

Washington

APPLICATION KIT

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Transamerica Life Insurance Company New Business Cover Sheet

Fax to: 866.297.3607

Date: _____ Number of pages including this cover sheet: _____

Agent # _____ Agent Name _____

Agent Phone # _____ Agent Fax # _____

Proposed Insured's Name _____

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

If this is a companion policy, write companion name: _____

Forms Checklist

For All Products

Primary Insured Additional Insured

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

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Office ID# 14610

For illustration software go to
www.agentnetinfo.com, Software
Downloads, TransWare

When completing the APA40 app be sure
to indicate:

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

Company Scheduled to do Paramed

- | | | |
|-------------------------------|-------------------------------------|--------------------------------|
| <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

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

I/we understand that omissions or misstatements in this application could cause an otherwise valid claim to be denied under any contract issued from this application, subject to any incontestability provision of such insurance.



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)

FRAUD WARNING: 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.

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

PICK A DATE TO DRAFT (1-28) _____

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

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

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

AUTHORIZATION TO HONOR PAC WITHDRAWALS

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

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

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



NOTICE OF DISCLOSURE OF INFORMATION

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

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

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

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

INSTRUCTIONS FOR CONDITIONAL RECEIPT

DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

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

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

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

CONDITIONAL RECEIPT
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: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, 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 you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

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 Date

If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust below. 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: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, 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 you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

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

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

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

Name: _____ Address: _____

Phone: _____ City/St/Zip: _____

Date and reason for last visit: _____

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

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

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

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

Details: _____

7.

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

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

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



* D T 0 3 8 *

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

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

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

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

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

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

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

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

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

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

Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

Print name of Proposed Insured

NON-MEDICAL

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

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

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

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1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
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| Signature of Primary Proposed Insured/Patient or Personal Representative | Date |
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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.)

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Date

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

Policy or contract number (if known): _____

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

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

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

IMPORTANT NOTICE REGARDING REPLACEMENT OF INSURANCE

(Save this notice! It may be important to you in the future.)

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one – or a mistake. It should be carefully considered. The Washington state insurance commissioner requires us to give you this notice to help you make a wise decision.

STATEMENT TO APPLICANT BY AGENT OR BROKER

(Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years? _____ No _____ Yes, explain:
2. Are there penalties, set up or surrender charges for the new policy? _____ No _____ Yes, explain, emphasizing any extra cost for early withdrawal:
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction? _____ No _____ Yes, explain:
4. Are there adverse tax consequences from the replacement under current tax law? _____ No _____ Yes, explain:
5. a) Are interest earnings a consideration in this replacement? _____ No _____ Yes
 b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy fees, and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid? _____ No _____ Yes, explain
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
 a) Are the interest rates quoted before _____ or after _____ fees and mortality charges have been deducted?
 b) Interest rates are guaranteed for how long? _____
 c) The minimum interest rate to be paid is how much? _____
- d) If applicable, the rate you pay to borrow is _____ and the limit on the amount that can be borrowed is _____
- e) The surrender charges are _____
- f) The death benefit is _____
8. Are there other short or long term effects from the replacement that might be materially adverse? _____ No _____ Yes, explain:

Signature of Agent or Broker

Date

Name of Agent or Broker
(Print or Type)

Address

LIST OF POLICIES OR CONTRACTS TO BE REPLACED:

| COMPANY | INSURED | CONTRACT NO. |
|---------|---------|--------------|
| | | |
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CAUTION: The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only; at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy

Received: _____
(Applicant's Signature) (Date)

THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.

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

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(Use additional sheets, as necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years? _____ No _____ Yes, explain:
2. Are there penalties, set up or surrender charges for the new policy? _____ No _____ Yes, explain, emphasizing any extra cost for early withdrawal:
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction? _____ No _____ Yes, explain:
4. Are there adverse tax consequences from the replacement under current tax law? _____ No _____ Yes, explain:
5. a) Are interest earnings a consideration in this replacement? _____ No _____ Yes
 b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set-up charges, policy fees, and other factors.
6. Are minimum amounts required to be on deposit before excess interest will be paid? _____ No _____ Yes, explain
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
 a) Are the interest rates quoted before _____ or after _____ fees and mortality charges have been deducted?
 b) Interest rates are guaranteed for how long? _____
 c) The minimum interest rate to be paid is how much? _____
- d) If applicable, the rate you pay to borrow is _____ and the limit on the amount that can be borrowed is _____
- e) The surrender charges are _____
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8. Are there other short or long term effects from the replacement that might be materially adverse? _____ No _____ Yes, explain:

Signature of Agent or Broker

Date

Name of Agent or Broker
(Print or Type)

Address

LIST OF POLICIES OR CONTRACTS TO BE REPLACED:

| COMPANY | INSURED | CONTRACT NO. |
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- Monumental Life Insurance Company
- Stonebridge Life Insurance Company
- Transamerica Life Insurance Company
- Western Reserve Life Assurance Co. of Ohio

4333 Edgewood Road NE, Cedar Rapids, IA 52499

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

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

Pre-Testing Considerations

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

The Department of Health and Human Services Office on HIV/AIDS has prepared the attached listing of medical facilities which provide HIV pre-test counseling. Behaviors that place you at risk for HIV infection include sexual contact or sharing needles or syringes with an infected person.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody/antigen test results do not mean that you have AIDS but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. A positive HIV antibody test result will probably mean you will be declined for the insurance for which you are applying.

A negative 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. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive or indeterminate, Washington state law [WAC 248-100-209 (4)] requires that post-test counseling occur at the time the test result is given to you. Please designate your private physician in the space provided below so that the insurer can have him or her tell you the test result and provide the required post-test counseling. If you do not designate a physician, the insurer will disclose the test result to the local health department so they may give the test result to you and provide the required post-test counseling. According to Washington state law positive or indeterminate test results cannot be sent directly to you.

Name of physician for reporting a positive or indeterminate test result:

Health Care Provider

Street

Phone Number

City, State, Zip Code

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

Consent

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

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

Name of Proposed Insured (*Please Print*)

Signature of Proposed Insured

Street

Date Signed

City, State, Zip Code

Date of Birth

HIV Antibody Testing/Counseling Services

Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by Washington law, the following list of counseling resources is being provided to you. It was provided by the Department of Health and Human Services Office on HIV/AIDS, which is subject to change without notice.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department or your local chapter of the American Red Cross for further information.

Adams County Health Department

103 West Main
Ritzville, Washington 99169-1407
(509) 659-3319

Asotin County Health District

431 Elm Street
Clarkston, Washington 99403
(509) 758-3344

Benton-Franklin Health District

506 McKenzie
Richland, Washington 99352-3520
(509) 943-2614 (Richland)
(509) 546-9737 (Pasco)
(509) 586-0207 (Kennewick)

Bremerton-Kitsap County Health Department

109 Austin Drive
Bremerton, Washington 98312
(360) 478-5235 / (800) 874-2437

Chelan-Douglas County Health District

P.O. Box 429
Wenatchee, Washington 98807-0429
(509) 664-5306 / (800) 336-5306

Clallam County Health Department

223 East Fourth Street
Port Angeles, Washington 98362-3098
(360) 417-2352

Columbia County Health District

221 E. Washington Street, Suite 101 PH
Dayton, Washington 99328
(509) 382-2181

Cowlitz-Wahkiakum Health District

600 Broadway
Longview, Washington 98632-7269
(360) 414-5599

Garfield County Health District

10th & Columbia (P.O. Box 130)
Pomeroy, Washington 99347
(509) 843-3412

Grant County Health District

1021 Broadway
Moses Lake, Washington 98837
(509) 776-7960

Grays Harbor County Health Department

2109 Sumner Avenue
Aberdeen, Washington 98520
(360) 532-8631

Island County Health Department

P.O. Box 5000
Coupeville, Washington 98239
(206) 679-7351

Jefferson County Health Department

Castle Hill Center
615 Sheridan
Port Townsend, Washington 98369-2439
(360) 385-9400

Kittitas County Health Department

507 Nanum
Ellensburg, Washington 98926
(509) 962-7515
(509) 773-4565 Goldendale
(509) 493-1558 White Salmon

Lewis County Health District

360 N.W. North Street
Chehalis, Washington 98532-1900
(360) 740-1223 / (800) 562-6130

Lincoln County Health Department

P.O. Box 1207
Davenport, Washington 99122
(509) 725-1001

Mason County Health Department

303 North 4th
Shelton, Washington 98584
(360) 427-9670, Ext. 400

Northeast Tri-County Health District

P.O. Box 270
Colville, Washington 99114
(509) 684-5048

Okanogan County Health District

P.O. Box 231
Okanogan, Washington 98840
(509) 422-3867

Pacific County Health Department

P.O. Box 26
South Bend, Washington 98586
(360) 875-9343

Pierce County Health Department

3629 S D Street
Tacoma, Washington 98408-6897
(253) 798-6060

San Juan County Health Department

P.O. Box 607
Friday Harbor, Washington 98250-0607
(360) 378-4474

King County - Seattle**AIDS Prevention Unit**

(206) 205-7837 / (800) 678-1595

Harborview Hospital STD Clinic

No anonymous testing
(206) 731-3590

Harborview Women's Clinic

(206) 223-3367

Seattle Gay Clinic

(206) 461-4540

Skagit County Health Department

700 South Second Street, Room 301
Mount Vernon, Washington 98273-3684
(360) 336-9380

Skamania County Health Department

683 SW Rock Creek Drive
Stevenson, Washington 98648
(509) 427-5138

Snohomish Health District

3020 Rucker Avenue, Suite #206
Everett, Washington 98201-3971
(206) 339-5251 or 1-800-344-2437

Southwest Washington Health District

2000 Fort Vancouver Way
Vancouver, Washington 98663
(360) 696-8425

Spokane County Health District

West 1101 College Avenue
Spokane, Washington 99201-2095
(509) 324-1600 / (800) 456-3236

Thurston County Health Department

529 Southwest Fourth Avenue
Olympia, Washington 98501-1097
(206) 786-5581 Ext. 6944

Wahkiakum County Health Department

P. O. Box 397
Cathlamet, Washington 98612
(360) 795-6207

Walla Walla County-City Health Department

310 West Poplar (P.O. Box 1753)
Walla Walla, Washington 99362
(509) 527-3290

Whatcom County Health Department

1500 N. State Street
Bellingham, Washington 98225
(206) 676-4593

Whitman County Health Department

North 310 Main Street
Colfax, Washington 99111
(509) 397-6280

Yakima County Health District

104 North First Street
Yakima, Washington 98901
(509) 249-6518 / (800) 535-2271

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

4333 Edgewood Road NE, Cedar Rapids, IA 52499

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

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

Pre-Testing Considerations

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

The Department of Health and Human Services Office on HIV/AIDS has prepared the attached listing of medical facilities which provide HIV pre-test counseling. Behaviors that place you at risk for HIV infection include sexual contact or sharing needles or syringes with an infected person.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody/antigen test results do not mean that you have AIDS but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. A positive HIV antibody test result will probably mean you will be declined for the insurance for which you are applying.

A negative 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. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are positive or indeterminate, Washington state law [WAC 248-100-209 (4)] requires that post-test counseling occur at the time the test result is given to you. Please designate your private physician in the space provided below so that the insurer can have him or her tell you the test result and provide the required post-test counseling. If you do not designate a physician, the insurer will disclose the test result to the local health department so they may give the test result to you and provide the required post-test counseling. According to Washington state law positive or indeterminate test results cannot be sent directly to you.

Name of physician for reporting a positive or indeterminate test result:

Health Care Provider

Street

Phone Number

City, State, Zip Code

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(509) 249-6518 / (800) 535-2271

Life Investors Insurance Company of America

Peoples Benefit Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy within 24 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose. In the event that our Physician provides a different diagnosis of the Insured's medical condition, you have the right to arbitration conducted in accordance with Washington Statutes chapter 7.04.

This benefit cannot be exercised:

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

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

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

If you receive payment of accelerated death benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Receipt of accelerated death benefits may be taxable and you should consult your personal tax advisor.

The accelerated life insurance benefit is intended to qualify under section 101(g) (26 U.S.C.101(g)) of the Internal Revenue Code of 1986 as amended by Public Law 104-191.

The table below is for illustration purposes only and is not a contract. These values will change based on the actual percentage of accelerated benefit elected, the applicable discount rate at the time the Single Sum Benefit is paid, any processing charge if applicable and when the claims process is completed.

Policy Values and Benefits

| Prior to Payment of Benefit | | | | After Payment of Benefit | | | |
|-----------------------------|---------------|---------------|----------------|--------------------------|---------------|---------------|----------------|
| Pol Year | Specified Amt | Death Benefit | Cash Sur Value | Single Sum Benefit | Specified Amt | Death Benefit | Cash Sur Value |
| 1 | \$70,000.00 | \$70,000.00 | \$0.00 | \$30,343.07 | \$35,000.00 | \$35,000.00 | \$0.00 |

This table assumes a Single Sum Benefit of 50% is elected and the discount rate used to determine this Benefit is 7.40%, the policy loan interest rate.

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

Date

Owner's (Applicant's) Signature

Agent's Signature

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

Life Investors Insurance Company of America

Peoples Benefit Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Terminal Illness Accelerated Death Benefit Disclosure Form

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| Pol Year | Specified Amt | Death Benefit | Cash Sur Value | Single Sum Benefit | Specified Amt | Death Benefit | Cash Sur Value |
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By signing below, you agree that you have read the above and received a copy of this disclosure form.

Date

Owner's (Applicant's) Signature

Agent's Signature

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

LIFE INSURANCE BUYER'S GUIDE

This guide can help you when you shop for life insurance. It discusses how to:

1. Find a policy that meets your needs and fits your budget
2. Decide how much insurance you need
3. Make informed decisions when you buy a policy

Prepared by the National Association of
Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

BUYING LIFE INSURANCE

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need— and for how long— and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or timely death. Life

insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

WHAT ABOUT THE POLICY YOU HAVE NOW?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

1. If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
2. It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
3. Ask your tax advisor if dropping your policy could affect your income taxes.
4. If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
5. You may have valuable rights and benefits in the policy you now have that are not in the new one.
6. If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
7. At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or

company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED?

Here are some questions to ask yourself:

1. How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
2. Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
3. How will my family pay final expenses and repay debts after my death?
4. Do I have family members or organizations to whom I would like to leave money?
5. Will there be estate taxes to pay after my death?
6. How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

WHAT IS THE RIGHT KIND OF LIFE INSURANCE?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period — even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY.

You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agency or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustrations are not guaranteed.

FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

1. Do premiums or benefits vary from year to year?
2. How much do the benefits build up in the policy?

3. What part of the premiums or benefits is not guaranteed?

4. What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

1. How quickly does the cash value grow? Some policies have low cash values in the early years that build up quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)

2. Are there special policy features that particularly suit your needs?

3. How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.



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 |
|-----------------------------------|-----|---------------|-----|--------|--------|
| | | | | | |
| | | | | | |
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| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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
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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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