

# Missouri

## APPLICATION KIT

**TransACE**  
**TransACE CV**  
**TransTerm**



# Transamerica Life Insurance Company New Business Cover Sheet

Fax to: 866.297.3607

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

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

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

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

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

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

## Forms Checklist

### For All Products

Primary Insured    Additional Insured

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

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TransACE CV®  
TransTerm®**

**Office ID# 14610**

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

When completing the APA40 app be sure  
to indicate:

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

### Company Scheduled to do Paramed

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

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

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

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

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



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 intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? 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

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**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 insurance producer has the authority to waive a complete answer to any question in the application, pass on insurability, make or alter any contract or waive any of the Company's other rights or requirements, and no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) only if 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. and its members or affiliates, 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. 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.

**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 two and one half years 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



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

**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**  
**PLEASE READ THIS CAREFULLY**

Received from \_\_\_\_\_, the sum of \$ \_\_\_\_\_ for the life insurance application dated \_\_\_\_\_, with \_\_\_\_\_ as the Proposed Insured.

**This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.**

**This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.**

**CONDITIONAL COVERAGE:** Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

**CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT:** Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

**60-DAY LIMIT OF CONDITIONAL COVERAGE:** Any conditional coverage under this Receipt shall expire after 60 days of the date you signed Part 1. In that case, the Company's liability shall be limited to returning any payment you have made. The Company also has the right to terminate conditional coverage at any time prior to 60 days upon mailing a refund of the payment made. If the Company continues to underwrite your application after any conditional coverage has expired or terminated, it will give you notice and the reason for the additional time needed to complete consideration of your application.

**DOLLAR LIMITS OF CONDITIONAL COVERAGE:** The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or \$1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, \$400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or \$100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

**IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT.** If one or more of this Receipt's conditions have not been met exactly, or if a Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

**Except as provided in this Conditional Receipt,** no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

**ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT**

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

X \_\_\_\_\_, 20\_\_\_\_  
Signature of Proposed Owner  
If Proposed Owner is a Trust, the Trustee must sign as Owner.  
Give full name and date of Trust below.

\_\_\_\_\_, 20\_\_\_\_  
Date  
If Proposed 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.

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

**Submit this completed and signed original with the application and payment.**

Original



**CONDITIONAL RECEIPT  
PLEASE READ THIS CAREFULLY**

Received from \_\_\_\_\_, the sum of \$ \_\_\_\_\_ for the life insurance application dated \_\_\_\_\_, with \_\_\_\_\_ as the Proposed Insured.

**This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.**

**This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.**

**CONDITIONAL COVERAGE:** Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

**CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT:** Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

**60-DAY LIMIT OF CONDITIONAL COVERAGE:** Any conditional coverage under this Receipt shall expire after 60 days of the date you signed Part 1. In that case, the Company's liability shall be limited to returning any payment you have made. The Company also has the right to terminate conditional coverage at any time prior to 60 days upon mailing a refund of the payment made. If the Company continues to underwrite your application after any conditional coverage has expired or terminated, it will give you notice and the reason for the additional time needed to complete consideration of your application.

**DOLLAR LIMITS OF CONDITIONAL COVERAGE:** The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or \$1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, \$400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or \$100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

**IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT.** If one or more of this Receipt's conditions have not been met exactly, or if a Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

**Except as provided in this Conditional Receipt,** no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at \_\_\_\_\_ on \_\_\_\_\_, 20\_\_\_\_ X  
City, State Date Insurance Producer or other Company Authorized Rep

**ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT**

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

**Leave this page with the proposed Owner if money is submitted with application**

<b>1. Proposed Insured:</b> <i>(Print Full Name)</i> _____	<b>2. Date of Birth:</b> Month _____ Day _____ Year _____	<b>3. Social Security #</b> _____
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**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. WITHIN THE PAST TEN YEARS HAVE YOU BEEN POSITIVELY DIAGNOSED OR TREATED BY A MEMBER OF THE MEDICAL PROFESSION 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 \*

- |    |   |                          |                          |
|----|---|--------------------------|--------------------------|
| 9. |   | <b>Yes</b>               | <b>No</b>                |
| 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 withdrawn, postponed, rated, modified or issued with exclusion rider? ..... | <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

**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.

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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.
- 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

**REPLACEMENT NOTICE  
REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY**

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Ask the company or agent that sold you your existing policy to provide you with a policy summary statement.

The reverse side contains a check list of some of the items you should consider in making your decision. **TAKE TIME TO READ IT.**

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

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

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

\_\_\_\_\_  
Applicants Signature

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Name and Address  
(printed)

\_\_\_\_\_  
Agent's Name, Address, Telephone Number and  
License Number  
(printed)

**ORIGINAL TO APPLICANT  
COPY TO REPLACING INSURER – COPY TO REPLACED INSURER**

### ITEMS TO CONSIDER

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rate increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change on terms which may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change – up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. **CAUTION**, you are urged not to take action to terminate, assign 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. And

**REMEMBER**, You have twenty (20) days following receipt to examine the contents of any individual life insurance policy or annuity. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office, or to the agent through whom it was purchased, for a full refund of premium.

- 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

<b>Notice and Consent for HIV-Related Testing MISSOURI</b>
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**Notice and Consent for Testing of Biological Specimens  
To Include HIV (AIDS Virus) Testing**

To determine your insurability, the Insurer designated above (the "Insurer") has requested that you provide a biological specimen for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV, the virus that causes AIDS. The test shows whether you have been exposed to the virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure.

The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. A normal result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. If your test results are other than normal, you should seek medical follow up with your personal physician because you may be infected with the virus. Positive HIV test results do not mean that you have AIDS, but that you are at a significantly increased risk of developing AIDS. Positive HIV test results or other significant abnormalities detected by additional tests of biological specimens will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles. If you have questions, you should consult your own physician or call the National AIDS Hotline (1-800-872-2437) or the Missouri AIDS Hotline (1-800-533-2437).

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the Insurer which may in turn disclose results to its employees, affiliates, reinsurers, contractors or attorneys who need the results for underwriting, claims or another necessary business purpose in connection with your insurance transaction. If the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the Medical Information Bureau, Inc. (MIB, Inc.), a generic code which signifies only a non-specific test abnormality. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the test has been done except as may be required or permitted by law or authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If a biological specimen other than blood is tested to determine the presence of HIV virus, its component parts, or its antibodies, the Insurer may at a later time request a specimen of your blood for further HIV testing. If you choose to decline that request, the results of all testing which has been performed will be provided to the physician which you have designated to receive such results.

If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician to whom you may authorize disclosure and with whom you may wish to discuss the results. If your HIV test(s) indicate confirmed infection with HIV and you have not provided the Insurer with the name of a physician to whom you authorize disclosure of test results, the Insurer will disclose test results to the Missouri Department of Health as required by law.

Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), cotinine, cocaine and screening for liver or kidney disorders, diabetes, immune disorders and other physical conditions.

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

I authorize the Insurer to send the test result(s) to the following physician or health care provider:

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Street

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State, Zip Code

**Consent**

**I have read and I understand this *Notice and Consent for Testing of Biological Specimen to Include HIV (AIDS Virus) Testing*. I voluntarily consent to provide biological specimen(s) for testing, to the testing of such specimen(s), and the disclosure of the test results as described.**

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

\_\_\_\_\_  
Name of Proposed Insured (*Please Print*)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date Signed



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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