



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

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

Signature of Primary Proposed Insured/Patient or Personal Representative

Date

Signature of Secondary Proposed Insured/Patient or Personal Representative

Date

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

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

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

Policy or contract number (if known): _____

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



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

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

Signature of Primary Proposed Insured/Patient or Personal Representative

Date

Signature of Secondary Proposed Insured/Patient or Personal Representative

Date

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

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

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

Policy or contract number (if known): _____

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

Transamerica Life Insurance Company

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

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

1

Proposed Primary Insured Personal Information



Legal First Name	Middle Name	Legal Last Name	Suffix
U.S. Social Security Number		Date of Birth (mm/dd/yyyy)	
- - - - -		- - / - - / - - - - -	
U.S. Tax ID Number			
- - - - -			
Place of Birth (State / Territory, Country)			

Gender	Marital Status
<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married (including common law) <input type="checkbox"/> Registered Domestic Partner
<input type="checkbox"/> Single	



Physical Address (Cannot be a P.O. Box)	Apartment / Unit
City	U.S. State / Territory
Zip Code	Country
	Years at Address



Mailing Address (If different from Physical Address)

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



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



Preferred Phone Number	Alternate Phone Number
<input type="checkbox"/> Mobile	<input type="checkbox"/> Mobile
Best Time to Call	Time Zone
<input type="checkbox"/> AM <input type="checkbox"/> PM	
Preferred method of communication	
<input type="checkbox"/> Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email	
Email Address	

2

Language

Is your primary language English?

What is your primary language?

If yes, go to
next section.☐**Yes**☐**No**

Was a translator used for this application?

☐**Yes**☐**No**

If yes

Relationship of the translator to the Proposed Primary Insured

☐**Producer**☐**Spouse**☐**Domestic Partner**☐**Parent**☐**Child**☐**Trustee**☐**Employer**☐**Business Partner**☐**Other**

Translator First Name

Translator Last Name

3

Nicotine Use

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

☐**Yes**☐**No**

4

Military**If you are active duty, please complete the Military Disclosure Form.**Are you a member, or have you entered into a written agreement to become a member of **any** armed forces including reserves?☐**Yes**☐**No**

If yes

Branch of Service

Occupation

Duties

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

☐**Yes**☐**No**

If yes

Deployment Date (mm/dd/yyyy)

Country

_ _ / _ _ / _ _ _ _

5

Education

What is the highest level of education you completed?

☐**Did not complete high school**☐**High School / GED**☐**Some college**☐**Trade / Tech School**☐**Associate's Degree**☐**Bachelor's Degree**☐**Master's Degree**☐**Doctorate Degree**

6

Personal Finances

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

Annual Earned Income

\$

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

Net Worth

\$

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

Annual Household Earned Income

\$

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

Total Active & Pending Spousal Insurance Coverage

\$

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

7

Business Finances

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

Fair market value of the business

\$

Net business income

\$

% of the business you own

%

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

☐

Yes

☐

No

If no

Please explain

8

Bankruptcy

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

☐

Yes

☐

No

If yes

Type of Bankruptcy

☐

Chapter 7

☐

Chapter 11

☐

Chapter 13

☐

Other

Filing Date (mm/dd/yyyy)

___ / ___ / ___

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

___ / ___ / ___

If dismissed, provide reason for dismissal

What circumstances led to the bankruptcy?

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

Length of repayment plan (in months)

Payment per month

\$

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

___ / ___ / ___

9

Travel

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

☐ **Yes** ☐ **No**

If yes →

Destination 1 (City and Country)

Start Date (mm/dd/yyyy)

____ / ____ / ____

End Date (mm/dd/yyyy)

____ / ____ / ____

Total number of days at the destination

Travel Purpose

☐ **Business** ☐ **Personal**

Destination 2 (City and Country)

Start Date (mm/dd/yyyy)

____ / ____ / ____

End Date (mm/dd/yyyy)

____ / ____ / ____

Total number of days at the destination

Travel Purpose

☐ **Business** ☐ **Personal**

Destination 3 (City and Country)

Start Date (mm/dd/yyyy)

____ / ____ / ____

End Date (mm/dd/yyyy)

____ / ____ / ____

Total number of days at the destination

Travel Purpose

☐ **Business** ☐ **Personal**

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

10

U.S. Citizenship

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

If yes, go to next section.

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

____ / ____ / ____

Country of Citizenship

Temporary Visa Type

Temporary Visa Expiration (mm/dd/yyyy)

____ / ____ / ____

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

____ / ____ / ____

Passport Country

Passport Expiration (mm/dd/yyyy)

____ / ____ / ____

Passport Number

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

____ / ____ / ____

No Green Card?

Complete all fields that are applicable and include a copy of all your immigration documents with this application.

Other Insurance

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

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

If yes ☐ Yes ☐ No

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

If yes ☐ Yes ☐ No

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

Type of Coverage	Company	Policy #	Face Amount	Replacement?
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
			\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

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

If yes ☐ Yes ☐ No

Insurance Company Name	Owner's Name	Total amount of insurance \$
------------------------	--------------	---------------------------------

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

If yes ☐ Yes ☐ No

Anticipated Cash Value Transfer
\$

Total accidental death insurance in-force with all companies?

\$

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

If yes ☐ Yes ☐ No

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

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

If yes ☐ Yes ☐ No

Please explain

Other Insurance

continued



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

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

☐

Yes

☐

No

If yes

Company	Policy #	Monthly Amount	Benefit Period	Elimination	Replacement?
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$			<input type="checkbox"/> Yes <input type="checkbox"/> No

Owner

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

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

☐

Person

☐

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

If person,
complete
this page.

Legal First Name

Middle Name

Legal Last Name

Suffix

U.S. Social Security Number

Date of Birth (mm/dd/yyyy)

U.S. Tax ID Number

Email Address

Gender

☐

Male

☐

Female

Physical Address (Cannot be a P.O. Box)

Apartment / Unit

City

U.S. State / Territory

Zip Code

Country

Years at Address

Preferred Phone Number

☐

Mobile

Mailing Address (If different from Physical Address)

City

U.S. State / Territory

Zip Code

Owner's relationship to Proposed Primary Insured

☐

Spouse

☐

Domestic Partner

☐

Parent

☐

Employer

☐

Business Partner

☐

Other

**Do you have
a Contingent
Owner?**

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

Owner*continued*

If yes, go to
next section.

No Green Card?

Complete all
fields that are
applicable
and include
a copy of all
immigration
documents with
this application.

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

If owner
is a **trust**,
complete a
Trust
Certification.

Is the owner a U.S. citizen?

☐ Yes☐ No

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

____ / ____ / ____

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

____ / ____ / ____

Country of Citizenship

Temporary Visa Type

Temporary Visa Expiration (mm/dd/yyyy)

____ / ____ / ____

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

____ / ____ / ____

Passport Country

Passport Expiration (mm/dd/yyyy)

____ / ____ / ____

Passport Number

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

____ / ____ / ____

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

Business Entity or Trust Name

U.S. Tax ID Number

____ - ____

**Complete this section for eDelivery.**

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

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

Email Address

Primary Beneficiaries



Total shares between all primary beneficiaries must equal 100%.



Primary Beneficiary 1 Percentage of Death Benefits

%

Total shares between all primary beneficiaries must equal 100%.

Legal First Name

Middle Name

Legal Last Name

Suffix

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

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

Business Entity or Trust Name (if applicable)

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

Mailing Address ☐ Same as Proposed Primary Insured

City

U.S. State / Territory

Zip Code

Phone Number

Relationship to the Proposed Primary Insured

☐ Spouse

☐ Domestic Partner

☐ Parent

☐ Child

☐ Trust

☐ Estate

☐ Business Partner

☐ Employer

☐ Other



Primary Beneficiary 2 Percentage of Death Benefits

%

Total shares between all primary beneficiaries must equal 100%.

Legal First Name

Middle Name

Legal Last Name

Suffix

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

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

Business Entity or Trust Name (if applicable)

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

Mailing Address ☐ Same as Proposed Primary Insured

City

U.S. State / Territory

Zip Code

Phone Number

Relationship to the Proposed Primary Insured

☐ Spouse

☐ Domestic Partner

☐ Parent

☐ Child

☐ Trust

☐ Estate

☐ Business Partner

☐ Employer

☐ Other

Primary Beneficiaries

continued



Primary Beneficiary 3 Percentage of Death Benefits

%

Total shares between all primary beneficiaries must equal 100%.

Legal First Name

Middle Name

Legal Last Name

Suffix

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

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

____ - ____ - ____

____ / ____ / ____

Business Entity or Trust Name (if applicable)

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

____ - ____ - ____

____ - ____ - ____

Mailing Address ☐ Same as Proposed Primary Insured

City

U.S. State / Territory

Zip Code

Phone Number

Relationship to the Proposed Primary Insured

☐ Spouse

☐ Domestic Partner

☐ Parent

☐ Child

☐ Trust

☐ Estate

☐ Business Partner

☐ Employer

☐ Other



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

For Contingent Beneficiaries, go to the next page.

Contingent Beneficiaries

i Total shares between all contingent beneficiaries must equal 100%.



Contingent Beneficiary 1 Percentage of Death Benefits

%

Total shares between all contingent beneficiaries must equal 100%.

Legal First Name	Middle Name	Legal Last Name	Suffix
U.S. Social Security Number (if a person)		Date of Birth or Trust Date (mm/dd/yyyy)	
____ - ____ - ____		____ / ____ / ____	
Business Entity or Trust Name (if applicable)		U.S. Tax ID Number (if a Business Entity or Trust)	
_____		____ - ____	
Mailing Address <input type="checkbox"/> Same as Proposed Primary Insured		City	
_____		_____	
U.S. State / Territory	Zip Code	Phone Number	
_____	_____	_____	
Relationship to the Proposed Primary Insured			
<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Parent	<input type="checkbox"/> Child <input type="checkbox"/> Trust
<input type="checkbox"/> Estate	<input type="checkbox"/> Business Partner	<input type="checkbox"/> Employer	<input type="checkbox"/> Other _____



Contingent Beneficiary 2 Percentage of Death Benefits

%

Total shares between all contingent beneficiaries must equal 100%.

Legal First Name	Middle Name	Legal Last Name	Suffix
U.S. Social Security Number (if a person)		Date of Birth or Trust Date (mm/dd/yyyy)	
____ - ____ - ____		____ / ____ / ____	
Business Entity or Trust Name (if applicable)		U.S. Tax ID Number (if a Business Entity or Trust)	
_____		____ - ____	
Mailing Address <input type="checkbox"/> Same as Proposed Primary Insured		City	
_____		_____	
U.S. State / Territory	Zip Code	Phone Number	
_____	_____	_____	
Relationship to the Proposed Primary Insured			
<input type="checkbox"/> Spouse	<input type="checkbox"/> Domestic Partner	<input type="checkbox"/> Parent	<input type="checkbox"/> Child <input type="checkbox"/> Trust
<input type="checkbox"/> Estate	<input type="checkbox"/> Business Partner	<input type="checkbox"/> Employer	<input type="checkbox"/> Other _____

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

16

Secondary Addressee

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

Legal First Name

Middle Name

Legal Last Name

Suffix

Mailing Address

City

U.S. State / Territory

Zip Code

Email Address

Phone Number

☐ **Mobile**

17

Product Details

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

Product Name

Coverage Amount

\$

This is the amount of life insurance coverage you are applying for.

Duration in years (Only applicable to Term Products)

☐ **10**☐ **15**☐ **20**☐ **25**☐ **30**☐ **Other** _____

Rate Class Applied for:

☐ **Preferred Elite**☐ **Preferred Plus**☐ **Preferred**☐ **Non-Tobacco**☐ **Preferred Tobacco**☐ **Tobacco**☐ **Juvenile**☐ **Other** _____

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

☐ **Elect**☐ **Do Not Elect**

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

Extra Substandard Rating of

☐ **Table Rating**☐ **Flat Extra**

What is the purpose of this insurance?

☐ **Personal: Income Replacement**☐ **Personal: Estate Planning**☐ **Business: Key Man/Person**☐ **Business: Loan Coverage**☐ **Business: Buy/Sell**☐ **Business: Other** _____

Death Benefit Option (if applicable to your product)

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

Life Insurance Compliance Test (if applicable to your product)

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

Product Details

continued

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

Benefit		Amount	
Complete the Additional Insured Rider Supplement Application	<input type="checkbox"/> Accidental Death Benefit Rider	\$	
	<input type="checkbox"/> Additional Insured Rider	Coverage amount included on the supplement form	
Complete the Children's Benefit Rider Supplemental Application	<input type="checkbox"/> Base Insured Rider	\$	
	<input type="checkbox"/> Children's Benefit Rider	\$	
	<input type="checkbox"/> Chronic Illness Rider	Amount not applicable	
	<input type="checkbox"/> Critical Illness Rider	Amount not applicable	
Complete the Disability Income Rider Questionnaire	<input type="checkbox"/> Disability Income Rider	Years	\$
	<input type="checkbox"/> Disability Waiver of Monthly Deductions Rider	Amount not applicable	
	<input type="checkbox"/> Disability Waiver of Premium Rider	Amount not applicable	
	<input type="checkbox"/> Enhanced Index Rider	Amount not applicable	
Complete the Income Protection Option Election Form	<input type="checkbox"/> Guaranteed Insurability Rider	\$	
	<input type="checkbox"/> Income Protection Option	Amount not applicable	
Complete the Long Term Care Rider Supplemental Application For Non-US citizens that are lawful permanent residents, a copy of your green card is required.	<input type="checkbox"/> Long Term Care Rider	Amount not applicable	
	<input type="checkbox"/> Term Insurance Rider	\$ <input type="checkbox"/> 10 yrs <input type="checkbox"/> 20 yrs <input type="checkbox"/> 30 yrs	
	<input type="checkbox"/> Other _____	\$	

Premium

Frequency

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

Recurring Payment Method

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

This is the recurring amount you will pay.

Planned Periodic Premium \$ _____

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

Lump Sum \$ _____

Source of Funds

☐ Employment☐ 1035 Exchange☐ Retirement☐ Other _____

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

Amount submitted with application

\$ _____

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

☐ EFT☐ Credit Card☐ Check**Premium Payor**

A person, trust or entity paying the premium

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

Legal First Name

Middle Name

Legal Last Name

Suffix

U.S. Social Security Number

Date of Birth (mm/dd/yyyy)

____ - ____ - ____

____ / ____ / ____

Business Entity or Trust Name

U.S. Tax ID Number

____ - ____

Physical Address (Cannot be a P.O. Box)

Apartment / Unit

City

U.S. State / Territory

Zip Code

Country

Phone Number

☐ Mobile

Email Address

Premium Payor

continued

Premium Payor's relationship if other than the Proposed Insured

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

If yes, go to next section.

No Green Card?

Complete all fields that are applicable and include a copy of all your immigration documents with this application.

Is the Premium Payor a U.S. citizen?

☐ Yes

☐ No

Green Card Number and Expiration

____ / ____ / ____

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

____ / ____ / ____

Country of Citizenship

Temporary Visa Type

Temporary Visa Expiration (mm/dd/yyyy)

____ / ____ / ____

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

____ / ____ / ____

Passport Country

Passport Expiration (mm/dd/yyyy)

____ / ____ / ____

Passport Number

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

____ / ____ / ____



Mail additional premium notices to

Legal First Name

Middle Name

Legal Last Name

Suffix

Mailing Address

City

U.S. State / Territory

Zip Code

Variable Universal Life, Universal Life, and Index Universal Life



For Variable Life Insurance (VUL) product:

Has the Owner received the current Prospectus for the policy?

☐ Yes

☐ No

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

☐ Yes

☐ No

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

☐ Yes

☐ No

Premium Allocation Options for VUL

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

Variable Universal Life, Universal Life, and Index Universal Life

continued

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

☐ Yes ☐ No

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

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

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

Illustration Certification

☐ **If this box is checked, the Applicant/Owner and the Producer certify that they have each read and agree with their respective statements below regarding the policy applied for:**

Applicant's/Owner's statement: By signing this supplemental application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date.

Producer's statement: By signing this supplemental application, I, the Producer certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

☐ **If this box is checked, the Applicant/Owner and the Producer certify that they have each read and agree with their respective statements below regarding the policy applied for:**

Applicant's/Owner's statement: By signing this supplemental application, I, the Applicant/Owner acknowledge that an illustration was presented to me, but it differs from the coverage I applied for. I understand that an illustration of the policy as issued will be provided no later than the policy delivery date.

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

Premium Allocation Options for IUL

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

Authorization to Obtain and Disclose Information

Each of the undersigned hereby certifies and represents as follows:

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

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

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

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

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

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

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

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

TAXPAYER IDENTIFICATION CERTIFICATION

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

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

21

Authorization to Obtain and Disclose Information

continued



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

Signature of Proposed Insured

____ / ____ / ____
Date (mm/dd/yyyy)

City

U.S. State / Territory



Signature of Parent or Legal Guardian
(Of children under age 18)

____ / ____ / ____
Date (mm/dd/yyyy)

City

U.S. State / Territory



Signature of Applicant/Owner
(If other than Proposed Insured)

____ / ____ / ____
Date (mm/dd/yyyy)

City

U.S. State / Territory

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

If trust, show trustee's name.

Title of Trust (If owner is trust)

Print Producer 1 Name

Producer 1 Number

Producer 1 Signature

Print Producer 2 Name

Producer 2 Number

Producer 2 Signature

22

Other Insurance (to be completed by the Producer)

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ N/A ☐ Yes ☐ No →

If no, explain.

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



Producer Signature

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

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

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to the Company, this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

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

CONDITIONAL COVERAGE: Conditional insurance on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Tobacco Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed it, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a notice and/or a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. \$400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. \$1,500,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. \$400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. \$100,000 of life insurance for a class of risk with extra ratings regardless of age.

There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a proposed primary Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed primary Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

X _____, 20____
Signature of Proposed Owner Date

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

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

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

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

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

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to the Company, this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

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

CONDITIONAL COVERAGE: Conditional insurance on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Tobacco Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed it, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a notice and/or a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. \$400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. \$1,500,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. \$400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. \$100,000 of life insurance for a class of risk with extra ratings regardless of age.

There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a proposed primary Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed primary Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in the application have been met.

Dated at _____ on _____, 20__ X _____
City, State Date Insurance Producer or
other Company Authorized Rep

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

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

NOTICE OF DISCLOSURE

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

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

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

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

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any: Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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

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

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our producer may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Transamerica Life Insurance Company, Attn: Director of Underwriting, 6400 C Street SW, Cedar Rapids, Iowa 52499.

Agent's Report

1

Producer 1 →	Writing Agent Name	Agent Number	Profile Number	Percent of Agent's Split
Producer 2 →	Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split
Producer 3 →	Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split
Producer 4 →	Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

2

Agent Disclosure

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

Are you financially responsible for the Proposed Primary Insured?

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes

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

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

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Yes ☐ No

If yes

Name and address of Broker/Dealer

City

U.S. State / Territory

Zip Code

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

☐ Yes ☐ No ☐ N/A

Please indicate how this sale was taken:

☐ In person

☐ Phone or Video Call
(Skype, FaceTime, etc.)

☐ Other _____

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

☐ Yes

☐ No

Type of Government issued photo ID

Issuer of Identification Document

Number

Expiration Date

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

☐ Yes

☐ No

If yes

Provide Details

3

**Correspondence
Information**

Case Manager Name (if applicable)

Agent/Case Manager Email

Office ID

Agent/Case Manager Phone Number

Agent/Case Manager Fax Number

4

Signature

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

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



Signature of Writing Agent/ Registered Representative

____ / ____ / ____
Date (mm/dd/yyyy)

Policy Number (for existing policies only)

Introduction

Instructions:

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



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



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

Questions?



Contact your
Financial
Professional



Visit us at:
transamerica.com



Call us at:
1-800-797-2643

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

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

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

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

Recurring Payment Frequency (choose one)

- ☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Total Premium

\$



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

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

Credit Card Payment Information

Credit Card Type: ☐ VISA ☐ MasterCard

PCI Token #



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

Cardholder First Name

Cardholder Last Name

Card Exp. Date

Payment Amount

The cardholder is the (choose one):

____/____/____

\$____,____.____

☐ Insured ☐ Owner ☐ Spouse ☐ Other: _____

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

X

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

Bank Draft (ACH/EFT) Payment Information

Account Type: ☐ Checking ☐ Savings

Account Holder First Name

Account Holder Last Name

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

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

The account holder is the (choose one):

☐ Insured ☐ Owner ☐ Spouse ☐ Other: _____

Account Holder Signature:

X

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

Consents

If a conditional receipt was issued along with this authorization, initial premium will be withdrawn/cashed upon receipt of the application by the Company. Unless a conditional receipt was issued along with this authorization, I/we agree this authorization shall not become effective for payment of the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in the application have been met.

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

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

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

Bank Account Will be Subject to Identity Verification

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

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:

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

Prepared by the National Association of Insurance Commissioners

The NAIC is an association of state insurance regulatory officials. This association helps the various Insurance Department to coordinate insurance laws for the benefits of all consumers.

This guide does not endorse any company or policy.

Reprinted by:

Transamerica Financial Life Insurance Company

Transamerica Life Insurance Company

Transamerica Premier Life Insurance Company

IMPORTANT THINGS TO CONSIDER

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

BUYING LIFE INSURANCE

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

First, decide how much you need – and for how long – and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for your future.

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

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

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

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

WHAT ABOUT A POLICY YOU HAVE

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

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy (you have now) helped pay for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older and your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.

- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may not pay benefits for some cause of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

HOW MUCH DO YOU NEED

Here are some questions to ask yourself:

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

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

WHAT IS THE RIGHT KIND OF LIFE INSURANCE

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

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

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term Insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value. You can renew most Term Insurance policies for one or more terms even if your health has changed. Each time you renew the policy or a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase. You may be able to trade many Term Insurance policies for a Cash Value Policy during a conversion period – even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the Term Insurance.

Cash Value Life Insurance is a type of insurance where the premium charges are higher at the beginning than they would be for the same amount of Term Insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and interest on it, the amount you owe will be subtracted from the benefits payable when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without have to pay more premiums.

You can also use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash Value Life Insurance may be one of several types: Whole Life, Universal Life and Variable Life are all types of Cash Value Insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of Term Insurance. But they are smaller than the premium you would eventually pay if you were to keep renewing a Term Policy until your later years. Some Whole Life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

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

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

LIFE INSURANCE ILLUSTRATIONS

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

FINDING A GOOD VALUE IN LIFE INSURANCE

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

- Do premiums or benefits vary from year to year?
- How much cash value builds up under the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

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

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent of company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are non-guaranteed values calculated? For example, interest rates are important in determining policy return. In some companies, increases reflect the average interest earnings on all of the company's policies regardless of when issued. In others, the return for policies issued in a recent year, or group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Transamerica Life Insurance Company

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

The Accelerated Death Benefit does not and is not intended to qualify as long-term care under Washington state law. Washington state law prevents this accelerated life benefit from being marketed or sold as long-term care.

If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds such as Medicare, Medicaid, Social Security, Supplemental Security, Supplemental Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

This disclosure form provides a brief description of the accelerated benefit options available under your policy. Read your policy carefully for details regarding your rights and obligations under the policy.

We pay the Accelerated Death Benefit available under your policy if you choose this option. 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 that 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 that the Insured:

- (a) Is unable to perform without substantial assistance from another person for a period of at least 90 days, at least two out of six Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or
- (b) Requires substantial supervision by another person, for a period of at least 90 consecutive days, to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

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

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

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

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

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

- A. The actuarial present value of the amount of the Available Death Benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your rider.
- B. Any amount necessary to provide insurance to the date of the Accelerated Death Benefit payment if we make the payment during a grace period or after the policy has lapsed.
- C. The Loan Balance, if any, at the time the Accelerated Death Benefit is paid, multiplied by the Election Percentage.
- D. The actuarial present value of future premiums, including premiums for any Base Insured Rider or Joint Insured Term Rider, but excluding other rider premiums, multiplied by the Election Percentage. The actuarial present value of future premiums is the amount as determined by us that would, prior to the acceleration, otherwise be payable to keep the policy In Force during the period of the Insured's remaining lifetime as determined by our physician's assessment, at time of the acceleration. This amount is determined by us using the applicable rated age, mortality tables, and interest rate described under 1), 2), and 3) of the Present Value of Accelerated Death Benefit provision. For the Terminal Illness Accelerated Death Benefit, the future premiums are assumed to be zero.
- E. An administration charge for each Accelerated Death Benefit Request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2016 is \$350, but will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index for All Urban Consumers (CPI) since January 1, 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used. In no event will the administrative charge for each Accelerated Death Benefit request exceed \$1,000.

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

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

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

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

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

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy.

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.



Premium Bank Draft
Accountholder Certification

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

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

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

Agent Printed Name

Agent Code

Agent Signature

Date

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



Important Notice Regarding Replacement of Insurance

Transamerica Life Insurance Company

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

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

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

STATEMENT TO APPLICANT BY AGENT OR BROKER

(Use additional sheets, as necessary.)

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

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

Signature of Agent or Broker

Date

Name of Agent or Broker
(Print or Type)

Address

LREP-WA-0917

Rev 0122

LIST OF POLICIES OR CONTRACTS TO BE REPLACED:

COMPANY	INSURED	CONTRACT NO.

CAUTION: The insurance commissioner suggests you consider these points:

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

Completed Copy

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

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

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

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

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

2. ☐ Yes ☐ No Are all the children being covered U.S. Citizens? If no, give details in Remarks.
3. ☐ Yes ☐ No Is coverage under the Children's Benefit Rider being requested for all minor children of the Proposed Insured?
If no, give details in Remarks.
4. ☐ Yes ☐ No Are any children proposed for coverage not living with the Proposed Insured?
If yes, give details in Remarks.

Give details to all yes answers in Remarks.

Remarks

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

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

- | | | |
|---|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Abnormalities | <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Malignancy | <input type="checkbox"/> Y <input type="checkbox"/> N Brain or Neurological Disorder |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Blood Disorder | <input type="checkbox"/> Y <input type="checkbox"/> N Asthma or other Lung Disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cystic Fibrosis | <input type="checkbox"/> Y <input type="checkbox"/> N Leukemia | <input type="checkbox"/> Y <input type="checkbox"/> N Muscular Dystrophy |
| <input type="checkbox"/> Y <input type="checkbox"/> N Down's Syndrome | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Disease | <input type="checkbox"/> Y <input type="checkbox"/> N Abnormalities from premature birth |
| <input type="checkbox"/> Y <input type="checkbox"/> N Injury or Illness requiring hospitalization | | |

Additional Details:

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

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

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

Additional Details:

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

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

Signed at _____
(city-state)

Date: _____

Signature of Proposed Insured

Witness of Proposed Insured Signature

Signed at _____
(city-state)

(date)

Signature of Owner (if other than Proposed Insured)

Witness of Owner Signature