RESET

TRANSAMERICA®
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Mailing Address: 6400 C Street SW
Cedar Rapids, IA 52499

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

1. Last Name	First Name	2. SS# Last 4 Digits

OWNER - if other than Primary Insured

1. Last Name	First Name	2. TIN/SS# Last 4 Digits

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	City

State	Zip Code	3. Home Phone ( )	4. Social Security Number

PRIMARY BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#

CONTINGENT BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#

AGENT

- ❑ I attest that, on behalf of the Company, I requested all information above and the applicant provided the information completed on the form.
- ❑ I attest that the applicant was unable/declined to provide any information missing from the form.

Date

Producer or Agent Signature

Owner Signature

TRANSAMERICA®

Application for Fixed Life Insurance

Transamerica Financial Foundation IUL®
Transamerica Financial Choice IUL℠

Please be advised the forms contained in this booklet are intended to be used with IUL only. Some forms may not be approved for use with other products.

MAIL TO:
6400 C Street SW
Cedar Rapids, IA 52499
1-800-322-3796

THIS APPLICATION PREPARED FOR

Application Prepared by

U327 0312W WA R1022

Application Checklist

Important Reminders	**DO:** ☐ Complete the entire application (front and back). ☐ Print application in blue or black ink. ☐ Have applicant initial all changes. ☐ Obtain all required signatures. ☐ Complete and sign the Agent's Report. ☐ Include certification if a trust or corporation is Owner of the policy. **DON'T:** ☐ Use pencil or whiteout. ☐ Accept or send money for total coverage on the proposed primary Insured over $2,000,000.00. ☐ Accept cash with application if the proposed primary Insured is age 76 and over. ☐ Submit an agent check as the initial premium. ☐ Submit starter checks or checking deposit slips for check-o-matic withdrawals. ☐ If within the past 12 months the proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.

PLEASE MAKE SURE ALL APPLICABLE FORMS WITHIN THE PACKET ARE COMPLETED

Leave with Applicant	**THE FOLLOWING PAGES NEED TO BE LEFT WITH THE CONSUMER:** ☐ Buyer's Guide (Where applicable) ☐ Privacy Notice ☐ Conditional Receipt (If money taken with application) ☐ Notices page (Notice of Investigative Report, Disclosure of Information, and Insurance Information Practices) ☐ HIPAA Authorization for Release of Health Related Information ☐ Replacement Disclosure - REPLDISC 0210 **(Required in CT, DC and ND)**

Agent Comments

RESET

LIFE APPLICATION – Transamerica Life Insurance Company Mailing Address: 6400 C Street SW, Cedar Rapids, IA 52499
Administrative Office: 6400 C Street SW, Cedar Rapids, IA 52499

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION 1. PROPOSED PRIMARY INSURED/OWNER — Face Amount $_____

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Employer	Years

15. Employer's Address and Phone Number

16. Occupation & Duties

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED — Face Amount $_____

If more than one Additional Insured, please use Additional Information Supplement.
We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED

If owner is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If owner is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Home Phone ( )	4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female	6. Date of Birth/Trust Date MM-DD-YYYY	7. Relationship to the proposed primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

SECTION 4. CHILDREN'S BENEFIT RIDER — Face Amount $ _____

Name	Relationship	Date of Birth	Height	Weight
		MM—DD—YYYY	ft in	lbs
		MM—DD—YYYY	ft in	lbs
		MM—DD—YYYY	ft in	lbs

Are all children listed? ☐ Yes ☐ No Are all children living with proposed primary Insured? ☐ Yes ☐ No

If not, explain why:_____

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 7. PROPOSED PLAN OF INSURANCE

☐ Transamerica Financial Foundation IUL®

☐ Transamerica Financial Choice IUL℠

SECTION 8. DEATH BENEFIT OPTION (if applicable)

☐ Level Benefit ☐ Increasing Benefit

SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)

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

SECTION 10. ADDITIONAL BENEFITS–PRIMARY INSURED ONLY Not all applicable with all products.

☐ Base Insured Rider..... $ _____

☐ Accidental Death Benefit Rider..... $ _____

☐ Guaranteed Insurability Rider..... $ _____

☐ Disability Waiver of Premium Rider

☐ Disability Waiver of Monthly Deductions Rider

☐ Long Term Care Rider (complete Supplemental Application)

☐ Other _____

SECTION 11. PREMIUMS PAYABLE

Initial Planned Premium..... $ ___,___.___

☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly ☐ Other _____

☐ Electronic (bank draft) _____ Draft Date (1st thru 28th) ☐ Direct Bill

A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

_____

Secondary Addressee

_____

Street Address (Cannot be a P.O. Box) City State Zip

SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)

Indicate your premium allocation percentages below. Total must equal 100% and must be whole percents only. Index disclosures are provided on the Index Disclosure Information page accompanying this application. Available index options vary by product.

_____.0% Global Index Account

_____.0% Global Plus Index Account

_____.0% S&P 500® Index Account

_____.0% S&P 500® Plus Index Account

_____.0% Fidelity SMID Multifactor Index℠ Account

_____.0% Basic Interest Account

100% Total

SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS

Does the proposed Insured (including any children applying) have existing life insurance, disability policies, critical illness or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?
					Yes No
					Yes No
					Yes No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ ___,___.___

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain._____ ☐ Yes ☐ No

_____

B) Will the insurance applied for on any proposed Insured (including any children applying) discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured (including any children applying) in this or any other company? If yes, give details in Insurance Producer's Report. ☐ Yes ☐ No

SECTION 14. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed primary Insured, not the Owner.

A) Gross Income Current Yr $ ____ , ____ . ____

B) Gross Income Previous Yr $ ____ , ____ . ____

C) Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange ☐ Other_____

D) Current Net Worth $ ____ , ____ . ____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 through 70 and $1,000,000 for ages 71 and up.

SECTION 15. BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

A) Current Estimated Market Value $ ____ , ____ , ____

B) Assets *Liquid* $ ____ , ____ , ____

Nonliquid $ ____ , ____ , ____

C) Liabilities $ ____ , ____ , ____

D) Net Worth $ ____ , ____ , ____

SECTION 16. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to "No" answer for medical question 16A and "Yes" answers to questions 16B-E in Section 17 below:

A) For the last 180 days has the proposed primary Insured been actively at work, on a full time basis, at their usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, Emphysema, Chronic Bronchitis, Tuberculosis, or any other Respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

C) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Sought or been advised to seek treatment, limit or discontinue use of alcohol? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or the HIV (Human Immunodeficiency Virus) infection? ☐ Yes ☐ No

E) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

SECTION 17. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.

A) The proposed Insured is a citizen of ☐ USA ☐ Other Country _____ Type of VISA_____

B) How many years has the proposed Insured resided in the USA?_____

C) Does any proposed Insured travel outside the USA? ☐ Yes ☐ No

If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year.

_____

_____

SECTION 20. DRIVING AND PUBLIC RECORDS –Each question must be individually asked and answered for each proposed Insured.

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

SECTION 22. OTHER INSURANCE–TO BE COMPLETED BY THE INSURANCE PRODUCER

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No

(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

C) Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

SECTION 23. ILLUSTRATION CERTIFICATION (if applicable) **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

☐ The Applicant/Owner and the Licensed Insurance 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 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 Insurance Producer's statement:** By signing this application, I, the Licensed Insurance 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.

SECTION 24. 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 correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the insurance 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 proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.
I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, LLC ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance 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.
This authorization will be valid for 30 months, but 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.
The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.
I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB 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.
I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

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 I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

If an application on a juvenile is $50,000 or less and issued without underwriting, this policy may be void or reduced when a claim is submitted if the total amount of life insurance in-force from all sources exceeds the underwriting limits established for issuance of this policy on the life of the juvenile.

Fraud Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at _____ (city) _____ (state) on MM – DD – YYYY (date)

Signature of proposed primary Insured/Owner (Child age 15 and over must sign)	Print Insurance Producer Name
Signature of parent or legal guardian for Insured(s) 14 and under	Insurance Producer #
Signature of proposed Additional Insured	
Signature of Applicant/Owner if other than the proposed primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)	Signature of Insurance Producer
	Signature of Split Insurance Producer

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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 Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

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

CONDITIONAL COVERAGE: Conditional insurance 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. $1,000,000 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 Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

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

X _____ _____ , 20 _____

Signature of Proposed Owner | Date

_____ _____

If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust.

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 original with the application and payment.

Original

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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 Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

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

CONDITIONAL COVERAGE: Conditional insurance 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. $1,000,000 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

---

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

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

Proposed Owner

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NOTICES

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 PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any. Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, 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. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Life Insurance 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 insurance 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.

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

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Additional Information Supplement

SECTION 1. PROPOSED CONTINGENT OWNER **If owner is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If owner is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.**

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Home Phone ( ) | 4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date | 7. Relationship to proposed primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

SECTION 2. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | Apt# | City

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth M | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 4. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☑ Juvenile

SECTION 5. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 6. DECLARATIONS

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at _____ _____ on MM-DD-YYYY

(city) (state) (date)

sec. 1 _____
Signature of proposed Additional Insured
(Child age 15 and over must sign)

sec. 3 _____
Signature of proposed Additional Insured
(Child age 15 and over must sign)

sec. 2 _____
Signature of proposed Additional Insured
(Child age 15 and over must sign)

sec. 4 _____
Signature of proposed Additional Insured
(Child age 15 and over must sign)

_____
Signature of Parent or Legal Guardian for Insured(s) 14 and under

_____
Signature of Applicant/Owner, if other than the proposed primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

_____
Witness (Insurance Producer)

INDEX DISCLOSURE INFORMATION

S&P 500 Index

The S&P 500 Index is a product of S&P Dow Jones Indices LLC ("SPDJI"), and has been licensed for use by the Company. Standard & Poor's®, S&P® and S&P 500® are registered trademarks of Standard & Poor's Financial Services LLC ("S&P"); Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC ("Dow Jones"); and these trademarks have been licensed for use by SPDJI and sublicensed for certain purposes by the Company. This Policy is not sponsored, endorsed, sold or promoted by SPDJI, Dow Jones, S&P, their respective affiliates, and none of such parties make any representation regarding the advisability of purchasing this product(s) nor do they have any liability for any errors, omissions, or interruptions of the S&P 500 Index.

Fidelity SMID Multifactor Index

The Fidelity Small-Mid Multifactor Index℠ 5% ER, also called the Fidelity SMID Multifactor Index℠, (the "Index") is a product of Fidelity Product Services LLC ("FPS"). It is a rules-based index that utilizes a dynamic asset allocation approach which blends multiple factors with the characteristics of stocks of small and mid-capitalization U.S. companies along with U.S. Treasuries, which may reduce volatility over time. Fidelity is a trademark of FMR LLC. The Index has been licensed for use for certain purposes by Transamerica Life Insurance Company ("the Company") on behalf of the Transamerica Financial Choice IUL℠("policy"). The Index is the exclusive property of FPS and is made and compiled without regard to the needs, including, but not limited to, the suitability needs, of the Company, the policy, or the policy owners. The policy is not sold, sponsored, endorsed or promoted by FPS or any other party involved in, or related to, making or compiling the Index.

FPS does not make any warranty or representation as to the accuracy, completeness, or availability of the Index or information included in the Index and shall have no responsibility or liability for the impact of any inaccuracy, incompleteness, or unavailability of the Index or such information. Neither FPS nor any other party involved in, or related to, making or compiling the Index makes any representation or warranty, express or implied, to the policy owner, the Company, or any member of the public regarding the advisability of purchasing life insurance generally or the policy particularly, the legality of the policy under applicable federal securities, state insurance and tax laws, the ability of the policy to track the performance of the Index, any other index or benchmark or general market or other asset class performance, or the results, including, but not limited to, performance results, to be obtained by the Company, the policy, policy owners, or any other person or entity. FPS does not provide investment advice to the Company with respect to the policy, or to the policy owners. The Company exercises sole discretion in determining whether and how the policy will be linked to the value of the Index. FPS does not provide investment advice to the policy, the policy owners, or any other person or entity with respect to the Index and in no event shall any policy owner be deemed to be a client of FPS.

Neither FPS nor any other party involved in, or related to, making or compiling the Index has any obligation to continue to provide the Index to the Company with respect to the policy. In the event that the Index is no longer available to the policy or policy owners, the Company may seek to replace the Index with another suitable index, although there can be no assurance that one will be available.

FPS disclaims all warranties, express or implied, including all warranties of merchantability or fitness for a particular purpose or use. FPS shall have no responsibility or liability with respect to the policy.

Not all indexes are available with all products.

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____ CASE MANAGER: _____

PRODUCER 1: _____ | _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 2: _____ | _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 3: _____ | _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

Indicate City/County Code as required in AL, GA, KY, LA, & SC _____

What is the purpose for insurance? _____

Are you related to the Proposed Insured? ☐ Yes ☐ No Relationship _____

How long have you known the Proposed Insured? _____

Proposed Insured is: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Yes ☐ No To the best of your knowledge, does the applicant have any existing life insurance or annuities?

☐ Yes ☐ No To the best of your knowledge, could replacement be involved?

X _____
Signature of Producer

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TRANSAMERICA®

Payment Authorization Form

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. Note that not all payment options are available on all products.

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

Insured FIrst Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Recurring Draft Day (1st through 27th only)

Initial modal premium is withdrawn upon receipt of the application and a completed Conditional Receipt and not on the day chosen for recurring payment. If a Conditional Receipt is not received with the application, then the initial premium is drafted at policy placement.

_____

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

Recurring Premium Payment Mode (choose one)

☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Planned Modal 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 ACH.)

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Check	☐ **Initial**	Mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	This method only available quarterly, semiannually, or annually.
Lump Sum	☐ **One Time Draft Amount** $ _____	At Issue I approve to have the One Time Draft amount drafted from the account below.

Draft upon Underwriter Approval? ☐ **Yes** ☐ **No**

Wait for acceptance to draft after confirmation from agent? ☐ **Yes** ☐ **No**

One-time ACH Debit Authorization

This section should be completed by the Bank Account Holder (Payor). Some policies may require an adjustment payment to cover a gap in premium when certain billing changes occur. This adjustment payment will keep the policy active until your recurring payments begin.

☐ By checking this box and signing this form, you authorize a one-time ACH debit in an amount needed to put your policy in an active status until your recurring payments begin. If this amount has not already been provided, contact us and we will provide you with the exact amount required. If authorized, this ACH debit will be made to your account on or after the date this request is received in good order.

NOTE: If you do not authorize this debit, and payment is still required, you will be contacted.

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

_____

Routing Number _____ Account Number _____

The account holder is the (choose one):

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

Account Holder Signature:

X _____ **Date:** _____

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 Life Insurance Company
6400 C Street SW, Cedar Rapids, IA 52499

Notice and Consent for BLOOD-BORNE PATHOGEN Testing WASHINGTON

To evaluate your eligibility for coverage, the Insurer designated above ("the Insurer") has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of blood-borne pathogens, including hepatitis B virus, hepatitis C virus, and human immunodeficiency virus. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Confidentiality of Test Results

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

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are indicative of infection with a blood-borne pathogen, such results will sent directly to you. You may designate a health care provider or health care agency to whom we will provide test results indicative of infection with a blood-borne pathogen for interpretation.

Name of physician for reporting a test result indicative of infection with a blood-borne pathogen:

Health Care Provider	Street
Phone Number	City, State, Zip Code

Consent

I have read and I understand this *Notice and Consent for BLOOD-BORNE PATHOGEN Testing.* I voluntarily consent to providing a sample of my bodily fluid(s), the testing of my bodily fluid(s) and the disclosure of the test results as described above.

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

Name of Proposed Insured (*Please Print*)	Signature of Proposed Insured
Street	Date Signed
City, State, Zip Code	Date of Birth

LIFE INSURANCE BUYER'S GUIDE

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

- Make informed decisions when you buy a policy.
- Decide how much insurance you need.
- Compare different types of life insurance.

Prepared by the National Association of Insurance Commissioners

As part of our state-based system of insurance regulation in the United States, the National Association of Insurance Commissioners (NAIC) provides expertise, data, and analysis for insurance commissioners to effectively regulate the industry and protect consumers. The U.S. standard-setting organization is governed by the chief insurance regulators from the 50 states, the District of Columbia and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer reviews, and coordinate regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. For more information, visit **www.naic.org**.

This guide does not endorse any company or policy.

Reprinted by:
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
January 2022

National Association of Insurance Commissioners

1100 Walnut Street, Suite 1500 Kansas City, MO 64106-2197 (816) 842-3600

Before you buy life insurance...

UNDERSTAND WHAT LIFE INSURANCE IS

Life insurance pays a death benefit if you die while the policy is in effect, in exchange for premiums you pay before your death. You can use the death benefit to protect against financial hardships such as loss of your income, funeral expenses, medical or nursing care expenses, debt repayments, and child care costs after your death. You can get information from the NAIC Life Insurance website -- https://content.naic.org/consumer.htm.

IF YOU NEED LIFE INSURANCE, DECIDE HOW MUCH COVERAGE TO BUY

How much life insurance to buy depends on the financial needs that will continue after your death. Examples include supporting your family, paying for child(ren)'s education, and paying off a mortgage. Some questions you may want to ask about your own needs include:

- Does anyone depend on me financially?
- How much of the family income do I provide?
- How will my family pay my final expenses and repay debts after my death?
- Do I want to leave money to charity or family?
- If I have life insurance through my employer, is it enough to meet my financial obligations?

The answers to these questions can help you decide how much coverage you need. An insurance agent, financial advisor, or insurance company representative can help you evaluate your insurance needs and give you information about available policies.

IF YOU ALREADY HAVE LIFE INSURANCE, ASSESS YOUR CURRENT LIFE INSURANCE POLICY

It's important to compare your current policy with any new policy you might buy. Keep in mind that you may be able to change your current policy to get benefits you want. Also, know that any changes in your health may impact your ability to get a new policy or the premium you'll pay. Don't cancel your current policy until you get the new one.

Also, while you may have free or low-cost life insurance through your employer, the death benefit usually is less than you need. And if you leave the employer, you may not be able to take this coverage with you.

COMPARE THE DIFFERENT TYPES OF INSURANCE POLICIES

There are many types of life insurance policies. You should choose a policy with features that fit your individual needs.

Some things to consider are:

TERM VS. CASH VALUE: Term insurance is intended to provide lower- cost coverage for a specific period of time ("a term"). If you want coverage for a longer period of time, such as for your lifetime, cash value insurance may be more cost effective. Most term policies don't build up cash values that you can use in the future.

RENEWABLE TERM VS. NONRENEWABLE TERM: Most term life insurance coverage can be continued ("renewed") at the end of the term, even if your health has changed. If you renew a term policy, the new premiums are higher. Ask what the premiums will be before you renew the policy. Also ask if you'll lose the right to renew the policy at a certain age. A nonrenewable term policy can't be continued. You'll have to apply for a new policy if you still want coverage.

WHOLE LIFE VS. UNIVERSAL LIFE: Whole life and universal life insurance are two types of cash value insurance. A key difference between the two is how you pay for the coverage. You typically pay premiums for whole life insurance according to a set schedule. In a universal life policy, you can choose a flexible premium payment pattern as long as you pay enough to keep your policy in force.

VARIABLE LIFE VS. NON-VARIABLE LIFE: The investments you will choose (such as stock and bond funds) in a variable life policy directly impact your cash value. These policies have the greatest potential to build cash value but also the greatest risk of losing cash value. Non-variable life policies often have guaranteed minimums for some features (interest or cash value, for example) but not all. Non-variable life policies also have less potential to build cash value than variable life policies.

BE SURE YOU CAN AFFORD THE PREMIUM

Before you buy a life insurance policy, be sure you can pay the premiums.

Can you afford the initial premium? If the premium increases later, will you still be able to afford it? The premiums for many life insurance policies are sensitive to changes in the company's investment earnings, claims costs, and other expenses. If those are worse than expected, you may have to pay a much higher premium. Ask what might be the highest premium you'd have to pay to keep your coverage.

UNDERSTAND THE APPLICATION PROCESS

You can apply for life insurance through life insurance agents, the mail, and online. In addition to basic information, such as your name, address, employer, job title, and date of birth, you'll be asked for more personal information.

Depending on the type of policy, the insurer may require you to see a doctor, answer health-related questions, or have a medical professional come to your home or office to assess your health. Usually a policy that doesn't require detailed health information will cost more and provide less coverage than one that does.

It's important to tell the truth on the application. The insurance company will check your answers so review the application before you sign. If the insurance company discovers false statements on your application after it issues your policy, it could reduce or cancel your coverage.

CHOOSE A BENEFICIARY

A beneficiary is the person(s) or organization(s) you name to receive your life insurance policy's death benefit.

You'll need to know the Social Security or tax identification number for all beneficiaries. Experts advise you not to name a minor child as a beneficiary.

Insurance companies won't pay a minor. Instead, consider leaving the money to your estate or trust.

EVALUATE THE FUTURE OF YOUR POLICY

Does your policy have a cash value? In some cash value policies, the values are low in the early years but build later on. In other policies the values build up gradually over the years. Most term policies have no cash value. Ask your insurance agent, financial advisor, or an insurance company representative for an illustration showing future values and benefits.

After you buy life insurance...

READ YOUR POLICY CAREFULLY

After you carefully read your policy, you should be able to answer the following important questions:

- Is your personal information correct?
- Do premiums or policy values vary from year to year?
- What part of the premium or policy value isn't guaranteed?
- How will the timing of money paid and received affect any interest the policy might earn?

Your insurance agent, financial advisor, or an insurance company representative can help you understand anything that isn't clear.

If you're not satisfied with your new policy, you can return it for a full refund within a certain period, usually 10 days after you receive it. The review period usually is stated on the first page of the policy.

REVIEW YOUR LIFE INSURANCE POLICY EVERY FEW YEARS

Review your policy with your insurance agent, financial advisor, or an insurance company representative every few years to keep up with changes in your policy and your needs.

- Have the premiums or benefits changed since your policy was issued?
- Do the death benefits still meet your needs?
- Do you need more or less coverage after life events, such as birth, adoption, marriage, job change, death, or divorce?

The insurance company can provide policy statements and illustrations to help with this review. As the policy owner, you can change beneficiaries at no cost. Be sure to review your beneficiaries every few years, especially after major life events that affect your life insurance needs.

Notes...

Transamerica Life Insurance Company
Transamerica Financial Life Insurance Company

Consent to do Business Electronically and Electronic Delivery of and/or Access to Policy Documents

What is the purpose of this Consent and Disclosure?
You are applying for an insurance policy ("Policy") from either Transamerica Life Insurance Company or Transamerica Financial Life Insurance Company (either individually or collectively, "Transamerica") and have expressed your desire to conduct business electronically and for electronic delivery and access, with regard to the Policy, as well as documents related to the Policy. To conduct business electronically, receive documents applicable to the Policy in electronic format, and access documents electronically via a hyperlink contained in an electronic mail ("email") or attached to an email, you must provide Transamerica, and its authorized designees and agents, with your consent. If you indicated your consent by electronically signing this document where indicated below, you will be providing Transamerica and its authorized designees and agents, with your consent:

1. To have the information described in this document (Consent to do Business Electronically and Electronic Delivery of and/or Access to Policy Documents, hereinafter referred to as "Consent") made available and delivered to you electronically;

2. To execute via electronic means the documents that are described in this Consent;

3. To submit, via electronic means, your application for an insurance product; and

4. To all of the terms and conditions set forth in this Consent.

What does this Consent cover once I consent?
This Consent covers your agreement to all of the terms and conditions of this Consent, including your agreement to:

1. **Permit the Owner of the Policy to receive via electronic means the documents that Transamerica is required by law or regulation to provide or make available to you in writing ("Required Documents"), as well as other information and documents (collectively, "Other Documents");**

2. **Permit the Owner of the Policy to receive via electronic means privacy notices from Transamerica, including those companies on whose behalf Transamerica sends privacy notices, including World Group Securities, Inc. and Transamerica Financial Advisors, Inc., as well as from any affiliate or subsidiary companies administering or supporting any Policy issued as part of your application (collectively "Privacy Notices");**

3. **Permit the Owner and Insured (and Third Party, if applicable) to submit via electronic means your application for an insurance product;**

4. **Permit the Owner and Insured (and Third Party, if applicable) to execute via electronic means certain Required Documents and Other Documents; and**

5. **Be bound with the same force and effect as if you had signed your name on paper by hand when you electronically sign this Consent where indicated below and click "OK" or otherwise apply your electronic signature to Required Documents or Other Documents.**

NOTE: IF THE OWNER IS NOT THE INSURED, THEN BOTH WILL NEED TO SIGN THE CONSENT BELOW

What is the Scope of this Consent?
This Consent applies to all documents related to your Policy, including, but not limited to, the following: Privacy Notices, prospectuses, prospectus supplements, annual and semiannual reports, annual and quarterly statements, confirmation statements, statements of additional information, proxy solicitation materials, conditional receipts, application, application supplements and addendums, Policy contract, illustrations, amendments, riders, replacement notices, customer correspondence, and any other Required Documents and Other Documents when available (collectively, "Policy Documents"). These Policy Documents will generally be accessible through a hyperlink delivered via email to the Owner's email address(es) written below when electronic access to the various Policy Documents is available from Transamerica.

Even though you have provided Transamerica with this Consent, Transamerica may, at its option, or as required by law: (a) deliver Policy Documents to you on paper, and (b) require that certain communications from you be delivered to Transamerica on paper.

Can I get paper copies of the Policy Documents?
Yes. You may obtain paper copies of any of the Policy Documents at any time and without charge by contacting Transamerica at the address provided below. If you do not wish to access all Policy Documents electronically, please call Transamerica's Customer Service Department at the telephone number provided below.

Should I maintain copies of the Policy Documents?

Yes. You agree to print or save this Consent and all Policy Documents, and to keep printed or electronic copies of them for your records. If you have any trouble with printing or saving, you should contact Transamerica.

How long will this Consent remain in effect?
This Consent shall become effective once you sign below and remains in effect for so long as your Policy remains in effect, or until you withdraw your consent (as described in the next section), whichever occurs first.

What if I change my mind?
If at any time you would like to cease doing business electronically with Transamerica with respect to your Policy, you will need to provide Transamerica with written notice of your withdrawal of your consent to do so, which will then terminate this Consent. You may withdraw consent at any time and without charge by contacting Transamerica. Your withdrawal of consent and the termination of this Consent will become effective two (2) business days after Transamerica's receipt of your withdrawal. Thereafter, all Policy Documents will be provided to you on paper and you will no longer be able to conduct business with us electronically, unless you provide your consent again.

What if my contact information changes?
You must keep Transamerica informed of any changes to your email address(es) and all other contact information by contacting Transamerica at the contact information provided below. You agree to hold Transamerica harmless with respect to any emails sent to the incorrect email address due to your failure to provide Transamerica with a current or valid email address.

You can contact Transamerica as follows:

For all products except Financial Foundation IUL:

Mail: 6400 C Street SW
Cedar Rapids, IA 52499
Telephone: 1-800-852-4678
Internet: www.transamerica.com

For Financial Foundation IUL:

Mail: 6400 C Street SW
Cedar Rapids, IA 52499
Telephone: 1-800-851-9777
Internet: https://tlic.transamerica.com

Are there any hardware or software requirements?
Yes. To access, receive, and retain the Policy Documents sent or made available to you electronically by Transamerica, you must have access to a computer with an Internet connection. You must have a valid email address, be able to send and receive emails, and be able to save the Policy Documents to a storage device for later reference or have the computer connected to a printer so you can print out such documents. Unless notified otherwise, Transamerica will be providing or making available these documents to your agents and insurance representatives. The minimum hardware and software requirements are:

Computer Compatibility

Item		Minimum	
Memory (RAM)		2 GB	
Hard Drive Space		1 GB available for storage of electronic documents	
Operating System		Windows Vista with Service Pack 2 or a later version MAC OS 10.x or higher	
Screen Resolution		1060 x 800 pixels at 16-bit color resolution	
Screen Display Size		12 inches measured diagonally	
Browser Application		Internet Explorer 9.0 or higher with all critical updates Mozilla Firefox: Google Chrome Safari 5 or higher *** We will not support beta versions of any browsers.	
PDF Reader		Adobe Acrobat Reader 6.0 or higher	
Speed		DSL or broadband service	

Mobile Device Compatibility

Operating Systems	Apple Devices: iOS7 or higher Android Devices: Android 4 or higher

You should check the Technical Requirements periodically for updates on supported software and browsers. From time to time we may offer services or features that require a certain type of browser of configuration. If we detect that your browser is not properly configured, we may provide you with a notice on how to properly update your browser. Also, the browsers we support may change over time. We reserve the right to discontinue supporting a certain browser or operating system if we believe that it suffers from a security flaw or other flaw that makes it unsuitable for use with the insurance products.

What else should I know about this Consent?
Your consent is voluntary. If you consent, you are consenting to conduct business electronically and to receive and access Policy Documents electronically. You cannot consent to receive or access Policy Documents electronically without consenting to conduct business electronically. However, if you wish to consent to conduct business electronically but do not wish to receive or access Policy Documents electronically, you need to sign this Consent and call Transamerica's Customer Service Department at the telephone number provided above to opt-out of electronic delivery and/or access and to receive Policy Documents by mail.

There is no charge for electronic delivery of Policy Documents, although your internet provider may charge for internet access. Unless required by law, you will NOT receive electronic copies in addition to paper copies.

For California Only: An additional consent for electronic delivery may be required before Required Documents are delivered to you electronically. Absent an additional consent, Policy Documents other than Required Documents may be delivered electronically under this Consent or Transamerica may elect to deliver all Policy Documents by mail.

By signing below, I attest that I: (i) have carefully read this Consent using computer hardware and software that meet the minimum hardware and software requirements described above; (ii) agree to conduct business electronically; (iii) agree to receive all mailings and communications, which may even include cancellation or nonrenewal notices, electronically; (iv) agree to receive Policy Documents in electronic format; (v) agree to access Policy Documents electronically; and (vi) accept and sign this Consent voluntarily and with full knowledge and understanding of its terms and conditions. I will save a copy of this Consent.

Name of Insured | **Insured Email Address**

Signature of Insured | **Date**

Phone Number of Insured

Please check the box below or complete Owner information. Complete Additional Owner information, if applicable.

☐ **Owner is same as Insured**

Name of Owner, if other than Insured | **Owner Email Address**

Signature of Owner, if other than insured | **Date**

Phone Number of Owner, if other than insured

Name of Additional Owner, if applicable | **Additional Owner Email Address**

Signature of Additional Owner, if applicable | **Date**

Note: If there are more than two (2) Additional Insureds, please complete additional forms.

Name of Additional Insured (if any)	**E-mail Address of Additional Insured (if any)**
Signature of Additional Insured (if any)	**Date**
Name of Additional Insured (if any)	**Email address of Additional Insured (if any)**
Signature of Additional Insured (if any)	**Date**

IF THERE ARE THIRD PARTIES SIGNING REQUIRED DOCUMENTS OR OTHER DOCUMENTS, PLEASE HAVE THEM COMPLETE THE INFORMATION BELOW. FOR ADDITIONAL THIRD PARTIES, PLEASE COMPLETE ADDITIONAL FORMS.

Name of Third Party	**Status of Third Party (*e.g.*, Guardian, Payor, *etc.*)**
Signature of Third Party	**Date**
Name of Additional Third Party	**Status of Third Party (*e.g.*, Guardian, Payor, *etc.*)**
Signature of Additional Third Party	**Date**

Name of Trustee	**Signature of Trustee**	**Date**
Name of Authorized Person	**Signature of Authorized Person**	**Date**

TRANSAMERICA®

eDELIVERY | SECURE! EASY! ENVIRONMENTALLY FRIENDLY!

eDelivery Terms and Conditions of Use

The Transamerica company using this form is:

☐ Transamerica Life Insurance Company ☐ Transamerica Financial Life Insurance Company

As used herein, "the Company", "we", "our", or "us" means the Transamerica company checked above.

ELECTRONIC INFORMATION CONSENT – I consent to receive documents and notices applicable to the Eligible Policy/Policies accessed through the Company website or portal, or websites or portals operated on behalf of the Company. These include, but are not limited to: Policy contracts, applications, application supplements and addendums, illustrations, amendments, riders, replacement notices, statements of additional information, conditional receipts, customer correspondence, prospectuses, prospectus supplements, annual and semiannual reports, quarterly statements and immediate confirmations, privacy notices, other notices, and documentation, permitted by law to be sent electronically, in electronic format, when available instead of receiving paper copies of these documents by U.S. mail.

Important Information Concerning Electronic Document Delivery:

- Your consent is voluntary. Documents will only be transmitted to you electronically if you consent.
- There is no charge for electronic delivery, although your internet provider may charge for Internet access.
- You are confirming that you have access to a computer with internet capabilities and an active email account to receive information electronically.
- This Electronic Document Delivery applies only to Eligible Policies accessed through the Company website or portal, or websites or portals operated on behalf of the Company.
- After consenting to Electronic Document Delivery, we will send an email to confirm that the email address you provided is correct. If we are unable to confirm an email address or have reasonable suspicion that an email address is incorrect, we will not activate the consent for electronic delivery, in which case you will continue to receive paper copies of your documents.
- Email filters must be updated to ensure you received email notifications from us.
- Not all contract documentation and notifications may currently be available in electronic format.
- You can request the Company provide paper copies of documents at any time for no charge.
- If an email address changes, you may notify us at any time by contacting us at the phone number listed below or editing your profile on the appropriate website.
- This consent will remain in effect until revoked. You may opt out of receiving records electronically at any time.
- If you choose to revoke your consent, withdrawal of this consent will become effective within two business days after the Company receives your request.

Please call 1-800-851-9777 or visit the Company website at www.transamerica.com 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.

☐ By checking this box, I consent to receive electronic transmission of documents and agree to the terms and conditions as described above.

Policy Owner: _____
Email Address Printed Name

Policy Number(s): _____

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 the Company at the time of the acceleration. This amount is determined by us using the applicable rated age, mortality tables, and inter- est 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, as of January 1,2020, for each Critical and Chronic Accelerated Death Benefit request is $500 and each Terminal Illness Accelerated Death Benefit request is $375, these charges 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 Life Insurance Company
6400 C Street SW, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

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.

Transamerica Life Insurance Company
6400 C Street SW, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

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.

Transamerica Financial Choice IUL[SM]

Offered by Transamerica Life Insurance Company, Cedar Rapids, IA ("the Company")

Statement of Understanding and Acknowledgment

Applicant's Name: _____

I am applying for an Index Universal Life Insurance Policy to be issued by the Company. In connection with my application I understand that:

THE POLICY

This policy is intended for people whose primary purpose in buying life insurance is for the death benefit.

Since a portion of the interest credited to the Index Account(s) is calculated in part by reference to outside indexes, there is the potential for greater volatility in the amount of Excess Index Interest credited than of interest credited to the Basic Interest Account (BIA). This policy works best for those individuals who can tolerate fluctuations in interest crediting and is not recommended for policyowners who do not intend to allocate a significant portion of their net premiums to the Index Account(s).

This policy is not an investment in the stock markets or indexes and does not participate in any stock or security.

PREMIUMS

I must pay premiums on a regular basis to keep the policy in effect. The policy may lapse if I do not have sufficient Cash Surrender Value (Policy Value less the Surrender Charge and less any Loan Balance) in the policy to pay the next Monthly Deduction and Index Account Monthly Charge and have not paid enough premiums to meet the Minimum No Lapse Premium requirement. In that event, I would be required to pay additional premiums to keep the policy in force.

ACCOUNT OPTIONS

The policy I am applying for allows me to allocate my net premium payments to more than one Account Option: the Basic Interest Account and the Index Accounts. Interest will be credited differently to the different Account Options.

INTEREST

Net premiums allocated to the Basic Interest Account will earn interest at the Current Interest Rate declared by the Company. This rate is guaranteed never to be less than 1% per year. Net Premiums received after a Monthly Policy Date that are to be allocated to the Basic Interest Account will earn interest at the Current Interest Rate.

Net Premiums allocated to the Index Accounts will earn interest at a guaranteed minimum annual interest rate of 0.25%. Net Premiums received after a Sweep Date (15th of the month) that are to be allocated to an Index Account will earn interest at the current BIA rate until the next Sweep Date, when they will be placed into the next Index Account Segment. Additional interest ("Excess Index Interest") may be credited at of the end of each one-year Segment Period.

EXCESS INDEX INTEREST

Excess Index Interest on the Index Accounts is determined using a formula based on changes in the index(es), excluding dividend income, and cannot exceed the applicable Cap established by the Company. The Company may determine a different Cap or Participation Rate for each Segment which may be changed by us at the Segment Anniversary. Current Caps and Participation Rates will be shown in Policy Statements and may be obtained from the Company's Administrative Office.

Excess Index Interest, if any, is credited to a segment at the end of each one year Segment Period. Any Policy Values, Death Benefit or Cash Surrender Value determined during a Segment Period will be based only on guaranteed minimum interest that has already been credited during the Segment Period. A Policy Statement reflecting Policy Values and the interest credited for a policy year will be provided annually.

EXCESS INDEX INTEREST (CONTINUED)

Monthly Deductions, Index Account Monthly Charges, and certain policyowner transactions, such as transfers, loans and withdrawals, occurring during a Segment Period will reduce the value used in determining Excess Index Interest. This will result in the reduction of any Excess Index Interest that might otherwise have been credited at the end of the Segment Period. Upon surrender of the policy, no Excess Index Interest will be credited for partial years on any Index Account Segment.

TRANSFERS

Transfers from an Index Account Segment will only be processed at the end of the Segment Period. For purposes of dollar cost averaging, transfers to an Index Account are processed on the Sweep Date following receipt of the request. Transfers from the Basic Interest Account will only be processed once per month on the Sweep Date.

LOANS AND WITHDRAWALS

Loans and withdrawals may be taken from the Basic Interest Account and the Index Accounts(s). Loans and withdrawals are subject to certain fees and charges and to the conditions and limitations specified in the policy. Withdrawals are subject to a Partial Surrender Charge if they occur during a surrender charge period. Interest may be charged and credited differently to different types of loans taken from the Policy.

SURRENDERS

If the policy is surrendered, the Cash Surrender Value of the policy will be equal to the greater of the Policy Value or Cumulative Guaranteed Value less any applicable surrender charges and any Loan Balance. Surrender charges apply for a period of up to 12 policy years from the issue date and from the date of any Face Amount increase. The surrender charge will vary based on the Face Amount and duration of the Policy and the issue age, gender and class of risk of the insured on the policy date and at the time of any increase in the Face Amount.

CHANGES IN FACE AMOUNT

You may request an increase or decrease in the Face Amount of the policy. Increases approved by the company will have their own surrender charge periods and charges. We will deduct a partial surrender charge for decreases in the Face Amount occurring during a surrender charge period.

CUMULATIVE GUARANTEED VALUE

This policy employs an alternate value that, if greater than the Policy Value, will be substituted for the Policy Value in the determination of Cash Surrender Value and the amount of the death benefit.The Cumulative Guaranteed Value can be negative, but a negative amount does not accrue interest charges nor does it reduce the Policy Value or death benefit.

PERSISTENCY CREDIT

A Persistency Credit is a nonguaranteed partial return of expenses credited annually to the Policy Value beginning on the later of the 10th Policy Anniversary and Age 60 and continuing each Policy Anniversary through Age 99.

CONSUMER BROCHURE

I have received a copy of the Consumer Brochure containing information regarding the policy. I understand that I have a certain period of time after receipt of the policy issued to me to review and return it for a refund of premium as described in the policy.

I have read and understand the above disclosures of certain limitations and restrictions regarding the policy and the Index Account(s).

The guaranteed minimum interest rates for the Basic Interest Account and Index Accounts are shown on the previous page. Non-guaranteed rates and other elements appearing on illustrations or other related materials are hypothetical and actual results may be less favorable than those shown on such documents. I understand I may select the assumed rates and elements used in illustrations or other related materials.

Date: _____ Applicant Name (print): _____

Signature of Applicant: _____

INDEX UNIVERSAL LIFE INSURANCE IS NOT A SECURITY and index universal life insurance policies are not an investment in the stock market or in the indexes. Index Account Interest is based, in part, on index performance.

Past performance of an index is not an indication of future index performance. There is no guarantee that any Excess Index Interest will be credited above the guaranteed minimum interest rate for the Index Account(s). Additionally, there is no guarantee that the company will declare an interest rate greater than the guaranteed minimum interest rate for the Basic Interest Account.

Index Universal Life Insurance offered by:
Transamerica Life Insurance Company, Cedar Rapids, IA • Home Office: Cedar Rapids, IA

SOU FCIUL 1222
Policy Form Numbers ICC22 TPIU10IC-0322 and state variations

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TRANSAMERICA®

LIFE

Instructions:
A. Please type or print.
B: Policy owner and policy insured must match between companies.
C: No Joint policy owners.
D: Term Policies do not qualify.
E: Some companies may have different requirements and/or a special transfer form. Please check with the distributing company to verify of any addt'l requirements.

IRC SECTION 1035 EXCHANGE FOR LIFE INSURANCE

SURRENDERING COMPANY INFORMATION

Name of Existing Company _____ Policy Number _____

Address of Company _____ City _____ State _____ Zip Code _____

Name of Insured on existing policy (Please Print) _____

Name of Policy Owner on existing policy _____ Policy Owner SS# _____-_____-_____

TYPE OF EXISTING POLICY:

☐ Whole Life ☐ Universal Life ☐ Modified Endowment ☐ Term Policy

ABSOLUTE ASSIGNMENT

TLIC Policy Number: _____

The above listed policy has been assigned to the Insured selected above (the "Company) In exchange for the TLIC policy to be issued by the company. It is intended that this will qualify as a tax-free exchange within the provisions of the Internal Revenue Code, Section 1035. Consequently, the policy issued by the Company will have the same Insured/Owner designations as the policy issued by the existing company. The Company assumes no responsibility or liability for the tax treatment under Internal Revenue Code Section 1035.

If your policy has an outstanding loan prior to the exchange, the Company will not issue a new policy with an outstanding loan. The Company will, however, process a 1035 Exchange on a policy transferring the net cash value (cash value less any loans). However, any policy loan that exists prior to the exchange, is discharged. This constitutes the receipt of income which is taxable, and subject to gain, to the extent of the loan (Reg.1.103(b)-1(c).

☐ If there is an existing policy loan, which would result in taxable income, please do not proceed with the surrender. Please advise us of the amount of the loan and the amount of taxable income.

☐ If there is an outstanding loan which would result in taxable income, please proceed with the surrender.

POLICY STATEMENT

☐ My policy/contract is attached
☐ My policy/contract is lost

TAX

☐ Please withhold Federal Income Tax
☐ Please DO NOT withhold Federal Income Tax

The undersigned hereby assign and transfer/surrender all right, title and interest in the above policy to the Company P.O.Box. Please make the check payable to the insurer selected below.

Transamerica Life Insurance Company
EIN# 39-0989781

Stonebridge Life Insurance Company
EIN# 03-0164230

For residents of **California**: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

SIGNATURES

Policyowner(s) Signature _____ Signature of Spouse (Community Property State) _____

Agent Signature _____ Date _____

Agent Name and Number (Please Print) _____ Signature of Witness _____

Accepting Signature of Company Officer _____ Title _____ Date _____

I agree that a photocopy of this 1035 Exchange Agreement and Assignment shall be as valid as the original.