TRANSAMERICA®

HIPAA Authorization for Release of Health-Related Information

Transamerica Life Insurance Company

Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

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.

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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.

Reset Form

TRANSAMERICA®

Individual Life Insurance Application

Transamerica Life Insurance Company

Home Office: 6400 C Street SW Cedar Rapids, IA 52499

Company above referred to as the "Company". Unless otherwise stated, "You" refers to the Proposed Primary Insured.

1

Proposed Primary Insured Personal Information

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number
__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

U.S. Tax ID Number
__ __ - __ __ __ __ __ __ __ __ __

Place of Birth (State / Territory, Country)

Gender
☐ **Male** ☐ **Female**

Marital Status
☐ **Single** ☐ **Married (including common law)** ☐ **Registered Domestic Partner**

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Years at Address

Mailing Address **(If different from Physical Address)**

City | U.S. State / Territory | Zip Code

U.S. Driver's License Number | U.S. State / Territory | Expiration Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Preferred Phone Number ☐ **Mobile**

Alternate Phone Number ☐ **Mobile**

Best Time to Call
☐ **AM** ☐ **PM**

Time Zone

Preferred method of communication
☐ **Mail** ☐ **Phone** ☐ **Email**

Email Address

2 Language

If **yes**, go to next section.

Is your primary language English? ☐ **Yes** ☐ **No** → What is your primary language?

Was a translator used for this application? ☐ **Yes** ☐ **No**

If yes →

Relationship of the translator to the Proposed Primary Insured

☐ **Producer** ☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent** ☐ **Child**

☐ **Trustee** ☐ **Employer** ☐ **Business Partner** ☐ **Other** _____

Translator First Name | Translator Last Name

3 Nicotine Use

Have you used nicotine in any form, smokeless or otherwise, or non-nicotine E-Cigarettes/Vapes in the last 5 years?

☐ **Yes** ☐ **No**

4 Military

ⓘ **If you are active duty, please complete the Military Disclosure Form.**

Are you a member, or have you entered into a written agreement to become a member of **any** armed forces including reserves?

☐ **Yes** ☐ **No**

If yes →

Branch of Service | Occupation | Duties

Are you on alert to go or have deployment orders for a location outside the U.S.?

☐ **Yes** ☐ **No**

If yes →

Deployment Date (mm/dd/yyyy) | Country

__ __ / __ __ / __ __ __ __

5 Education

What is the highest level of education you completed?

☐ **Did not complete high school** ☐ **High School / GED** ☐ **Some college**

☐ **Trade / Tech School** ☐ **Associate's Degree** ☐ **Bachelor's Degree**

☐ **Master's Degree** ☐ **Doctorate Degree**

6 Personal Finances

If the Proposed Primary Insured is a **juvenile**, provide financial information for their legal guardian(s). **Note:** Complete a Financial Supplement for coverage over $2,000,000 for ages 18 through 70 and coverage over $1,000,000 for ages 71 and up.

Annual Earned Income
$

Includes salary, bonuses, commissions, cash tips, and deferred compensation before taxes. It excludes income from investments.

Net Worth
$

Assets such as home, bank accounts, and investments minus debt such as mortgage, loans and credit card balances, etc.

Annual Household Earned Income
$

The total of annual earned income from the Proposed Primary Insured and their spouse or domestic partner.

Total Active & Pending Spousal Insurance Coverage
$

Total amount of life insurance coverage on your spouse or domestic partner.

7 Business Finances

Please fill out this section when applying for business purposes or if you are a sole proprietor of a business.

Fair market value of the business
$

Net business income
$

% of the business you own
%

Is business insurance applied for or existing on other key members of the business?

☐ **Yes** ☐ **No**

If no →

Please explain

8 Bankruptcy

Are you or a business you own currently in bankruptcy or have you or a business you have owned been the subject of any voluntary or involuntary bankruptcy including Chapter 7, 11, or 13 proceeding pending within the last 5 years?

☐ **Yes** ☐ **No**

If yes →

Type of Bankruptcy

☐ **Chapter 7** ☐ **Chapter 11** ☐ **Chapter 13** ☐ **Other** _____

Filing Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

If discharged, provide date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

If dismissed, provide reason for dismissal

What circumstances led to the bankruptcy?

If you filed chapter 11 or 13 bankruptcy please answer the following:

Length of repayment plan (in months)

Payment per month
$

Date of last payment to be made under the plan (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

9 Travel

Do you plan to travel in the next 12 months, for business or pleasure, to destinations outside the U.S., other than: Canada, Western Europe, Hong Kong, Australia or New Zealand?

☐ **Yes** ☐ **No**

If yes →

Destination 1 (City and Country)

For multiple trips to the same destination, please identify the start date of the first trip and the end date of the last trip.

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
Total number of days at the destination	Travel Purpose ☐ **Business** ☐ **Personal**

Destination 2 (City and Country)

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
Total number of days at the destination	Travel Purpose ☐ **Business** ☐ **Personal**

Destination 3 (City and Country)

Start Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __
Total number of days at the destination	Travel Purpose ☐ **Business** ☐ **Personal**

ⓘ **If more room is required, please attach a Travel Supplement.**

10 U.S Citizenship

Are you a U.S. citizen? ☐ **Yes** ☐ **No** →

Green Card Number and Expiration

If yes, go to next section.

No Green Card? Complete all fields that are applicable and include a copy of all your immigration documents with this application.

Date of entry to the U.S. (mm/dd/yyyy)	Country of Citizenship
__ __ / __ __ / __ __ __ __	
Temporary Visa Type	Temporary Visa Expiration (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

I-94 Expiration Date (mm/dd/yyyy)	Passport Country	Passport Expiration (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __		__ __ / __ __ / __ __ __ __

Passport Number	Employee Authorization Document (EAD) Category Code and Expiration (mm/dd/yyyy)
	__ __ / __ __ / __ __ __ __

11 Other Insurance

If you are doing an Internal Replacement, please fill out the Withdrawal/ Surrender Request form.

Do you have any existing life insurance or annuities? **If yes**, please fill out the table for all existing life/annuity coverage and complete the state required forms, if applicable.

☐ **Yes** ☐ **No**

If yes

Will the insurance applied for on your life discontinue, replace or change any existing life or annuity coverage? **If yes**, please note the coverage to be replaced in the table and complete the state required forms, if applicable.

If yes

☐ **Yes** ☐ **No**

Type of Coverage: Personal, Business, Employer Provided, Group

Type of Coverage	Company	Policy #	Face Amount	Replacement?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

Are there any life insurance policies on your life that you do not own, including but not limited to any that you have sold or settled?

☐ **Yes** ☐ **No**

If yes

Insurance Company Name | Owner's Name | Total amount of insurance $

Is this intended to be a 1035 Exchange? **If yes**, please complete the 1035 Exchange and Rollover form.

☐ **Yes** ☐ **No**

If yes

Anticipated Cash Value Transfer

$

Total accidental death insurance in-force with all companies?

$

Is any application for life insurance on your life pending with any company, including Transamerica?

☐ **Yes** ☐ **No**

If yes

Insurance Company Name | Amount applied for $ | Total amount to be placed $

Have you ever had life, disability, or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed?

☐ **Yes** ☐ **No**

If yes

Please explain

12 Other Insurance

continued

Only complete if you are applying for Monthly Disability Income Rider.

Do you have any existing *Disability Income* insurance in-force?

☐ **Yes** ☐ **No**

If yes

Company	Policy #	Monthly Amount	Benefit Period	Elimination	Replacement?
		$			☐ Yes ☐ No
		$			☐ Yes ☐ No
		$			☐ Yes ☐ No

13 Owner

Complete this section only if the owner is not the Proposed Primary Insured.

Is the owner a Person or a Business Entity or Trust?

☐ **Person** ☐ **Business Entity or Trust - (go to the next page)**

If person, complete this page.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number
__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

U.S. Tax ID Number
__ __ - __ __ __ __ __ __ __

Email Address

Gender
☐ **Male** ☐ **Female**

Do you have a Contingent Owner? If you have a contingent owner, complete the Contingent Owner Supplement.

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory | Zip Code

Country | Years at Address | Preferred Phone Number
☐ **Mobile**

Mailing Address **(If different from Physical Address)**

City | U.S. State / Territory | Zip Code

Owner's relationship to Proposed Primary Insured

☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent**
☐ **Employer** ☐ **Business Partner** ☐ **Other** _____

13

Owner
continued

If yes, go to next section.

Is the owner a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

No Green Card? Complete all fields that are applicable and include a copy of all immigration documents with this application.

Date of entry to the U.S. (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Country of Citizenship

Temporary Visa Type

Temporary Visa Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

I-94 Expiration Date (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Passport Country

Passport Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Passport Number

Employee Authorization Document (EAD) Category Code and Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

If owner is a corporation, partnership or institutional body, complete an Entity Certification.

Complete this section only if the owner is a Business Entity or Trust.

Business Entity or Trust Name

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

If owner is a trust, complete a Trust Certification.

Complete this section for eDelivery.

By providing an email address below, I consent to receive an email that will initiate the process of receiving electronic documents and notices applicable to any contract issued on this application. A link within the email will direct you to the Company e-delivery terms and conditions as well as our registration and consent process. I have access to the Internet for the purpose of accepting electronic delivery of documents.

Electronic Delivery Document notifications will be provided to only one email address. Any email provided above will override any existing email address, if applicable. Please call 877-234-4848 if you would like to revoke your consent, wish to receive a paper copy of the information above, or need to update your email address.

Email Address

14 Primary Beneficiaries

Total shares between all primary beneficiaries must equal 100%.

Primary Beneficiary 1

Primary Beneficiary 1 Percentage of Death Benefits

___ %

Total shares between all primary beneficiaries must equal 100%.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number (if a person) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Business Entity or Trust Name (if applicable)

U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent** ☐ **Child** ☐ **Trust**

☐ **Estate** ☐ **Business Partner** ☐ **Employer** ☐ **Other** _____

Primary Beneficiary 2

Primary Beneficiary 2 Percentage of Death Benefits

___ %

Total shares between all primary beneficiaries must equal 100%.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number (if a person) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Business Entity or Trust Name (if applicable)

U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent** ☐ **Child** ☐ **Trust**

☐ **Estate** ☐ **Business Partner** ☐ **Employer** ☐ **Other** _____

14

Primary Beneficiaries
continued

Primary Beneficiary 3 Percentage of Death Benefits

%

Total shares between all primary beneficiaries must equal 100%.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __

Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Business Entity or Trust Name (if applicable)

U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured

City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent** ☐ **Child** ☐ **Trust**

☐ **Estate** ☐ **Business Partner** ☐ **Employer** ☐ **Other** _____

If you need space for more primary beneficiaries, complete the Beneficiary Supplement.

For Contingent Beneficiaries, go to the next page.

15 Contingent Beneficiaries

Total shares between all contingent beneficiaries must equal 100%.

Contingent Beneficiary 1 Percentage of Death Benefits

_____ %

Total shares between all contingent beneficiaries must equal 100%.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __

Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Business Entity or Trust Name (if applicable)

U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent** ☐ **Child** ☐ **Trust**

☐ **Estate** ☐ **Business Partner** ☐ **Employer** ☐ **Other** _____

Contingent Beneficiary 2 Percentage of Death Benefits

_____ %

Total shares between all contingent beneficiaries must equal 100%.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __

Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Business Entity or Trust Name (if applicable)

U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Domestic Partner** ☐ **Parent** ☐ **Child** ☐ **Trust**

☐ **Estate** ☐ **Business Partner** ☐ **Employer** ☐ **Other** _____

If you need space for more contingent beneficiaries, complete the Beneficiary Supplement.

16 Secondary Addressee

Complete this section if you would like to list an additional person to receive copies of notices and letters regarding possible lapses in coverage.

Legal First Name | Middle Name | Legal Last Name | Suffix

Mailing Address

City | U.S. State / Territory | Zip Code

Email Address | Phone Number

☐ **Mobile**

17 Product Details

If applying for multiple products, complete the Product Details Supplement.

Product Name | Coverage Amount **$** | *This is the amount of life insurance coverage you are applying for.*

Duration in years (Only applicable to Term Products)

☐ **10** ☐ **15** ☐ **20** ☐ **25** ☐ **30**

☐ **Other** _____

Rate Class Applied for:

☐ **Preferred Elite** ☐ **Preferred Plus** ☐ **Preferred**

☐ **Non-Tobacco** ☐ **Preferred Tobacco** ☐ **Tobacco**

☐ **Juvenile** ☐ **Other** _____

Automatic Premium Loan (may not be available on all policies).

☐ **Elect** ☐ **Do Not Elect**

If you're applying for an additional rating fill in this question. →

Extra Substandard Rating of ☐ **Table Rating** ☐ **Flat Extra**

What is the purpose of this insurance?

☐ **Personal: Income Replacement** ☐ **Personal: Estate Planning**

☐ **Business: Key Man/Person** ☐ **Business: Loan Coverage**

☐ **Business: Buy/Sell** ☐ **Business: Other** _____

Death Benefit Option (if applicable to your product)

☐ **Level** ☐ **Increasing** ☐ **Graded**

Life Insurance Compliance Test (if applicable to your product)

☐ **Guideline Premium Test (GPT)** ☐ **Cash Value Accumulation Test (CVAT)**

☐ **Other** _____

17

Product Details

continued

Complete the **Additional Insured Rider Supplement Application**

Complete the **Children's Benefit Rider Supplemental Application**

Complete the **Disability Income Rider Questionnaire**

Complete the **Income Protection Option Election Form**

Complete the **Long Term Care Rider Supplemental Application**

For Non-US citizens that are lawful permanent residents, a copy of your green card is required.

Additional Benefits (Not available with all products and not available in all States)

Benefit	Amount
☐ **Accidental Death Benefit Rider**	**$**
☐ **Additional Insured Rider**	Coverage amount included on the supplement form
☐ **Base Insured Rider**	**$**
☐ **Children's Benefit Rider**	**$**
☐ **Chronic Illness Rider**	Amount not applicable
☐ **Critical Illness Rider**	Amount not applicable
☐ **Disability Income Rider**	**Years** **$**
☐ **Disability Waiver of Monthly Deductions Rider**	Amount not applicable
☐ **Disability Waiver of Premium Rider**	Amount not applicable
☐ **Enhanced Index Rider**	Amount not applicable
☐ **Guaranteed Insurability Rider**	**$**
☐ **Income Protection Option**	Amount not applicable
☐ **Long Term Care Rider**	Amount not applicable
☐ **Term Insurance Rider**	**$** ☐ **10 yrs** ☐ **20 yrs** ☐ **30 yrs**
☐ **Other** _____	**$**

18 Premium

Frequency

- ☐ **Monthly**
- ☐ **Quarterly**
- ☐ **Annually**
- ☐ **Single Premium**
- ☐ **Semi-annually**
- ☐ **Other** _____

Recurring Payment Method

- ☐ **Electronic Funds Transfer/Bank Draft** *(Complete the Electronic Payment form)*
- ☐ **Direct Bill**
- ☐ **Military Allotment**
- ☐ **Civil Service Allotment**
- ☐ **List Bill** _____

This is the recurring amount you will pay. →

Planned Periodic Premium **$** _____

Lump Sum equals additional funds in the contract or 1035 money, leave this blank if not applicable. →

Lump Sum **$** _____

Source of Funds

- ☐ **Employment**
- ☐ **1035 Exchange**
- ☐ **Retirement**
- ☐ **Other** _____

If any Proposed Insured has been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for heart trouble, stroke, or cancer within the past 12 months, then no payment of premium should be accepted with the application.

Amount submitted with application

$ _____

- ☐ **EFT**
- ☐ **Credit Card**
- ☐ **Check**

For EFT and Credit Card please complete the Electronic Payment form. Credit card not applicable for all products.

19 Premium Payor

A person, trust or entity paying the premium

Complete this section if the premium payor is different than the owner.

Legal First Name	Middle Name	Legal Last Name	Suffix

U.S. Social Security Number	Date of Birth (mm/dd/yyyy)
__ __ __ - __ __ - __ __ __ __	__ __ / __ __ / __ __ __ __

Business Entity or Trust Name	U.S. Tax ID Number
	__ __ - __ __ __ __ __ __ __

Physical Address (Cannot be a P.O. Box)	Apartment / Unit

City	U.S. State / Territory

Zip Code	Country	Phone Number
		☐ **Mobile**

Email Address

19

Premium Payor

continued

Premium Payor's relationship if other than the Proposed Insured

☐ **Spouse** ☐ **Child** ☐ **Domestic Partner** ☐ **Employer** ☐ **Grandparent**
☐ **Parent** ☐ **Trust** ☐ **Business Partner** ☐ **Other** _____

Is the Premium Payor a U.S. citizen?

☐ **Yes** ☐ **No** →

If yes, go to next section.

Green Card Number and Expiration

__ __ / __ __ / __ __ __ __

No Green Card? Complete all fields that are applicable and include a copy of all your immigration documents with this application.

Date of entry to the U.S. (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Country of Citizenship

Temporary Visa Type

Temporary Visa Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

I-94 Expiration Date (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Passport Country

Passport Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Passport Number

Employee Authorization Document (EAD) Category Code and Expiration (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

ⓘ Mail additional premium notices to

Legal First Name | Middle Name | Legal Last Name | Suffix

Mailing Address

City | U.S. State / Territory | Zip Code

20

Variable Universal Life, Universal Life, and Index Universal Life

ⓘ For Variable Life Insurance (VUL) product:

Has the Owner received the current Prospectus for the policy?

☐ **Yes** ☐ **No**

Premium Allocation Options for VUL

I have completed and signed the **Allocation Form**. Allocate funds accordingly.

DOES THE OWNER UNDERSTAND THAT THE DEATH BENEFIT MAY BE VARIABLE OR FIXED UNDER SPECIFIED CONDITIONS?

☐ **Yes** ☐ **No**

DOES THE OWNER UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE ENTIRE AMOUNT OF THE POLICY VALUE MAY INCREASE OR DECREASE DEPENDING UPON THE INVESTMENT EXPERIENCE?

☐ **Yes** ☐ **No**

20

Variable Universal Life, Universal Life, and Index Universal Life

continued

With this in mind, is the policy in accordance with Owner's insurance objectives and anticipated financial needs?

☐ **Yes** ☐ **No**

Transfer Authorization Your policy applied for, if issued, will automatically include transfer privileges described in the applicable prospectus. These privileges allow the Owner and the Producer of record to make transfers and to change the allocation of future payments unless declined below. The Company will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. The Company will employ reasonable procedures to confirm that transfer instructions are genuine. If The Company does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐ **The Producer does not have authority to make transfers or change payment allocations on my behalf.**

For Universal Life (UL) & Indexed Universal Life (IUL) products:

Premium Allocation Options for IUL

I have completed and signed the **Allocation Form**. Allocate funds accordingly.

Illustration Certification

☐ **If this box is checked, the Applicant/Owner and the Producer 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 supplemental 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.

Producer's statement: By signing this supplemental application, I, the Producer 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.

☐ **If this box is checked, the Applicant/Owner and the Producer 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 supplemental application, I, the Applicant/Owner acknowledge that an illustration was presented to me, but it differs from the coverage I applied for. I understand that an illustration of the policy as issued will be provided no later than the policy delivery date.

Producer's statement: By signing this supplemental application, I, the Producer certify that an illustration was presented to the Applicant/Owner at the time of the sale of the life insurance policy in accordance with state regulations and company requirements. However, the illustration differs from the life insurance policy applied for on the accompanying application and I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

21 Authorization to Obtain and Disclose Information

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and complete to the best of my knowledge and belief. I acknowledge and agree (A) this application shall consist of the Individual Life Insurance Application, the Individual Life Insurance Application - Personal History, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (B) that the Producer does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the Owner must have personally received and accepted the policy during the lifetime of each Insured and there must have been no change in the insurability of any Insured; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete. Unless otherwise stated the undersigned Insured is the premium payor and Owner of the policy applied for.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, wellness/fitness, financial services or insurance company, MIB, Inc. ("MIB"), consumer reporting agency, data aggregator, or any other organization, institution or person, that has any records or knowledge of me or my health/fitness, finances, credit history, credit standing, credit capacity, life activities or purchase history, to give to the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I understand a credit report may be requested in connection with this authorization. I also understand that any credit reporting agency contacted in connection with this authorization may retain and use any information provided about me to the credit reporting agency to the extent that the information is in addition to or more current than the information currently held by such credit reporting agency, and do consent to such use of my information.

I hereby expressly consent to receive calls about my application from the Company or its representatives that involve the use of an automatic telephone dialing system and/or an artificial or prerecorded voice.

This authorization will be valid for 30 months, or the period permitted by applicable law in the state where the policy is delivered or issued for delivery, if shorter. Information released shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in-force. I understand the Company may use the information collected via this authorization: (1) to underwrite my insurance application, (2) to support the operations of the Company's business, (including performing actuarial or internal business studies, research and analytics and other analysis), or (3) if a policy is issued, to evaluate contestability and eligibility for benefits, the policy's continuation or replacement, the policy's reinstatement, or to contest a claim under the policy.

The Company shall have 60 days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Owner or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the Notice of Disclosure for (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

Products are available under both companies listed on the top of Page 1. If approved, the product applied for will be issued under the company checked on the top of Page 1 unless the situation requires issuance under the other company. Such situations may include, but are not limited to, producer licensing requirements, mismatch of company selected and sales materials or a failure to select, or error in selecting, a company on the top of Page 1.

TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding, or the IRS has notified me I am no longer subject to backup withholding, or I am not subject to backup withholding because I am exempt; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification. You must cross out item (2) if you are currently subject to backup withholding.

21 Authorization to Obtain and Disclose Information

continued

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

Signature of Proposed Insured	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory
Signature of Parent or Legal Guardian (Of children under age 18)	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory
Signature of Applicant/Owner (If other than Proposed Insured)	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory

If entity, show title of officer and name of entity.

If trust, show trustee's name.

Title of Trust (If owner is trust)

Print Producer 1 Name	Producer 1 Number	Producer 1 Signature
Print Producer 2 Name	Producer 2 Number	Producer 2 Signature

22 Other Insurance (to be completed by the Producer)

Does the Proposed Insured have existing life insurance policies or annuity contracts with the company or any other company?

☐ **Yes** ☐ **No**

Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity?

☐ **Yes** ☐ **No**

If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements?

☐ **N/A** ☐ **Yes** ☐ **No** → If no, explain.

I certify that I used only company approved sales materials and copies of all sales materials used during the solicitation were provided to the applicant.

Producer Signature

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to 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 on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, 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 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 primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts 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 (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured 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 Tobacco 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 it, 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 notice and/or 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 the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,500,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance 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. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

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 primary 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 primary 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 the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by the 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.

If Proposed Owner is a Corporation, an authorized officer, other than the proposed primary Insured must sign as Owner. Give corporate title and full name of corporation.

Submit this completed and signed document with the application and payment.

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to 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 on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, 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 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 primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts 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 (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured 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 Tobacco 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 it, 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 notice and/or 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 the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,500,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance 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. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

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 primary 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 primary 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 the application have been met.

Dated at _____ on _____ ,20____ X _____

City, State | Date | Insurance Producer or other Company Authorized Rep

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by the 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.

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

NOTICE OF DISCLOSURE

Please provide a copy of these notices to the applicant and to any proposed Insureds not living in the household.

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

Proposed Insured and other persons proposed to be insured, if any: Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which 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, upon request, will 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. Please contact MIB at 866-692-6901 (TTY 866-346-3642). 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 (www.ftc.gov). The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our producer 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, 6400 C Street SW, Cedar Rapids, Iowa 52499.

Reset Form

Agent's Report

1

Producer 1 →

Writing Agent Name	Agent Number	Profile Number	Percent of Agent's Split

Producer 2 →

Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

Producer 3 →

Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

Producer 4 →

Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

2

Agent Disclosure

How long have you known the Proposed Primary Insured?	Relationship to Proposed Primary Insured

Are you financially responsible for the Proposed Primary Insured?

☐ **Yes** ☐ **No**

Are you or any of your family members named as a beneficiary on this policy application?

☐ **Yes** ☐ **No**

If yes →

If, yes what insurable interest do you/your family member have in the life of the insured(s)?

Do you intend to submit multiple applications on any of the proposed insureds?

☐ **Yes** ☐ **No**

Is the Agent or Split Agent also the Owner, Applicant or Payor?

☐ **Yes** ☐ **No**

Is the Proposed Primary Insured or owner related to any affiliated Broker/Dealer office or employee?

☐ **Yes** ☐ **No**

If yes →

Name and address of Broker/Dealer

City	U.S. State / Territory	Zip Code

Did you provide the "Notice of Disclosure" to the Proposed Primary Insured?

☐ **Yes** ☐ **No** ☐ **N/A**

Please indicate how this sale was taken:

☐ In person ☐ Phone or Video Call (Skype, FaceTime, etc.) ☐ Other _____

Was the identification of the Proposed Primary insured verified during the sale?

☐ **Yes** ☐ **No**

Type of Government issued photo ID

Issuer of Identification Document	Number	Expiration Date

Are you aware of anything about the health, habits, hazardous sports, environment or mode of living, which may affect the insurability of any person proposed for insurance that was not disclosed on the application?

☐ **Yes** ☐ **No**

If yes

Provide Details

3 Correspondence Information

Case Manager Name (if applicable)

Agent/Case Manager Email	Office ID

Agent/Case Manager Phone Number	Agent/Case Manager Fax Number

4 Signature

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of the person(s) seeking to open this policy and verified that person seeking to open this policy is the same person in the documents reviewed. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action or prosecution for violation of state or federal criminal laws.

Payment with application not accepted if the primary proposed insured total coverage over $1,000,000.00, age 76 and over, or treated for or experienced heart trouble, stroke or cancer within the past 12 months.

Signature of Writing Agent/ Registered Representative

__ __ / __ __ / __ __ __ __

Date (mm/dd/yyyy)

Reset Form

Payment Authorization Form

TRANSAMERICA®

Policy Number (for existing policies only)

Introduction

Instructions:

Use this form to choose the initial premium payment method on your application for insurance or to update how you pay for an existing policy. Take care to fill in each field accurately so letters and numbers cannot be misinterpreted. Please attach a separate sheet if there is more than one policy number.

Return Completed Form To:
Transamerica Life Insurance Company
Transamerica Financial Life Insurance Company
6400 C St. SW
Cedar Rapids, IA 52499

Or fax it to us at:
1-800-235-4782

Questions?

Contact your Financial Professional

Visit us at: transamerica.com

Call us at: 1-800-797-2643

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Draft Date (MM/DD, 1st through 28th only)

__/__

If you select an initial premium draft date in the future, it cannot be greater than 30 days after the application date, and you will not have potential coverage until that date under the Conditional Receipt.

Leave the above blank to have initial and recurring premiums drafted on day policy is issued.

Recurring Payment Frequency (choose one)

☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Total Premium

$___,___.___

Please select your preferred payment type/s by checking the box for initial and/or recurring payments next to the option you favor. (Ex: I want to make my initial payment by check and recurring payments with my credit card.)

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Credit Card	☐ **Initial** ☐ **Recurring**	Tokenize your card number, and complete the Credit Card Payment section below
Check	☐ **Initial**	No additional form required; mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	No additional form required; this method only available quarterly, semiannually, or annually.

Credit Card Payment Information

Credit Card Type: ☐ **VISA** ☐ **MasterCard**

PCI Token #

Create your PCI token at: creditcardtoken.transamerica.com
(Reminder: When you enter your credit card information on the Token website, your unique number will start with a "T". Be sure to write the full number, including the T, on the line to the left.)

Cardholder First Name

Cardholder Last Name

Card Exp.Date ____/____

Payment Amount $____,____.____

The cardholder is the (choose one):

☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

X _____

By signing I acknowledge that I have read and agreed to all of the following consents that pertain to my preferred premium payment method.

Bank Draft (ACH/EFT) Payment Information

Account Type: ☐ **Checking** ☐ **Savings**

Account Holder First Name

Account Holder Last Name

Trust or Entity (if entity, add the title of officer and name of entity; if trust, add trustee's name)

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

The account holder is the (choose one):

☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Account Holder Signature:

X _____

By signing I acknowledge that I have read and agreed to all of the following consents that pertain to my preferred premium payment method.

Consents

If a conditional receipt was issued along with this authorization, initial premium will be withdrawn/cashed upon receipt of the application by the Company. 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 the application have been met.

As a convenience to me, I request and authorize the Company named above to make withdrawals, by draft or electronic transfer, from my account with the financial institution named for: (1) premiums becoming due (including premiums which have increased from the initial payment amount under the terms of the policy(ies) or due to changes made to the policy(ies)); (2) other amounts due under the policy(ies) listed above (including any amendments, endorsements, riders, or amounts past due); (3) loan payments if authorized above or later agreed to by me; and/or (4) such other payments as I may authorize the Company to make. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made to the policy(ies). I understand that if a withdrawal is not honored for payment by the financial institution, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request the financial institution named above (and its successors and assigns) to accept and honor the draft or transfer withdrawals made by the Company from my account. I agree the financial institution shall be fully protected in honoring such draft or transfer.

This authorization shall take effect when recorded and processed by the Company and financial institution and will remain in effect until I notify the Company or the financial institution in writing to terminate and the Company or financial institution has a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Company to initiate charges to this account for the above policy(ies) effective the date on which the initial charge is made under this authorization. I also understand and agree that if a withdrawal is not honored by the financial institution for any reason, the Company may cease attempting to make withdrawals through the use of this authorization.

Bank Account Will be Subject to Identity Verification
To help ensure the security of your funds, if bank account information is provided, the Company may obtain a consumer report from a Consumer Reporting Agency (“CRA”) to help verify the validity and accuracy of the account information provided. If I have provided the company with bank account information, I authorize the Company to obtain a consumer report from the CRA as described above, and acknowledge that I: (i) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA; and (ii) consent to such sharing, retention, and use.

TRANSAMERICA®

Terminal Illness, Chronic Illness and Critical Illness Accelerated Death Benefit Riders Disclosure

Transamerica Life Insurance Company

Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

This disclosure form provides a brief description of accelerated death benefit riders that may be available under your policy. For details of the riders available and your rights and obligations under the policy, please read your policy carefully. Accelerated benefits are payments made to you during the lifetime of the Insured in lieu of payment of the full death benefit of the policy.

Terminally Ill means the Insured has a medical condition, resulting from bodily injury or disease, or both, which is expected to result in the death of the Insured within 12 months of diagnosis.

Chronically Ill means the Insured:

(a) Is unable to perform, without Substantial Assistance from another person for a period of at least 90 days, at least two out of six Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or

(b) Requires Substantial Supervision by another person, for a period of at least 90 consecutive days, to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

Critically Ill means the Insured has been diagnosed by a Physician with one or more of the following health conditions or underwent one or more of the following medical procedures:

(a) Heart Attack
(b) Stroke
(c) Cancer
(d) End Stage Renal Failure
(e) Major Organ Transplant
(f) Blindness
(g) Paralysis
(h) AIDS
(i) Aplastic Anemia
(j) First Coronary Angioplasty
(k) First Coronary Artery Bypass
(l) Motor Neuron Disease
(m) Central Nervous Disease

Conditions Under which Accelerated Benefits May be Elected: If the Insured becomes Terminally Ill, Critically Ill or Chronically Ill while the policy and rider are in effect, you may elect to receive an Accelerated Death Benefit payment subject to the provisions of the policy and rider and the following conditions:

1. You must provide us with the required certification applicable to the requested form of Accelerated Death Benefit; and
2. The policy and the rider must be in effect at the time of your Accelerated Death Benefit request; and
3. The Face Amount of the policy at the time the Accelerated Death Benefit request is received must be at least $25,000; and
4. We must receive the written consent of all irrevocable Beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

Amount of Accelerated Death Benefit: The Accelerated Death Benefit payment we make to you will be less than the amount of the Available Death Benefit which you request to accelerate, but never less than the Election Percentage multiplied by the difference between the Policy Value, if any, and any Loan Balance. For each form of Accelerated Death Benefit, the Accelerated Death Benefit payment for the amount of the death benefit which you request to accelerate will be calculated as A minus B minus C minus D minus E where A, B, C, D and E are determined as follows:

A. The actuarial present value of the amount of the Available Death Benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your rider.

B. Any amount necessary to provide insurance to the date of the Accelerated Death Benefit payment if we make the payment during a grace period or after the policy has lapsed.

C. The Loan Balance, if any, at the time the Accelerated Death Benefit is paid, multiplied by the Election Percentage.

D. The actuarial present value of future premiums, including premiums for any Base Insured Rider or Joint Insured Term Rider, but excluding other rider premiums, multiplied by the Election Percentage. The actuarial present value of future premiums is the amount as determined by us that would, prior to the acceleration, otherwise be payable to keep the policy In Force during the period of the Insured's remaining lifetime as determined by our physician's assessment, at time of the acceleration. This amount is determined by us using the applicable rated age, mortality tables, and interest rate described under 1), 2), and 3) of the Present Value of Accelerated Death Benefit provision. For the Terminal Illness Accelerated Death Benefit, the future premiums are assumed to be zero.

E. An administrative charge for each Accelerated Death Benefit request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2016 is $350, but will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index for All Urban Consumers (CPI) since January 1, 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used. In no event will the administrative charge for each Accelerated Death Benefit request exceed $1,000.

If we approve your request for a Chronic Illness Accelerated Death Benefit or Critical Illness Accelerated Death Benefit, the amount that may be payable will be based in part on the Insured's remaining life expectancy as determined by us at the time of the acceleration. Generally, the longer the Insured's remaining life expectancy, the lower the payment amount will be. The shorter the Insured's remaining life expectancy, the higher the payment amount will be.

Maximum Accelerated Death Benefit: The maximum death benefit you may accelerate over the lifetime of the Insured is equal to the lesser of:

1. 90% of the Available Death Benefit of this policy for Critical Illness and Chronic Illness; 100% of the Available Death Benefit of this policy for Terminal Illness; or
2. A maximum Accelerated Death Benefit amount declared by us. This amount will never be less than $500,000.

The maximum death benefit you may accelerate in any 12 month period because the Insured is Chronically Ill is the lesser of (1) 24% of the Available Death Benefit of the policy at the time of the initial acceleration, and (2) the annual equivalent of the per diem limitation set forth in Title 26, Section 7702B (d) of the Internal Revenue Code, as adjusted for inflation.

Effect of the Accelerated Death Benefit Payment on the Policy: The policy's benefits and values, as those amounts exist on the date the Accelerated Death Benefit is paid, will be reduced by the Election Percentage. The premium and/or charges and monthly deductions, as applicable, for the policy and any affected riders will also be adjusted after an Accelerated Death Benefit is paid.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Payment of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits and entitlements. Accelerated Death Benefits do not and are not intended to qualify as long-term care insurance.

We intend that payments we make under the Accelerated Death Benefit options will receive favorable tax treatment; however, there are circumstances when receipt of an Accelerated Death Benefit payment may be taxable. Please consult your personal tax advisor to determine the tax status of any benefits paid under these options.

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.

TRANSAMERICA®

Terminal Illness Accelerated Death Benefit Disclosure

Transamerica Life Insurance Company

Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

This disclosure form provides a brief description of accelerated death benefits that may be available under your policy. For details of the benefits available and your rights and obligations under the policy, please read your policy carefully. Accelerated death benefits are payments made to you during the lifetime of the Insured in lieu of payment of the full death benefit of the policy.

Terminally Ill or Terminal Illness means the Insured has a medical condition, resulting from bodily injury or disease, or both, which is expected to result in the death of the Insured within 12 months of diagnosis.

Conditions Under which Accelerated Benefits May be Elected: If the Insured becomes Terminally Ill while the policy and rider/endorsement are in effect, you may elect to receive an Accelerated Death Benefit payment subject to the provisions of the policy and rider/endorsement and the following conditions:

1. You must provide us with a Physician's certification of Terminal Illness dated within 30 days of the Accelerated Death Benefit request; and
2. The policy and the rider/endorsement must be in effect at the time of your Accelerated Death Benefit request; and
3. The Face Amount of the policy at the time of the Accelerated Death Benefit request must exceed the minium required by the Accelerated Death Benefit rider/endorsement; and
4. We must receive the written consent of all irrevocable Beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

Charges for Accelerated Death Benefits: There is no premium charge for the Accelerated Death Benefit rider/endorsement, however, an administrative charge and interest discount will be assessed as part of the calculation of an Accelerated Death Benefit payment.

Effect of the Accelerated Death Benefit on the Policy: The policy's benefits and values, as those amounts exist on the date the Accelerated Death Benefit is paid, will be reduced after payment of an Accelerated Death Benefit. The premium and/or charges and monthly deductions, as applicable, for the policy and any affected riders will also be adjusted after an Accelerated Death Benefit is paid.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Payment of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits and entitlements. Accelerated Death Benefits do not and are not intended to qualify as long-term care insurance.

We intend that payments we make under the Accelerated Death Benefit options will receive favorable tax treatment; however, there are circumstances when receipt of an Accelerated Death Benefit payment may be taxable. Please consult your personal tax advisor to determine the tax status of any benefits paid under these options.

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.

TRANSAMERICA®

Premium Bank Draft
Accountholder Certification

○ **Transamerica Financial Life Insurance Company**
Home Office: Harrison, New York
○ **Transamerica Life Insurance Company**
Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

Company selected above referred to as "the Company". I have viewed proof of the bank account information provided for automatic premium bank drafts on the Company life insurance policy application dated _____ for (insured name) _____.

I certify that the bank accountholder is _____. This individual holds an acceptable payor relationship to the contract per Company guidelines* and has authorized use of their funds from the account to pay for premiums on this policy.

_____ _____
Agent Printed Name Agent Code

_____
Agent Signature

_____
Date

*Acceptable payor relationships are: any acceptable party to the contract (e.g. owner, insured, beneficiary), immediate and verifiable family relationship (e.g. parent, grandparent, etc.) or any established and verifiable business relationship (e.g. employer in a key-employee agreement). The Company reserves the right to request an alternative payor.

TRANSAMERICA®

Notice to Applicants Regarding Replacement of Life Insurance or an Annuity

Transamerica Life Insurance Company

Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

THIS NOTICE IS FOR YOUR BENEFIT AND IS REQUIRED BY LAW.

1. If you are urged to purchase life insurance and to surrender, lapse, or in any other way change the status of existing life insurance, the agent is required to give you this notice.

2. It may not be advantageous to drop or change existing life insurance in favor of new life insurance, whether issued by the same or a different insurance company. Some of the disadvantages are:

   a. The amount of the annual premium under an existing policy may be lower than that under a new policy having the same or similar benefits.
   b. Generally, the initial costs of life insurance policies are charged against the cash value increases in the earlier policy years, the replacement of an old policy could result in the policyholder sustaining the burden of these costs twice.
   c. The incontestable and suicide clauses begin anew in a new policy. This could result in a claim under a new policy being denied by the company which would have been paid under the old policy.
   d. Existing policies may have more favorable provisions than new policies in such areas as settlement options and disability benefits.
   e. An existing policy may have a reserve value in addition to any cash value which may be of some benefit to the insured.
   f. The insurance company carrying your current insurance policy can often make a desired change on terms which would be more favorable than if existing insurance is replaced with new insurance.

3. It may not be advantageous to change an existing policy to reduce paid-up or extended term insurance or to borrow against its loan value beyond your expected ability or intention to repay in order to obtain funds for premiums on a new policy.

4. There may be a situation in which a replacement policy is advantageous. You may want to receive the comments of the present insurance company before deciding this important financial matter.

I hereby acknowledge that I received the above “Notice to Applicants Regarding Replacement of Life Insurance or an Annuity” before I signed the application for the proposed new insurance.

_____ _____

Date Signature of Applicant

STATEMENT BY APPLICANT REGARDING NOTIFICATION OF REPLACEMENT TO THE REPLACED INSURER

I have read the "NOTICE TO APPLICANTS REGARDING REPLACEMENT OF LIFE INSURANCE OR AN ANNUITY" which was furnished to me by the agent taking the application for this policy.

(Applicant: Please sign ONE of the following statements.)

1. Please notify my present insurer(s) regarding this transaction.

   Date _____ Signature of Applicant _____

2. Please do not notify my present insurer(s) regarding this transaction.

   Date _____ Signature of Applicant _____

The signature of the applicant shall be that of the insured unless someone other than the insured is the owner of the policy. If someone other than the insured is the owner of the policy, the owner must sign. If the insured is under eighteen (18) years of age, the parent is deemed to be the owner of the policy.

Certification by the agent:

I hereby certify that nothing was said or done during the sales presentation to influence the decision of the applicant regarding this statement.

Date _____ Signature of Agent _____

Insurance Agency or Agent _____ License Number _____

DEFINITIONS

PREMIUMS: Premiums are the payments you make on the life insurance or annuity contract. They are unlike deposits in a savings or investment program because if you drop the policy you might get back less than you paid in.

CASH SURRENDER VALUE: This is the amount of money you can get if you surrender your life insurance policy or annuity. If there is a policy loan, the cash surrender value is the difference between the cash value printed in the policy and loan value. Not all policies have cash surrender values.

LAPSE: A life insurance policy may lapse when you do not pay the premiums within the grace period. If your policy had a cash surrender value, the insurer might change your policy to as much extended term insurance or paid-up insurance as the cash surrender value will buy. Sometimes the policy lets the insurer borrow from the cash surrender value to pay the premiums.

SURRENDER: You surrender a life insurance policy when you either let it lapse or tell the company you want to drop it. If a policy has a cash surrender value, you can receive such value in cash if you return the policy to the company with a written request.

PLACE ON EXTENDED TERM: This means you use your cash surrender value to change your insurance to term insurance with the same insurer. In this case, the net death benefit will be the same as before but you will only be covered for a specified period of time.

BORROW POLICY LOAN VALUES: If your life insurance policy has a cash surrender value, you can usually borrow all or part of said amount from the insurer. Interest will be charged according to the terms of the policy, and if the loan and unpaid interest ever exceeds the cash surrender value the policy will be terminated. If you die, the amount of the loan and any unpaid interest due will be subtracted from the death benefits.

EVIDENCE OF INSURABILITY: This means proof that you are an acceptable risk. You have to meet the standards of the insurer regarding age, health, occupation, and such other standards as the insurer feels necessary to be eligible for coverage.

INCONTESTABLE CLAUSE: This says that after one (1) or two (2) years, according to the provisions of the contract, the insurer shall not resist a claim because you made a false or incomplete statement when you applied for the policy. During the first two (2) years if there are false or incomplete answers on the application and the insurer discovers them, the insurer can deny a claim as if the policy has never existed.

SUICIDE CLAUSE: This says that if you commit suicide after being insured for less than two (2) years, your beneficiaries will receive only a refund of the premiums that were paid.

TRANSAMERICA®

Application Supplement for
Children's Benefit Rider

Transamerica Life Insurance Company

Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

1. Child(ren) proposed for coverage under the Children's Benefit Rider

First Name	Middle Initial	Last Name	Suffix	Date of Birth	Gender	Height	Weight

2. ☐ Yes ☐ No Are all the children being covered U.S. Citizens? If no, give details in Remarks.

3. ☐ Yes ☐ No Is coverage under the Children's Benefit 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.

Give details to all yes answers in Remarks.

Remarks

For the following: Use space on pages 2 and 3 to provide additional details for all YES items selected.

5. Has any child proposed for coverage ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

☐ Y ☐ N Congenital Heart Abnormalities
☐ Y ☐ N Heart Disorder
☐ Y ☐ N Diabetes
☐ Y ☐ N Cystic Fibrosis
☐ Y ☐ N Down's Syndrome
☐ Y ☐ N Injury or Illness requiring hospitalization

☐ Y ☐ N Cancer
☐ Y ☐ N Malignancy
☐ Y ☐ N Blood Disorder
☐ Y ☐ N Leukemia
☐ Y ☐ N Kidney Disease

☐ Y ☐ N Epilepsy
☐ Y ☐ N Brain or Neurological Disorder
☐ Y ☐ N Asthma or other Lung Disease
☐ Y ☐ N Muscular Dystrophy
☐ Y ☐ N Abnormalities from premature birth

Additional Details:

Child's Name	
Diagnosis, Disease, Symptom, Injury	Date of onset (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
Treatment (including any medications, therapies, and surgeries)	
Test(s) Performed	Result
Physician / Facility / Physician Specialty	Date of Last Visit (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Child's Name	
Diagnosis, Disease, Symptom, Injury	Date of onset (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
Treatment (including any medications, therapies, and surgeries)	
Test(s) Performed	Result
Physician / Facility / Physician Specialty	Date of Last Visit (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Child's Name	
Diagnosis, Disease, Symptom, Injury	Date of onset (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
Treatment (including any medications, therapies, and surgeries)	
Test(s) Performed	Result
Physician / Facility / Physician Specialty	Date of Last Visit (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Additional Details:

Child's Name	
Diagnosis, Disease, Symptom, Injury	Date of onset (mm/dd/yyyy) __ __ / __ __ / __ __ __ __
Treatment (including any medications, therapies, and surgeries)	
Test(s) Performed	Result
Physician / Facility / Physician Specialty	Date of Last Visit (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

It is represented that the statements and answers given in this supplement are true, complete and correctly recorded to the best of my knowledge and belief. It is agreed that this supplement shall be a part of the application for life insurance for _____as Proposed Insured.

Signed at _____ Date: _____
(city-state)

_____ _____
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