

# **South Dakota**

**APPLICATION KIT**

**Jet Simplified Issue**

# Transamerica Life Insurance Company New Business Cover Sheet

Fax to: 866.297.3607

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

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

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

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

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

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

## Forms Checklist

### For All Products

Primary Insured    Additional Insured

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

**TransACE®  
TransACE CV®  
TransTerm®**

**Office ID# 14610**

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

When completing the APA40 app be sure  
to indicate:

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

### Company Scheduled to do Paramed

- 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





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

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

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

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

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

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

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

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

\_\_\_\_\_  
 Signature of proposed Primary Insured

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

\_\_\_\_\_  
 Signature of Parent or Legal Guardian  
 (if proposed Primary Insured is Under 18 years of age)

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

**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** \_\_\_\_\_

**AGENT INFORMATION & SIGNATURE**

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

# CONDITIONAL RECEIPT

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

## PLEASE READ THIS CAREFULLY

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

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

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

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

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

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

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

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

### Authorization (Signatures Required)

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

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

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

### **NOTICE OF INSURANCE INFORMATION PRACTICES**

To proposed Insured: Personal information may be collected from persons other than the individual(s) 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.**

## PRE-AUTHORIZED WITHDRAWAL PLAN

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

### INITIAL PAYMENT (MUST CHECK ONE BOX)

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

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

### ACCOUNT INFORMATION

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

### COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

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

### SIGNATURE

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

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

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

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

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

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

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

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

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

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

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

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

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

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

|   |                           |                                     |
|---|---------------------------|-------------------------------------|
| _____<br>Name of Primary Proposed Insured/Patient   | _____<br>Date of birth    | _____<br>Last four digits of SSN    |
| _____<br>Name of Secondary Proposed Insured/Patient | _____<br>Date of birth    | _____<br>Last four digits of SSN    |
| _____<br>Name(s) of Unemancipated Minors            | _____<br>Date(s) of birth | _____<br>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:

- 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.
- 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.
- 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.**
- 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.

|   |               |
|---|---------------|
| _____<br>Signature of Primary Proposed Insured/Patient or Personal Representative   | _____<br>Date |
| _____<br>Signature of Secondary Proposed Insured/Patient or Personal Representative | _____<br>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

This is a notice of intention to replace the following EXISTING life insurance policy or annuity:

NAME OF INSURED: \_\_\_\_\_

ADDRESS OF INSURED: \_\_\_\_\_

\_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF EXISTING INSURER: \_\_\_\_\_

EXISTING POLICY NUMBER: \_\_\_\_\_

NAME OF EXISTING AGENT: \_\_\_\_\_

TYPE OF EXCHANGE OF EXISTING COVERAGE: \_\_\_\_\_ (Example: lapsed policy, loan or surrender)

The REPLACEMENT coverage is as follows:

NAME OF REPLACING INSURER: \_\_\_\_\_

NAME OF REPLACING AGENT: \_\_\_\_\_

REPLACEMENT POLICY NUMBER: \_\_\_\_\_ (or other identifying number [application or receipt number])

GENERIC DESCRIPTION OF REPLACING POLICY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I presently have a policy with \_\_\_\_\_  
(Company Name)

And wish to replace it with \_\_\_\_\_  
(Name of company and generic description)

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

I, as agent for \_\_\_\_\_, am replacing \_\_\_\_\_  
(Company Name)

policy, with policy \_\_\_\_\_ and have explained the provisions of the policy and any  
(Company name and generic description) penalties for surrender.

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

**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

This is a notice of intention to replace the following EXISTING life insurance policy or annuity:

NAME OF INSURED: \_\_\_\_\_

ADDRESS OF INSURED: \_\_\_\_\_

\_\_\_\_\_ PHONE: \_\_\_\_\_

NAME OF EXISTING INSURER: \_\_\_\_\_

EXISTING POLICY NUMBER: \_\_\_\_\_

NAME OF EXISTING AGENT: \_\_\_\_\_

TYPE OF EXCHANGE OF EXISTING COVERAGE: \_\_\_\_\_ (Example: lapsed policy, loan or surrender)

The REPLACEMENT coverage is as follows:

NAME OF REPLACING INSURER: \_\_\_\_\_

NAME OF REPLACING AGENT: \_\_\_\_\_

REPLACEMENT POLICY NUMBER: \_\_\_\_\_ (or other identifying number [application or receipt number])

GENERIC DESCRIPTION OF REPLACING POLICY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I presently have a policy with \_\_\_\_\_  
(Company Name)

And wish to replace it with \_\_\_\_\_  
(Name of company and generic description)

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

I, as agent for \_\_\_\_\_, am replacing \_\_\_\_\_  
(Company Name)

policy, with policy \_\_\_\_\_ and have explained the provisions of the policy and any  
(Company name and generic description) penalties for surrender.

Signature of Agent \_\_\_\_\_ Date \_\_\_\_\_

## AGENT REPLACEMENT GUIDE

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

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

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

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

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

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

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

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

**In addition, you must:**

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

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

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

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

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

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

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

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

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