signature

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 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

This
Page
Left
Blank
Intentionally