

Wyoming

APPLICATION KIT

Index Universal Life

- Freedom Global IUL IISM
- Freedom Index Universal Life IISM

Universal Life

- Accumulation UL

Transamerica Life Insurance Company New Business Cover Sheet

Fax to: 866.297.3607

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

Agent # _____ Agent Name _____

Agent Phone # _____ Agent Fax # _____

Proposed Insured's Name _____

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

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

Forms Checklist

For All Products

Primary Insured Additional Insured

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

**TransACE®
TransACE CV®
TransTerm®**

Office ID# 14610

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

When completing the APA40 app be sure
to indicate:

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

Company Scheduled to do Paramed

- APPS ExamOne Other
 EMSI Portamedic

Lab Slip/Bar Code #: _____ Date Taken: _____

Special Instructions: _____

Tip! To speed processing...

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

PROPOSED INSURED INFORMATION

| | | | | | | | |
|---|-----------|------------------------------|--|--|--|--|--|
| 1. Name (First, M.I., Last) | | | 2. Mailing Address (Cannot be a P.O. Box) City, State, Zip | | | | |
| 3. Home Telephone No. () | | 4. Work Telephone No. () | | 5. Birth Date | Age | 6. Birth State / Country | |
| 7. Height | 8. Weight | 9. Marital Status | | 10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | 11. U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No | 12. If no, give immigration status/type of visa: | |
| 13. Occupation & Duties | | | 14. Annual Income Current Year _____ | | | 15. Social Security No. or Tax I.D. No. | |
| | | | Annual Income Previous Year _____ | | | 16. Drivers License No./ State | |
| | | | Net Worth _____ | | | 17. E-mail Address | |
| 18. Have you used any tobacco or nicotine products within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type and when used last | | | | | | | |

BENEFICIARY AND OWNER DESIGNATION (Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed Insured.)

| | | | |
|--------------------------|--|-----------------------------|--|
| 19. Primary Relationship | | Primary Relationship | |
| Primary Relationship | | 20. Contingent Relationship | |

OWNER (Unless otherwise noted, the Owner will be the Insured.)

| | | | | | |
|---|--|-------------------------------------|---------------|---------------------------|-----------------|
| 21. Name | | a. Relationship to Proposed Insured | | b. Social Security Number | |
| c. Address (Cannot be a P.O. Box) | | | d. Birth Date | | e. Phone () |
| f. Are you a citizen of <input type="checkbox"/> USA <input type="checkbox"/> Other Country _____ <input type="checkbox"/> Type of VISA _____ | | | | | |

POLICY INFORMATION

| | | | | | | | |
|--|--|------------------------|--|-------------------------|--|---------------------|--|
| 22. Plan: UL _____ | | Term _____ | | 23. Amount of Insurance | | 24. Planned Premium | |
| <input type="checkbox"/> Level <input type="checkbox"/> Increasing | | Guarantee Period _____ | | \$ | | \$ | |

25. Mode of Payment (for bank draft, complete authorization, and collect initial payment.)
 Monthly Bank Draft Quarterly Semiannually Annually Other _____

26. ADDITIONAL BENEFITS and AMOUNTS

| | |
|--|---|
| <input type="checkbox"/> Additional Insured Rider (AIR) \$ _____ | <input type="checkbox"/> Waiver of Premium Benefit Rider (WP) |
| <input type="checkbox"/> Base Insured Rider (BIR) \$ _____ | <input type="checkbox"/> Waiver of Monthly Deduction |
| <input type="checkbox"/> Children's Benefit Rider \$ _____ | <input type="checkbox"/> Disability Income Rider (AIR) Monthly Payout \$ _____ Occupation/Income _____ |
| <input type="checkbox"/> Accidental Death Benefit Rider (ADB) \$ _____ | <input type="checkbox"/> Critical Illness Rider \$ _____ |
| <input type="checkbox"/> Disability Income Rider Monthly Payout \$ _____ | <input type="checkbox"/> Other _____ \$ _____ |
| <input type="checkbox"/> Guaranteed Insurability Rider (GIR) \$ _____ | |

| 27. Name of Proposed Additional Insured(s) including any children applying | Birth Date | Sex | Height | Weight | Social Security Number | Relationship to Insured | Amount of Insurance | Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last. |
|--|------------|-----|--------|--------|------------------------|-------------------------|---------------------|--|
| | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |
| | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |
| | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |
| | | | | | | | | <input type="checkbox"/> No <input type="checkbox"/> Yes _____ |

28. LIFE INSURANCE IN FORCE If none check this box

| Insured's Name | Company (only need if replacing) | Policy Number (only need if replacing) | Face Amount |
|----------------|----------------------------------|--|-------------|
| | | | \$ |
| | | | \$ |
| | | | \$ |

29. DISABILITY INCOME - INSURANCE IN FORCE If none check this box Complete only if applying for Disability Rider.

| Insured's Name | Company | Policy Number | Monthly Amount | Benefit Period | Elimination Period |
|----------------|---------|---------------|----------------|----------------|--------------------|
| | | | | | |
| | | | | | |

30. GENERAL QUESTIONS Complete the following. For YES answers, give full details in the space provided in Section 52.

31. Will the insurance applied for replace or change any existing insurance or annuity? Yes No
- Have you or any proposed Additional Insured (including any children applying),**
32. Had any health, disability or life insurance pending or contemplated with another company? Yes No
33. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? Yes No
34. Within the past 5 years,
- a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? Yes No
(If yes, provide state and drivers license number.)
- b. Been or is now fully or partially disabled? Yes No
- c. Been charged with or convicted of any felony or been on probation? Yes No
35. Within the past 2 years, (any yes answer to 35a or 35b, complete the Aviation and Avocation Questionnaire)
- a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? Yes No
- b. Flown other than as a passenger, or plan to? Yes No
- c. Foreign residence or travel contemplated? Yes No
36. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? Yes No
37. Family History: Is there a history of cardiovascular disease (including coronary artery disease, stroke or transient ischemic attack), internal cancer or melanoma in parents/siblings prior to age 60? If yes, please provide details including, type of cancer (if applicable) and if there was a death due to this condition. Yes No
38. Have you or any proposed Additional Insured sought protection from creditors within the past 5 years? Yes No
39. Do you or any proposed Additional Insured currently or within the past two years consume six or more alcoholic beverages per week? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. Yes No
40. Have you or any proposed Additional Insured had any weight change of 10 or more pounds in the past year? Yes No

41. MEDICAL QUESTIONS Each question must be individually asked and answered. For YES answers, give full details in the space provided in Section 52.

42. Have you or any proposed Additional Insured (including any children applying) EVER been diagnosed as having or been treated for AIDS, or AIDS Related Complex (ARC) or tested positive for the AIDS virus? Yes No
- (Questions 43 to 49) Within the past 10 years, have you or any proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having any disease or disorder of the:**
43. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? Yes No
44. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? Yes No
45. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? Yes No
46. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? Yes No
47. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? Yes No
48. Endocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? Yes No
49. Cancer, tumor, polyps, melanoma or other malignancy? Yes No
50. Have you or any proposed Additional Insured (including any children applying) had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? Yes No
51. Are you or any proposed Additional Insured (including any children applying) currently under the observation of a physician or taking medication? Yes No

52. ADDITIONAL INFORMATION Explain all "yes" answers below. If additional space required, use Supplemental Form SA-ADINFO.

| Question Number | Name of Proposed Insured | Details to General and Medical Questions (Diagnosis, Dates, Durations) Medical Facilities & Physicians Names, Addresses, Phone Numbers |
|-----------------|--------------------------|---|
| | | |
| | | |
| | | |

53. PERSONAL PHYSICIAN(S) If additional space required, use Supplemental Form SA-ADINFO.

| Name of Proposed Insured | Personal Physician(s) Name, Address, Phone Number | Date Last Visited, Reason, Result |
|--------------------------|---|-----------------------------------|
| | | |
| | | |

SECTION 54. ILLUSTRATION CERTIFICATION The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application. (Universal Life only)

- The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:
- Applicant's/Owner's statement:** By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

CONDITIONAL RECEIPT

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

PLEASE READ THIS CAREFULLY

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

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

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

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

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

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

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

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

Authorization (Signatures Required)

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

Dated at _____ on _____
City State Date Signature of Agent or Authorized Company Rep

Signature of proposed Insured Signature of Applicant (if other than proposed Insured)

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

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

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

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Transamerica Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

AGENT'S REPORT

How well do you know proposed Insured? _____

Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance? Yes No

(If "yes," explain in Remarks Section)

Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?)

(If "yes," explain relationship _____)

Did you see all of those to be insured on the date the application was written? *(If "no," explain in Remarks Section)*

Class of Risk Quoted:

Term

- Preferred Plus
- Preferred Nontobacco
- Standard Plus
- Standard Nontobacco
- Preferred Tobacco
- Standard Tobacco

UL & IUL

- Preferred Elite
- Preferred Plus
- Preferred
- Non-Tobacco
- Preferred Tobacco
- Tobacco

| | | |
|-----------------|-----------|------------|
| 1. Agent's Name | Agent No. | % if Split |
| 2. Agent's Name | Agent No. | % if Split |

COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED

What is the relationship of the Owner to the primary Insured (please explain)?

What is the relationship of the Payor to the primary Insured (please explain)?

ADDITIONAL REMARKS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed Insured not fully set forth herein. I will not deliver the policy if the health of the Insured has changed.

Signature of Writing Agent

PRE-AUTHORIZED WITHDRAWAL PLAN

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

INITIAL PAYMENT (MUST CHECK ONE BOX)

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

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

ACCOUNT INFORMATION

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

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

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

SIGNATURE

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

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

Monumental Life Insurance Company

Transamerica Life Insurance Company

Stonebridge Life Insurance Company

Western Reserve Life Assurance Co. of Ohio

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

REPLACEMENT NOTICE

ASK QUESTIONS – IT’S YOUR MONEY – GET THE FACTS

Whether it is to your advantage to replace or change your existing insurance or annuity program, only you can decide. It is in your best interest to obtain adequate information in order to compare relatively short and long range costs and benefits before a final decision is made.

The agent or insurance company assisting you with this new purchase must notify your existing agent or company so that they may prepare a detailed, current statement concerning your existing program for your comparison.

EXISTING INSURANCE WHICH MAY BE REPLACED OR CHANGED

Full name of
Insurance Company
Including home
Office location

Policy or Contract
Number *

Insured

| | | |
|-------|-------|-------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*If a number has not been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.

ITEMS TO CONSIDER

1. Due to a possible change in insurability status (health, occupation or high risk recreational activities) you might be denied new coverage, or the premium may be higher than a standard premium.
2. The Incontestability and Suicide Clause time periods would probably begin anew in a new policy. This could possibly result in a claim being denied that might otherwise have been paid under an existing policy or contract.
3. Your present insurance company may be able to modify your existing plan on terms which may be more favorable for you than completely replacing it with a new policy or contract.
4. Don't terminate or alter your existing policy until after the new policy has been delivered to you and accepted by you.
5. REMEMBER: Following receipt of a new life insurance policy or annuity contract you should immediately examine its contents. If you are *not satisfied* with it for *any* reason, you have the right to return it within the twenty-day (20) "examination period" to the insurer at its home office or branch office or to the agent through whom it was purchased, for a full refund of premium. If you do return the policy or contract, you should request a dated receipt indicating that it was returned.

DID YOU READ THE “ITEMS TO CONSIDER”?

Applicant's Signature

Date

Agent's Signature

Date

Applicant's Name (printed)

Agent's Name and License Number (printed)

Address

Address

City, State, Zip Code

City, State, Zip Code

Telephone Number

Telephone Number

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EXISTING INSURANCE WHICH MAY BE REPLACED OR CHANGED

Full name of
Insurance Company
Including home
Office location

Policy or Contract
Number *

Insured

| Full name of Insurance Company Including home Office location | Policy or Contract Number * | Insured |
|--|--------------------------------|---------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

*If a number has not been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.

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DID YOU READ THE “ITEMS TO CONSIDER”?

Applicant's Signature

Date

Agent's Signature

Date

Applicant's Name (printed)

Agent's Name and License Number (printed)

Address

Address

City, State, Zip Code

City, State, Zip Code

Telephone Number

Telephone Number

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.



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

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Page
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