

# Transamerica Life Insurance Company New Business Cover Sheet

Fax to: 800.535.1325

Date: \_\_\_\_\_ Number of pages including this cover sheet: \_\_\_\_\_

Agent #: \_\_\_\_\_ Agent name: \_\_\_\_\_

Agent phone #: \_\_\_\_\_ Agent fax #: \_\_\_\_\_

Preferred e-mail address for pending policy updates: \_\_\_\_\_

Proposed insured's name: \_\_\_\_\_

Best time of day/evening to call them: \_\_\_\_\_ Special language needs? \_\_\_\_\_

If this is a companion policy, write companion name: \_\_\_\_\_

## Forms Checklist

Please Write the Name of the Product Being Applied for Here \_\_\_\_\_

### For All Products

Primary Insured    Additional Insured

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

### Office ID# 15770

For illustration software go to  
[www.agentnetinfo.com](http://www.agentnetinfo.com),  
Software Downloads, TransWare®

When completing the APA40 app be sure  
to indicate:

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

### Company Scheduled to do Paramed

- |                               |                                     |                                |
|-------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> APPS | <input type="checkbox"/> ExamOne    | <input type="checkbox"/> Other |
| <input type="checkbox"/> EMSI | <input type="checkbox"/> Portamedic |                                |

Lab Slip/Bar Code #: \_\_\_\_\_ Date Taken: \_\_\_\_\_

Special Instructions: \_\_\_\_\_

### Tips! To speed processing...

- Submit initial application and forms **ONLY ONCE**, either via fax, [www.agentnetinfo.com](http://www.agentnetinfo.com), or mail.
- If you choose to fax your application, please retain your original copy of this fax. We reserve the right to request a re-fax of the original if we are unable to read the fax. Do NOT mail the original application and forms you have previously faxed, unless requested to do so.
- Print legibly, in English, and use black ink.
- Do NOT use white-out.
- Make sure all necessary supplemental forms are included.

Life insurance products issued by Transamerica Life Insurance Company, Cedar Rapids, IA. 52499



Transamerica Life Insurance Company  
Home Office: 4333 Edgewood Road NE  
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

**Special Information Regarding Possible Lapse in Coverage:**

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

Name: \_\_\_\_\_ Billing Address: \_\_\_\_\_

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?
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Total Accidental Death insurance in force with all companies: \$ \_\_\_\_\_

**APPLICATION (NB)**

continued on next page

Rev 01/13



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.**



# FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

**ARKANSAS, LOUISIANA and WEST VIRGINIA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**COLORADO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DISTRICT OF COLUMBIA:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**KENTUCKY:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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

**MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**NEW MEXICO:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OHIO:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**OKLAHOMA:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**PUERTO RICO:** Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars (\$5000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**TENNESSEE , VIRGINIA and WASHINGTON:** 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.

**ALL OTHER STATES:** 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.

## 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. **(NOTE: This authorization excludes the release of any information relating to previously administered tests for HIV antibodies, T-Cell Counts, AIDS or ARC, by my family doctor or regular caregiver or any other entity or person which may possess this information. Further, I DO NOT authorize the Company to forward the results of any new test to any outside non-affiliated company nor to any entity that is not under specific contract with the Company to perform underwriting services.)**

**I understand** the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

**I know** that I may request to receive a copy of this Authorization. I agree this Authorization shall be valid for two years from the date shown below, regardless of my condition and whether I am living or not.

**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 OR LEAVE PAYEE SPACE BLANK.

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

Signed at \_\_\_\_\_ on \_\_\_\_\_ , \_\_\_\_\_  
City-State Date

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at \_\_\_\_\_ on \_\_\_\_\_ , \_\_\_\_\_  
City-State Date

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

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

(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

**PRE-AUTHORIZED CHECK/WITHDRAWAL PLAN ("PAC")**

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 Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

- ☐ **MONTHLY** (This will be elected if no box is checked)
- ☐ **QUARTERLY**
- ☐ **SEMI-ANNUAL**
- ☐ **ANNUAL**
- ☐ **PREMIUM**
- ☐ **LOAN REPAY**
- ☐ **SAVINGS**
- ☐ **CHECKING**
- ☐ **NEW AUTHORIZATION**
- ☐ **BANK CHANGE**
- ☐ **ADD TO EXISTING POLICY**
- ☐ **OTHER** \_\_\_\_\_

PICK A DATE TO DRAFT (1-28) \_\_\_\_\_

**NAME OF FINANCIAL INSTITUTION:** \_\_\_\_\_  
**PHONE #:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_  
**CITY, STATE, ZIP:** \_\_\_\_\_  
**ACCOUNT NUMBER:** \_\_\_\_\_  
**NAME(S) ON BANK ACCOUNT:** \_\_\_\_\_  
**ROUTING#:** \_\_\_\_\_

**AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM**

I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements or riders), or as agreed to by me, and for such other payments as I may authorize the Company to make. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on the earliest due date. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this authorization in no way affects the terms of the policy, other than the mode of payment, and I understand that if the premiums are not paid within the grace period allowed by a policy, as in the event any such withdrawal being dishonored, or for any reason, then the policy shall terminate subject to any nonforfeiture provisions in the policy.

**AUTHORIZATION TO HONOR PAC WITHDRAWALS**

As a convenience to me, I hereby request the financial institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company and/or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these authorizations.

_____	_____	_____
BANK SIGNATURE(S) OF DEPOSITOR(S)	DATE	SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR

TAPE VOIDED CHECK HERE



\* D T O 8 4 \*  
TG-NF

## 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](http://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 or write the Company at its Administrative Office, 4333 Edgewood Road NE, 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.

---

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

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

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

X \_\_\_\_\_, 20\_\_\_\_  
Signature of Proposed Owner Date

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

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, 4333 Edgewood Road NE, 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.**

Original

APA401008TVT



**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.

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**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\_\_\_\_ ☒ \_\_\_\_\_  
City, State Date Insurance Producer or other Company Authorized Rep

---

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

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

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

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, 4333 Edgewood Road NE, 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**



Transamerica Life Insurance Company  
Home Office: Cedar Rapids, IA  
Mailing Address: 4333 Edgewood Road NE  
Cedar Rapids, IA 52499

## Beneficiary/Additional Insured Information Form

### PRIMARY INSURED

1. Last Name	First Name	2. SS# Last 4 Digits
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### OWNER - if other than Primary Insured

1. Last Name	First Name	2. TIN/SS# Last 4 Digits
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### 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. The applicant was unable/declined to provide any information missing from the form.

Date

\_\_\_\_\_  
Producer or Agent Signature

\_\_\_\_\_  
Owner Signature

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

ADDITIONAL INFORMATION		
Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers
ADDITIONAL INFORMATION		

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ , \_\_\_\_\_  
City State Month Year

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

Signature of Parent or Legal Guardian (if Proposed Insured is Under 18 years of age) Signature of Additional Insured

Signature of Agent

<b>1. Proposed Insured: (Print Full Name)</b> _____	<b>2. Date of Birth:</b> Month _____ Day _____ Year _____	<b>3. Social Security #</b> _____
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**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.**

<b>6. HAVE YOU EVER HAD, BEEN TOLD BY A LICENSED MEDICAL DOCTOR THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:</b>	Details:																																							
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 80%;"></th> <th style="width: 10%; text-align: center;">Yes</th> <th style="width: 10%; text-align: center;">No</th> </tr> </thead> <tbody> <tr> <td>a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood (excludes any disorder related to HIV Antibody, T-Cell counts, AIDS, ARC)? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. 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a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	<input type="checkbox"/> <input type="checkbox"/>																																							
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?	<input type="checkbox"/> <input type="checkbox"/>																																							
<b>8. OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:</b>	<b>Yes No</b>																																							
a. Consulted, been examined or been treated by any physician or practitioner?	<input type="checkbox"/> <input type="checkbox"/>																																							
b. Had or been advised to have an X-ray, electrocardiogram, laboratory (except an HIV test) test or other diagnostic study?	<input type="checkbox"/> <input type="checkbox"/>																																							
c. Had observation or treatment at a clinic, hospital or other medical facility?	<input type="checkbox"/> <input type="checkbox"/>																																							
d. Had or been advised to have a surgical procedure?	<input type="checkbox"/> <input type="checkbox"/>																																							
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	<input type="checkbox"/> <input type="checkbox"/>																																							
f. Had any injury requiring treatment?	<input type="checkbox"/> <input type="checkbox"/>																																							



\* D T 0 3 8 \*

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. **(NOTE: This authorization excludes the release of any information relating to previously administered tests for HIV antibodies, T-Cell Counts, AIDS or ARC, by my family doctor or regular caregiver or any other entity or person which may possess this information. Further, I DO NOT authorize the Company to forward the results of any new test to any outside non-affiliated company nor to any entity that is not under specific contract with the Company to perform underwriting services.)**

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**

**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:

- 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.
- 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.
- 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, and use of alcohol, drugs and tobacco. This authorization **EXCLUDES** the release of any information about previously administered tests or new tests requested by the Companies for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured/applicant **IS NOT** authorizing the Companies to forward the results from any new test requested by the Companies to any outside, non-affiliated Companies or any entity not under specific contract to perform underwriting services. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- 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 from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Signature of Primary Proposed Insured/Patient or Personal Representative

Date

Signature of Secondary Proposed Insured/Patient or Personal Representative

Date

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

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

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

Policy or contract number (if known): \_\_\_\_\_

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



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

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
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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:

- 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.
- 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.
- 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, and use of alcohol, drugs and tobacco. This authorization EXCLUDES the release of any information about previously administered tests or new tests requested by the Companies for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured/applicant IS NOT authorizing the Companies to forward the results from any new test requested by the Companies to any outside, non-affiliated Companies or any entity not under specific contract to perform underwriting services. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- 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 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**

☐ **Transamerica Premier Life Insurance Company**

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

**IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? \_\_\_ YES \_\_\_ NO**
2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? \_\_\_ YES \_\_\_ NO**

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy number or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because \_\_\_\_\_.  
I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Signature and Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature and Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_ **I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)**

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

**PREMIUMS:**

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

**POLICY VALUES:**

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expenses and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

**INSURABILITY:**

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- [Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.]

**IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:**

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

**IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:**

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

**30 DAY RIGHT TO CANCEL**

In the event of a replacement transaction, you may cancel this policy by delivering or mailing a written request to the Company. You must return the policy to the Company before midnight of the thirtieth day after the day you receive it. You will receive an unconditional full refund of all premiums or considerations paid on it, less any withdrawals and indebtedness, including any policy fees or charges or, in the case of a variable or market value adjustment policy, payment of the cash surrender value provided under the policy plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy. Your written request given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid.

**REPLACEMENT ADVERTISING**  
**AGENT STATEMENT**

I, \_\_\_\_\_, have complied with the following in connection with the replacement sales transaction:

- a. I have used only company approved sales advertising.
- b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**AGENT SIGNATURE**

- ☐ Transamerica Life Insurance Company  
☐ Transamerica Premier Life Insurance Company  
4333 Edgewood Road NE, Cedar Rapids, IA 52499

**Notice and Consent for  
HIV-Related Testing  
VERMONT**

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**HIV Testing Information Statement & Consent Form**

Vermont law requires that this entire statement be read aloud to you. It contains important information about HIV testing and your rights under Vermont law. A copy of it will be given to you to keep.

The insurance company you are applying to for coverage may want to take a sample from you to be tested by a laboratory for the presence of antibodies to the HIV virus. This information may be used as part of its decision whether to offer you insurance coverage. The insurance company may request a sample of your blood, urine or oral fluids (OMT) in order to conduct the test. The insurance company will pay for this test.

HIV is the virus that causes AIDS (Acquired Immunodeficiency Syndrome). Presence of antibodies in the sample means that a person has been infected with the HIV virus. While a positive HIV antibody test result does not mean that you have AIDS, it does mean that you are at a seriously increased risk of developing AIDS. A negative test result means that no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not guarantee that you have not been infected with the virus. In addition, the absence of HIV antibodies does not mean that you are immune to the virus.

If after listening to this statement you do not wish to be tested, do not sign the **Notice and Consent for HIV-Related Testing form** and the application process will end. You may consult, at your expense, with a personal physician or counselor or the state health department before deciding whether to consent to this testing. In addition, you may obtain an anonymous test before deciding to consent to this testing (call the Vermont Aids Hotline for information about free testing, the number is listed below) and any delay will not affect the status of your application or policy.

You may choose to receive the test results directly or to designate in writing on the **Notice and Consent for HIV-Related Testing form** any other person whom you want to receive the results.

All test results will be treated confidentially. The laboratory that conducts the test will report the results to the Insurer which may in turn disclose results to its employees, affiliates, reinsurers, contractors or attorneys who need the results for underwriting, claims or another necessary business purpose in connection with your insurance transaction. The Insurer may disclose your test results as permitted or required by law or as authorized in writing by you. Test results will not be shared with your insurance agent or broker. You have the right to sue a person for damages arising from the unauthorized negligent or unauthorized knowing disclosure of HIV-related test results.

If your test result is positive or indeterminate, the insurance company may report a nonspecific test code to MIB, Inc. (MIB). MIB is a central databank that keeps on file a record of information of the applicants for life and health insurance for use by insurance companies. In addition, positive test results must be reported to the Vermont Department of Health using a unique identifier code.

You have rights that include the following:

1. If a test is indeterminate, you may request in writing to be re-tested after six months, but not later than eight months. Pre-existing insurance will not be affected. If the new test is indeterminate or negative, a new application for coverage may not be denied based on either test, and any prior decision to grant a substandard classification or exclusion based on prior HIV-related test results will be reversed;
2. If the test result of urine or oral fluids is positive or indeterminate, the insurance company must provide you with the opportunity to re-test once, within 30 days following receipt of those test results. You have the option of choosing a blood, urine or oral sample for that re-test.
3. If you are denied insurance because of a positive test result, you may request a re-test once within the three-year period following the date of the most recent test or if an alternative test has been approved for use by the Vermont Insurance Commissioner. If such re-test is negative, an insurer may not deny coverage based upon the initial test results.

**Notice and Consent for  
HIV-Related Testing  
VERMONT**

It is very important to seek counseling in the event you test positive for HIV antibodies. You can obtain helpful information from the Vermont AIDS Hotline at (800) 882-2437 and the Centers for Disease Control and Prevention at (800) 342-2437.

You will now be asked to sign a written **Notice and Consent for HIV-Related Testing form** permitting the insurance company to have you tested for HIV antibodies.

**Informed Consent**

To be signed at the time when a medical professional or company agent obtains a sample.

This statement has been read aloud to me and I understand this **Notice and Consent for HIV-Related Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing**. I voluntarily consent to the collection of blood, urine or OMT samples for the purpose of testing to determine if HIV antibodies are present and the disclosure of the test results as described above.

\_\_\_\_\_  
Proposed Insured (Please Print)

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
State of Residence

\_\_\_\_\_  
Name of Medical Professional or Company Agent  
Collecting Sample

\_\_\_\_\_  
Signature of Medical Professional or Company Agent

**Notification of Test Results**

To be completed at time of application or when a medical professional or company agent obtains sample.

You may choose to receive the test results directly or to designate below another person to whom the results should be sent:

PLEASE SEND MY TEST RESULTS TO:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code



Transamerica Life Insurance Company  
Home Office: 4333 Edgewood Road NE  
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:
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Abnormalities, Heart Disorder, Epilepsy, Cancer, Malignancy, Blood Disorder, Leukemia, Diabetes, Cystic Fibrosis, Kidney Disease, Brain or Neurological Disorder?
<input type="checkbox"/>	<input type="checkbox"/>	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 \_\_\_\_\_  
(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



\* D T 2 0 8 \*



Transamerica Life Insurance Company  
Home Office: 4333 Edgewood Road NE  
Cedar Rapids, IA 52499

## Illustration Notice

*To be completed by the Applicant:*

I understand the following concerning the application for the life insurance policy accompanying this form: *(check the appropriate box)*

- ☐ 1. No illustration has been presented to me prior to the application for this policy.
- ☐ 2. An illustration was presented to me, but it differs from the coverage I have applied for.

If a policy is issued, an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery. I will review the illustration and sign the acknowledgment to that effect when I receive it and return a copy of the signed illustration to the Company's representative.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

\*\*\*\*\*  
*To be completed by the Sales Representative*

This is to certify that: *(check the appropriate box)*

- ☐ 1. No illustration was presented at the time of the sale of the life insurance policy applied for on the accompanying application.

Or

- ☐ 2. An illustration was presented to the Applicant at the time of the sale that was in compliance with state regulations and company requirements. However, the illustration differs from the life insurance policy applied for on the accompanying application.

\_\_\_\_\_  
Signature of Sales Representative

\_\_\_\_\_  
Date







Transamerica Life Insurance Company  
Home Office: Cedar Rapids, IA

## APPLICATION AMENDMENT

Life Insured:

The Application for Policy/Certificate ("Policy") No.

is amended as follows:

### REQUEST TO BACKDATE POLICY TO "SAVE AGE"

I request that Transamerica Life Insurance Company ("Transamerica") date the life insurance Policy for which I am applying in the application so as to "save age." I understand that dating to "save age" means that each of the regular premium payments I make on the Policy will be lower in dollar amounts than if I did not date to "save age." **I also recognize that dating to save age means part of my first premium payment will be for a period of time during which insurance coverage will not be in effect.** The precise length of that period will depend on a number of factors, such as:

- (a) how far back in weeks or months the Policy needs to be dated in order to qualify for the younger insurance age,
- (b) how long it takes to process my application, which includes how quickly I respond to any requests for information from Transamerica, and
- (c) how quickly I am able to obtain delivery of the Policy and make the first premium payment, **which in most cases is when coverage commences.**

I further understand that I may have the option of making an initial estimated premium payment with my application and that doing so may eliminate or reduce the period of time for which I would be paying premiums without coverage.

I/We declare that I/we have, in an identical manner, completed and signed the copy of this amendment that is attached to and made part of the Policy issued by the Company.

It is agreed that this amendment shall be part of the application for the Policy.

Signed at \_\_\_\_\_ on \_\_\_\_\_ Date

Witness to all signatures (Licensed Resident Agent, as required)

Policyowner



Transamerica Life Insurance Company  
Home Office: Cedar Rapids, IA

## APPLICATION AMENDMENT

Life Insured:

The Application for Policy/Certificate ("Policy") No.

is amended as follows:

### REQUEST TO BACKDATE POLICY TO "SAVE AGE"

I REQUEST THAT Transamerica Life Insurance Company ("Transamerica") backdate the life insurance Policy for which I am applying in the attached application so as to "save age".

I understand that backdating means that this application is amended to be "dated back" to the time specified in this amendment. I also understand that the Policy I am purchasing is the Policy then available for sale as of the date specified on this amendment.

I understand dating to "save age" means that each of the required Policy premiums I make on the Policy will be lower in dollar amounts than if I did not date to "save age". I realize that backdating means my required fixed premium will be due and payable from my "dated back to save age" date. **I recognize and understand my monthly deductions taken from my premium payments will start from the same date and will be for a period of time during which life insurance will not be in effect.** Likewise, the Surrender Charge period of my Policy will begin from that same date. Interest will not begin to accrue until either the Policy issue date or the premium payment is received in our Administrative Offices, whichever is later. The precise length of that period in which interest will not accrue depends on a number of factors such as:

- a) how far back in weeks or months the Policy needs to be dated in order to qualify for the applied for plan,
- b) how long it takes to process my application, which includes how quickly I respond to any requests for information from Transamerica, and
- c) how quickly I am able to obtain delivery of the Policy and make the first premium payment, which in most cases is when coverage begins.

I further understand that I may have the option of making an initial estimated premium payment with my application and that in so doing may eliminate or reduce the period of time for which I would be paying premiums without coverage.

I/We declare that I/we have, in an identical manner, completed and signed the copy of this amendment that is attached to and made part of the Policy issued by the Company.

It is agreed that this amendment shall be part of the application for the Policy.

Signed at \_\_\_\_\_ on \_\_\_\_\_ Date

Witness to all signatures (Licensed Resident Agent, as required)

Policyowner

**Transamerica Life Insurance Company**  
**Transamerica Premier Life Insurance Company**  
4333 Edgewood Road NE, Cedar Rapids, IA 52499

<b>VERMONT DISCLOSURE</b>
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Vermont law requires that we provide this disclosure to the prospective Insured in situations where a life insurance policy is being applied for which irrevocably names a 501(c)(3) organization or nonprofit as owner and beneficiary.

This is to remind the prospective insured to consider his or her current state of health and to consult with a tax advisor or estate planner.

Date\_\_\_\_\_

Signed\_\_\_\_\_  
(Insured)

\_\_\_\_\_  
(Producer)

- ☐ Transamerica Life Insurance Company  
☐ Transamerica Premier Life Insurance Company

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

# Illustration Certification Form

☐ I certify that I displayed a **computer screen illustration** for \_\_\_\_\_  
that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information: APPLICANT

1. Gender ..... Male \_\_\_\_\_ Female \_\_\_\_\_
2. Age..... \_\_\_\_\_
3. Underwriting Class..... \_\_\_\_\_
4. Generic Name (check one)..... ☐ Universal Life: ☐ Flexible Premium Adjustable Life  
☐ Single Premium  
☐ Term

- Policy Name ..... \_\_\_\_\_
5. Type of Rider(s)..... \_\_\_\_\_
  6. Initial Death Benefit..... \_\_\_\_\_
  7. Nonguaranteed Interest Rate..... \_\_\_\_\_
  8. Guaranteed Interest Rate ..... \_\_\_\_\_
  9. Policy Years Illustrated ..... \_\_\_\_\_
  10. Premium Amount Illustrated..... \_\_\_\_\_
  11. Assumed number of years premiums  
are paid ..... \_\_\_\_\_

DATE

AGENT

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

DATE

APPLICANT

☐ I certify that **no illustration was used** by me or any other authorized agent of \_\_\_\_\_  
Insurance Company **in the sale** of life insurance to \_\_\_\_\_  
on this date. An illustration conforming to the requirements of the \_\_\_\_\_ APPLICANT state regulation on  
illustrations will be delivered to this applicant no later than the policy delivery date. STATE

DATE

AGENT

I acknowledge that no illustration conforming to the policy applied for was provided to me at the point of sale. I understand an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

DATE

APPLICANT

☐ I certify that the **illustration shown at the point of sale is other than the policy as applied for** by \_\_\_\_\_  
\_\_\_\_\_. An illustration conforming to the requirements of \_\_\_\_\_ state  
regulations on illustrations shall be delivered to this applicant no later than the policy delivery date. APPLICANT STATE

DATE

AGENT

I acknowledge that no illustration conforming to the policy applied for was provided to me at the point of sale. I understand an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

DATE

APPLICANT