RESET

TRANSAMERICA LIFE INSURANCE COMPANY

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

# HIPAA Authorization for Release of Health-Related Information

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

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

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

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], 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 Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its 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 Company, 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 Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in its 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 Company 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 Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

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

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

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

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

Policy or contract number (if known): _____

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

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

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

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], 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 Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its 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 Company, 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 Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in its 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 Company 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 Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

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

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

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

Policy or contract number (if known): _____

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

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TRANSAMERICA®
LIFE INSURANCE COMPANY

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

GA # _____

# Individual Life Insurance Application For One Life Part 1

**Proposed Insured:** _____ _____
First Middle Last Suffix Mr./Mrs./Ms./Dr.

Birthdate: _____ Age _____ Birth Place: _____ Male ☐ Female ☐
Mo. Day Yr.

Soc. Sec. No.: _____ U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: _____ _____
Area Code & Work Phone

Occupation: _____

Annual Income $ _____ Net Worth $ _____

Residence: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Area Code & Home Phone

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: _____

_____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Date of Trust, if Applicable

1. Plan Applied For: _____ Kind Code: _____
2. Risk Classification: Preferred Plus/Select ☐ Preferred ☐ Standard Plus ☐ Standard ☐
   Extra Rating of ☐ _____ Other ☐ _____
3. Nicotine Classification: Nicotine ☐ Non-Nicotine ☐
4. Amount Applied For $ _____
5. Additional Benefits by Rider: ☐ Waiver of Premium/Waiver Provision ☐ Accident Indemnity $ _____ ☐ Other _____ $ _____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Other _____
   ☐ PAC ☐ Direct Bill
7. Complete for Flexible Premium Plans:
   Required Premium Per Year (RAP) $ _____
   Planned Periodic Premium $ _____
   + Initial Lump Sum $ _____
   = Total Initial Premium $ _____
8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ☐ Yes ☐ No (APL will be in effect unless no is checked.)
9. Do you have any existing life insurance or annuities? If none, check this box ☐. If yes, please list the policies below.
   a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.

| Type of Coverage (Personal / Business / Employer Provided / Group) | Company/Policy Number | Face Amount | Replacement? |
|---|---|---|---|
| | | $ | ☐ Yes ☐ No |
| | | $ | ☐ Yes ☐ No |
| | | $ | ☐ Yes ☐ No |

   b. Total Accidental Death insurance inforce with all companies: $ _____


continued on next page

10. Is any application for life insurance pending with any other company? ☐ Yes ☐ No
If yes, give company name, amount applied for and total amount to be placed. _____

11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? ☐Yes ☐ No If yes, give insurance company name, owner's name, and amount of insurance of each policy.

_____

12. Mail Additional Premium Notices To: _____

Address: _____
No. & Street City State Zip Country

| Yes | No | **"You" means any person proposed to be insured.** |
|---|---|---|
| ☐ | ☐ | 13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire. |
| ☐ | ☐ | 14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire. |
| | | 15. Have you used nicotine at any time? Date Last Used |
| ☐ | ☐ | Cigarettes _____ |
| ☐ | ☐ | Cigar/Pipe/Chewing Tobacco _____ |
| ☐ | ☐ | Other _____ |
| | | 16. Driver's License #: _____ State: _____ |
| | | In the past five years, have you been convicted of or pleaded guilty to: |
| ☐ | ☐ | a. Moving violations? If yes, give dates and type. _____ |
| ☐ | ☐ | b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____ |
| ☐ | ☐ | c. Reckless driving? If yes, give dates. _____ |
| ☐ | ☐ | 17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire. |
| ☐ | ☐ | 18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense. |
| ☐ | ☐ | 19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details. |
| ☐ | ☐ | 20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any. |

**Remarks:** Give details for any questions answered yes

_____

_____

_____

_____

_____

_____

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

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

## NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to you under Section 101(j) of the Internal Revenue Code to the extent it exceeds the premiums and other considerations paid by you for the policy unless the written Notice and Consent is obtained **prior to policy issue** and certain other requirements of such section are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

## AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 30 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

**I acknowledge** receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. ☐ Yes ☐ No

**PLEASE MAKE CHECKS PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT/PRODUCER OR LEAVE PAYEE SPACE BLANK.**

Amount paid with this Application $ _____ ☐ Check # _____ ☐ Credit Card (Complete Credit Card Order Confirmation Form)

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

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

Signed at _____ (City-State) on _____ (Date), _____

X _____
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor)
(Child age 15 and over must sign)

X _____
Witness to Signature of Proposed Insured

Signed at _____ (City-State) on _____ (Date), _____

X _____
Signature of Owner (if other than Proposed Insured)

X _____
Witness to Signature of Owner

X _____
Signature of Parent or Legal Guardian of Children age 14 and under

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

X _____
Signature of Licensed Producer

_____

LICENSED PRODUCER:
Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? ☐ Yes ☐ No

_____

(NOT PART OF APPLICATION)

**REPORT BY AGENCY OFFICE**

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL: _____

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

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

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

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

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

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

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

What is the purpose for insurance? _____

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

How long have you known the Proposed Insured? _____

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

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

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

X _____
Signature of Producer

TRANSAMERICA®

# Payment Authorization Form

Policy Number (for existing policies only)

## Introduction

**Instructions:**

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

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

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

**Recurring Draft Day (1st through 28th only)**
*Initial modal premium is withdrawn upon receipt of the application and a completed Conditional Receipt and not on the day chosen for recurring payment. If a Conditional Receipt is not received with the application, then the initial premium is drafted at policy placement.*

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

**Recurring Premium Payment Mode (choose one)**
☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

**Planned Modal Premium**
$ _____

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

| Payment Type Options | Initial and/or Recurring Payment | Form Information |
|---|---|---|
| **Bank Draft (ACH/EFT)** | ☐ **Initial** ☐ **Recurring** | Complete the ACH payment section below |
| **Credit Card** | ☐ **Initial** | Tokenize your card number, and complete the Credit Card Payment section below |
| **Check** | ☐ **Initial** | Mail your check to the address at the top of this form |
| **Direct Bill** | ☐ **Recurring** | This method only available quarterly, semiannually, or annually. Monthly premium available for minimum of $83.33. |

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

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

**One-time ACH Debit Authorization**

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

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

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

## 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 Signature:

**X** **Date:**

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

## Bank Draft (ACH/EFT) Payment Information

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

Account Holder First Name

Account Holder Last Name

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

Financial Institution Name

Routing Number

Account Number

**The account holder is the (choose one):**
☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Account Holder Signature:

**X** **Date:**

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

## Consents

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

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

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

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

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

## NOTICE OF DISCLOSURE OF INFORMATION

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

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

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

**Notice of Insurance Information Practices:** The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent/producer or write the Company at its Administrative Office, 6400 C Street SW, Cedar Rapids, IA 52499.

## INSTRUCTIONS FOR CONDITIONAL RECEIPT

**DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:**

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

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

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

**CONDITIONAL RECEIPT**
**PLEASE READ THIS CAREFULLY**

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

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

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

**CONDITIONAL COVERAGE:** Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

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

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

**60-DAY LIMIT OF CONDITIONAL COVERAGE:** If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

**DOLLAR LIMITS OF CONDITIONAL COVERAGE:** The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, $400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

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

***Except as provided in this Conditional Receipt,*** no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

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**ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT**

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

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

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

_____ , 20 _____
Date
If Proposed Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner. Give corporate title and full name of corporation below.

_____ _____

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 6400 C Street SW, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

**Submit this completed and signed original with the application and payment.**

**CONDITIONAL RECEIPT**
**PLEASE READ THIS CAREFULLY**

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

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

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

**CONDITIONAL COVERAGE:** Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

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

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

**60-DAY LIMIT OF CONDITIONAL COVERAGE:** If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

**DOLLAR LIMITS OF CONDITIONAL COVERAGE:** The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, $400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

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

***Except as provided in this Conditional Receipt,*** no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at _____ on _____ ,20 _____ X _____

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

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**ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT**

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

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

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 6400 C Street SW, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

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



Proposed Owner

RESET

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

# Beneficiary/Additional Insured Information Form

**PRIMARY INSURED**

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

**OWNER - if other than Primary Insured**

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

**ADDITIONAL/OTHER PROPOSED INSURED - if applicable**

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

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

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

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

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

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

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

**AGENT**

❑ I attest that, on behalf of the Company, I requested all information above and the applicant provided the information completed on the form.

❑ I attest that the applicant was unable/declined to provide any information missing from the form.

Date

Producer or Agent Signature

Owner Signature

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

# Notice and Consent for BLOOD-BORNE PATHOGEN Testing WASHINGTON

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

**Confidentiality of Test Results**

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

**Notification of Test Results**

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

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

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

**Consent**

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

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

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

**LIFE INSURANCE BUYER'S GUIDE**

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

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

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**Prepared by the National Association of Insurance Commissioners**

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

**This guide does not endorse any company or policy.**

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

**National Association of Insurance Commissioners**

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

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**Before you buy life insurance...**

**UNDERSTAND WHAT LIFE INSURANCE IS**

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

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

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

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

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

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

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

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

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**COMPARE THE DIFFERENT TYPES OF INSURANCE POLICIES**

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

Some things to consider are:

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

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

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

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

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**BE SURE YOU CAN AFFORD THE PREMIUM**

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

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

**UNDERSTAND THE APPLICATION PROCESS**

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

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

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

**CHOOSE A BENEFICIARY**

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

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

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

**EVALUATE THE FUTURE OF YOUR POLICY**

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

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**After you buy life insurance...**

**READ YOUR POLICY CAREFULLY**

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

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

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

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

**REVIEW YOUR LIFE INSURANCE POLICY EVERY FEW YEARS**

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

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

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

**Notes...**

# Transamerica Life Insurance Company
# Transamerica Financial Life Insurance Company

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Should I maintain copies of the Policy Documents?**

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

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

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

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

**You can contact Transamerica as follows:**

For all products except Financial Foundation IUL:

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

For Financial Foundation IUL:

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

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

**Computer Compatibility**

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

**Mobile Device Compatibility**

| | |
|---|---|
| **Operating Systems** | Apple Devices: iOS7 or higher<br>Android Devices: Android 4 or higher |

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

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

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

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

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

**Name of Insured** | **Insured Email Address**

**Signature of Insured** | **Date**

**Phone Number of Insured**

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

☐ **Owner is same as Insured**

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

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

**Phone Number of Owner, if other than insured**

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

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

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

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

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

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

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

TRANSAMERICA®

eDELIVERY | SECURE! EASY! ENVIRONMENTALLY FRIENDLY!

# eDelivery Terms and Conditions of Use

The Transamerica company using this form is:

☐ Transamerica Life Insurance Company ☐ Transamerica Financial Life Insurance Company

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

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

Important Information Concerning Electronic Document Delivery:

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

Please call 1-800-851-9777 or visit the Company website at www.transamerica.com if you would like to revoke your consent, wish to receive a paper copy of the information above, or need to update your email address.

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

Policy Owner: _____
Email Address Printed Name

Policy Number(s): _____

TRANSAMERICA®

# Summary and Disclosure Notice
# Accelerated Death Benefit Option

## 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 form 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 with one or more of the following health conditions:

(a) Heart Attack
(b) Stroke
(c) Cancer
(d) End Stage Renal Failure
(e) Major Organ Transplant
(f) Amyotrophic Lateral Sclerosis (ALS)
(g) Blindness
(h) Paralysis

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. This policy must be In Force at the time of your Accelerated 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. At the time you request to exercise the Accelerated Benefit option, there must be at least two (2) years remaining before the Expiry Date of the policy; and
5. We must receive the consent of all irrevocable beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

If we approve your acceleration request, we will make the payment on the next Monthly Policy Date.

Amount of Benefit: The Accelerated Death Benefit payment we make to you will be less than the amount of the death benefit which you request to accelerate. 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 - B - C - D where A, B, C, and D are determined as follows:

A. The present value of the amount of the death benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your policy form.
B. Any due or unpaid premium if we make payment during the grace period.
C. The actuarial present value of future premiums, excluding rider premiums that would otherwise be payable to keep this policy In Force during the period of the Insured's remaining lifetime at time of the acceleration, using the applicable rated age, mortality table, and interest rate. For the Terminal Illness Accelerated Death Benefit, the future premiums are assumed to be zero.
D. An administration charge for each Accelerated Death Benefit Request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2015 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, 2015. 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, subject to the approval of the Interstate Insurance Product Regulation Commission. In no event will the administrative charge 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 nature and severity of the Insured's health condition and the Insured's remaining life expectancy at the time of the acceleration. 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 Benefit: The maximum death benefit you may accelerate over the lifetime of the Insured is equal to the lesser of:

1. 90% of the Face Amount of this policy for Critical Illness and Chronic Illness; 100% of the Face Amount of this policy for Terminal Illness; or
2. [$1,500,000].The maximum death benefit you may accelerate in any 12 month period because the Insured is Chronically Ill is 24% of the Face Amount of the policy at the time the option is exercised.

Effect of Benefit on Policy: The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the Accelerated Death Benefit is paid will also be reduced. The reduced premium will equal the appropriate premium rate applied to the reduced face amount plus any applicable policy fee. We will provide you with information showing the reduced face amount resulting from the accelerated death benefit payment.

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.

Reset Form

TRANSAMERICA® LIFE INSURANCE COMPANY

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

GA # _____

# Application Part 2
# Non-Medical Health History

File # _____

| 1. **Proposed Insured:** *(Print Full Name)* | 2. **Date of Birth:** Month Day Year | 3. **Social Security #** |
|---|---|---|

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

Name: _____ Address: _____

Phone: _____ City/St/Zip: _____

Date and reason for last visit: _____

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

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

| 6. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:** | **Yes** | **No** | Details: |
|---|---|---|---|
| a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain? | ☐ | ☐ | |
| b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood? | ☐ | ☐ | |
| c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system? | ☐ | ☐ | |
| d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? | ☐ | ☐ | |
| e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? | ☐ | ☐ | |
| f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands? | ☐ | ☐ | |
| g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones? | ☐ | ☐ | |
| h. Any disease or abnormality of the eyes, ears, nose, throat or skin? | ☐ | ☐ | |
| i. Cancer, tumor, polyp or cyst? | ☐ | ☐ | |
| j. Any physical deformity or amputation? | ☐ | ☐ | |
| k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder? | ☐ | ☐ | |
| l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test? | ☐ | ☐ | |

| 7. | **Yes** | **No** |
|---|---|---|
| a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician? | ☐ | ☐ |
| b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? | ☐ | ☐ |

| 8. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:** | **Yes** | **No** |
|---|---|---|
| a. Consulted, been examined or been treated by any physician or practitioner? | ☐ | ☐ |
| b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study? | ☐ | ☐ |
| c. Had observation or treatment at a clinic, hospital or other medical facility? | ☐ | ☐ |
| d. Had or been advised to have a surgical procedure? | ☐ | ☐ |
| e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever? | ☐ | ☐ |
| f. Had any injury requiring treatment? | ☐ | ☐ |

* D T 0 3 8 *

 File # _____

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

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

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

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

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

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

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

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

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

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

_____
Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

_____
Print name of Proposed Insured

**NON-MEDICAL**

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

# Application Supplement for Children's Insurance Rider

File # _____

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

| Name: First, Middle Initial, Last | Age | Date of Birth | Sex | Height | Weight |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

3. ☐ Yes ☐ No Is coverage under the Children's Insurance Rider being requested for all minor children of the Proposed Insured?
If no, give details in Remarks.

4. ☐ Yes ☐ No Are any children proposed for coverage not living with the Proposed Insured?
If yes, give details in Remarks.

5. Give details to all yes answers in Remarks, including all dates and diagnoses.

| Yes | No | Has any child proposed for coverage been diagnosed with: |
|---|---|---|
| ☐ | ☐ | Congenital Heart Abnormalities, Heart Disorder, Epilepsy, Cancer, Malignancy, Blood Disorder, Leukemia, Diabetes, Cystic Fibrosis, Kidney Disease, Brain or Neurological Disorder? |
| ☐ | ☐ | Asthma or other lung disease or injury or illness requiring hospitalization? |

**Remarks**

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

Signed at _____ Date: _____
(city-state)

_____ _____
Signature of Proposed Insured — Witness of Proposed Insured Signature

Signed at _____ _____
(city-state) (date)

_____ _____
Signature of Owner (if other than Proposed Insured) — Witness of Owner Signature



*DT208*