# Authorization Form

This Authorization is HIPAA compliant

ASH BROKERAGE

Date: _____ Advisor Name: _____ Advisor Phone: (_____) _____

Insured Name: _____ Maiden Name: _____ Date of Birth: _____

SSN: _____ Driver's License #: _____ State: _____

The purpose of this Authorization is to permit Ash Brokerage to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for, and obtaining insurance products and services from, one or more of the insurers or other institutions listed below.

I specifically authorize any physician or other medical practitioner, hospital, clinic, or other health-related facility, medical testing laboratory, insurer, state motor vehicle department, my past or current employer(s), the Social Security Administration and any other organization, institution or person who has information or documentation about me to release such information and documentation to Ash Brokerage, its authorized representatives and one or more of the insurers or other institutions listed below. The information and documentation to be released to Ash Brokerage shall specifically include any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition including, but not be limited to, documents relating to my mental and physical health, mental health records, psychotherapy notes, drug/alcohol abuse treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("Information").

Additionally, I specifically authorize Ash Brokerage to release any and all Information it receives about me to the companies listed below. I also specifically authorize Ash Brokerage and the companies listed below to release any and all Information about me to their respective reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB*) to release any and all Information about me directly to any company listed below, upon such company's request, provided the company is a member of MIB.

This Authorization shall be effective for two (2) years after the date signed below. I understand I have the right to revoke this Authorization at any time by sending a written notice of revocation to Ash Brokerage, 7609 W. Jefferson Blvd., Fort Wayne, IN 46804. I understand any action taken in reliance on this Authorization prior to Ash Brokerage's receipt of the written notice of the revocation shall be valid. I also understand any information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy rules.

I understand execution of this Authorization is voluntary and that I can refuse to sign this Authorization. I understand my refusal to sign this Authorization will not affect my ability to obtain treatment or payment or my eligibility for health care benefits. However, I understand my refusal to sign this Authorization may prevent me from obtaining insurance products or services from one or more of the companies below.

I acknowledge that I have read and understand the above and agree this Authorization was completed prior to my signature. I further agree that a copy of this Authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by Ash Brokerage and/or any third party designated herein.

_____ _____

Proposed Insured's Signature / Guardian or Custodian / Authorized Representative — Date

_____ _____

Broker / Advisor / Agency / Firm Signature — Date

Accordia Life
AIG / American General
Allianz
Allianz Life of NY
American Continental
American Equity
American Memorial
American National
American National of NY
Ameritas
Assurity
Athene Annuity & Life
AVIVA
AVIVA Life of NY
AXA Equitable
Banner Life
Columbian Mutual Life
Companion Life of NY
Equitrust
Fidelity & Guaranty
Fidelity & Guaranty of NY
Fidelity Life
Fidelity Security
Foresters
Forethought Life Insurance Co.
Genworth Life
Genworth Life and Annuity Ins. Co.
Genworth Life Ins. Co of New York
Genworth LTC
Gleaner
Guarantee Trust Life
Guggenheim
Great American
Illinois Mutual
ING Northern Life
ING Reliastar
ING Reliastar of NY
ING Security Life of Denver
ING Annuity and Life
Integrity Life
John Hancock LTC
John Hancock of NY
John Hancock USA (MAN)
Kemper
Lafayette Life
Legacy Insurance Services, Inc.
Liberty Life
Life Insurance Co. of the Southwest
Lincoln Life of NY
Lincoln National Life
Lincoln National Life of NY
MassMutual LTC
MetLife Investors
MetLife DI
Midland National
Minnesota Life
Mutual of Omaha
National Guardian
National Integrity Life
National Life Group
National Western
Nationwide – Provident Mutual
New York Life
North American
Petersen International
Phoenix Life Insurance Co.
Presidential
Presidential Life Disability NY
Principal Life Insurance Company
Principal National Insurance Company
Protective Life
Protective Life of NY
Prudential Insurance Company of America
Pruco Life Insurance Co.
Reliance Standard
Savings Bank Life Insurance Co. of MA
Security Mutual of NY
The Standard
The Standard Life Insurance Company of NY
State Life
Symetra
Transamerica Insurance Company
Transamerica of NY
United Home Life
United of Omaha
US Life of New York
Voya
William Penn of NY
Zurich

Other Company: _____ Insured Initials: _____

**Ash Brokerage will employ its best efforts to disclose information only to those insurance companies deemed necessary to provide the best result for the proposed insured.**

*MIB is a not-for-profit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file.
**MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 or email infoline@mib.com**

# Privacy Policy

ASH BROKERAGE

Protecting your privacy is very important to Ash Brokerage. We are committed to safeguarding the information you provide us and using it responsibly. Because of our commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

## Collection of Information

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms and fact-finding questionnaires;
- Your transactions with us, our affiliates and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties including, but not limited to, consumer reporting agencies;
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

## Disclosure of Information

We will not share nonpublic personal information concerning our potential, current or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law. We will not sell, trade or rent your personal information to any third parties.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations and other product sponsors to affect purchases and sales and allow for the servicing of your account;
- Your advisor or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third-party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, such as banks and other financial institutions, with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Recordkeeping companies

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure there are contractual restrictions on their use and disclosure of that information.

## Protection of Information

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Ash Brokerage, your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.

# Authorization Form

This Authorization is HIPAA compliant

ASH BROKERAGE

Date: _____ Advisor Name: _____ Advisor Phone: (_____) _____
Insured Name: _____ Maiden Name: _____ Date of Birth: _____
SSN: _____ Driver's License #: _____ State: _____

The purpose of this Authorization is to permit Ash Brokerage to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for, and obtaining insurance products and services from, one or more of the insurers or other institutions listed below.

I specifically authorize any physician or other medical practitioner, hospital, clinic, or other health-related facility, medical testing laboratory, insurer, state motor vehicle department, my past or current employer(s), the Social Security Administration and any other organization, institution or person who has information or documentation about me to release such information and documentation to Ash Brokerage, its authorized representatives and one or more of the insurers or other institutions listed below. The information and documentation to be released to Ash Brokerage shall specifically include any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition including, but not be limited to, documents relating to my mental and physical health, mental health records, psychotherapy notes, drug/alcohol abuse treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("Information").

Additionally, I specifically authorize Ash Brokerage to release any and all Information it receives about me to the companies listed below. I also specifically authorize Ash Brokerage and the companies listed below to release any and all Information about me to their respective reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB*) to release any and all Information about me directly to any company listed below, upon such company's request, provided the company is a member of MIB.

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I acknowledge that I have read and understand the above and agree this Authorization was

completed prior to my signature. I further agree that a copy of this Authorization, whether a photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by Ash Brokerage and/or any third party designated herein.

Proposed Insured's Signature / Guardian or Custodian / Authorized Representative _____ Date _____

Broker / Advisor / Agency / Firm Signature _____ Date _____

Accordia Life
AIG / American General
Allianz
Allianz Life of NY
American Continental
American Equity
American Memorial
American National
American National of NY
Ameritas
Assurity
Athene Annuity & Life
AVIVA
AVIVA Life of NY
AXA Equitable
Banner Life
Columbian Mutual Life
Companion Life of NY
Equitrust
Fidelity & Guaranty
Fidelity & Guaranty of NY
Fidelity Life
Fidelity Security
Foresters
Forethought Life Insurance Co.
Genworth Life
Genworth Life and Annuity Ins. Co.
Genworth Life Ins. Co of New York
Genworth LTC
Gleaner
Guarantee Trust Life
Guggenheim
Great American
Illinois Mutual
ING Northern Life
ING Reliastar
ING Reliastar of NY
ING Security Life of Denver
ING Annuity and Life
Integrity Life
John Hancock LTC
John Hancock of NY
John Hancock USA (MAN)
Kemper
Lafayette Life
Legacy Insurance Services, Inc.
Liberty Life
Life Insurance Co. of the Southwest
Lincoln Life of NY
Lincoln National Life
Lincoln National Life of NY
MassMutual LTC
MetLife Investors
MetLife DI
Midland National
Minnesota Life
Mutual of Omaha
National Guardian
National Integrity Life
National Life Group
National Western
Nationwide – Provident Mutual
New York Life
North American
Petersen International
Phoenix Life Insurance Co.
Presidential
Presidential Life Disability NY
Principal Life Insurance Company
Principal National Insurance Co.
Protective Life
Protective Life of NY
Prudential Insurance Company of America
Pruco Life Insurance Co.
Reliance Standard
Savings Bank Life Insurance Co of MA
Security Mutual of NY
The Standard
The Standard Life Insurance Company of NY
State Life
Symetra
Transamerica Insurance Company
Transamerica of NY
United Home Life
United of Omaha
US Life of New York
Voya
William Penn of NY
Zurich

Other Company: _____ Insured Initials: _____

Ash Brokerage will employ its best efforts to disclose information only to those insurance companies deemed necessary to provide the best result for the proposed insured.

*MIB is a not-for-profit organization of life insurance companies and operates an information exchange for its members. Upon request of a membercompany, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file.
MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 or email infoline@mib.com

# Privacy Policy

Protecting your privacy is very important to Ash Brokerage. We are committed to safeguarding the information you provide us and using it responsibly. Because of our commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

## Collection of Information

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms and fact-finding questionnaires;
- Your transactions with us, our affiliates and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties including, but not limited to, consumer reporting agencies;
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

## Disclosure of Information

We will not share nonpublic personal information concerning our potential, current or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law. We will not sell, trade or rent your personal information to any third parties.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations and other product sponsors to affect purchases and sales and allow for the servicing of your account;
- Your advisor or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third-party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, such as banks and other financial institutions, with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Recordkeeping companies

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure there are contractual restrictions on their use and disclosure of that information.

## Protection of Information

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Ash Brokerage, your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

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 to the best of my knowledge and belief. **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.

**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.

This authorization will be valid for 26 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 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

## 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 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 to the best of my knowledge and belief; 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 _____
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, [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.**

**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 to the best of my knowledge and belief; 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, [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**



Proposed Owner

TRANSAMERICA
LIFE INSURANCE COMPANY

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

# Notice and Consent for HIV-Related Testing California

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. It may take a few weeks to many years for symptoms to appear but they usually include fever, diarrhea, tiredness and enlarged lymph glands.

To evaluate your insurability, the insurer named above (the "Insurer") has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of HIV antibodies. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body's way of fighting the infection. By signing and dating this Consent, you agree that this test may be done.

## The HIV Antibody Test

A series of tests will be performed by a licensed laboratory through a medically accepted procedure. The most commonly used tests are the ELISA or "EIA" and the Western blot. If the ELISA shows the sample is positive for HIV, then the Western blot is done to confirm that initial result.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally the test may be negative in persons who are infected with HIV.

## Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others. A positive HIV antibody test result will probably mean you will be declined for the insurance for which you are applying.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

## Counseling

Many public health organizations have recommended that before taking an HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your physician or health care provider. A list of counseling resources is provided for your information. Other counseling services may also be available to you.

# Notice and Consent for HIV-Related Testing California

## Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting or claims decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer. Negative test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results 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 AIDS, or for the preparation of statistical reports that do not specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date you sign this Consent.

## Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your physician or health care provider so that the Insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked ''Personal & Confidential'', at your residence address.

Name of physician or health care provider:

_____

_____
Street

_____
City, State, Zip Code

## Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing*. I voluntarily consent to provide a sample of my bodily fluid(s), the testing of my bodily fluid(s) for HIV antibodies, and disclosure of the test results as described.

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)*

_____
Date of Birth

_____
Signature of Proposed Insured

_____
Date Signed

# Counseling Resources List

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Transamerica Life Insurance Company (TLIC). Therefore, TLIC makes no representations or warranties that this information is accurate as of the date you receive this list. Also, TLIC makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross for further information.

**HIV/AIDS HOTLINE — National**
(800) 342-2437 English
(800) 222-9432 Spanish
(800) 243-7889 TTY/TDD users

**HIV/AIDS HOTLINE - California**
(800) 367-2437 English, Spanish & Filipino
(888) 225-2437 TTY users

**California Dept. of Health Services**
(916) 449-5905

**Alameda County HIV/AIDS Services**
(510) 873-6500

**Contra Costa County AIDS Program**
(925) 313-6771

**Fresno County Human Health Services**
(559) 445-3434

**Kern County Dept. of Health**
(661) 868-0503

**Los Angeles County**
(213) 351-8000
Long Beach (562) 570-4320
Pasadena (626) 794-6025

**Marin County HIV Services**
(415) 499-7804

**Monterey County Dept. of Health**
(831) 647-7932

**Orange County Health Care**
(714) 834-7700

**Riverside County HIV/AIDS Hotline**
(800) 243-7275 or (909) 358-5307

**Sacramento County Department**
(916) 874-7720

**San Bernardino County Health Department**
(800) 255-6560 or (909) 383-3060

**San Diego County Office of AIDS Coordination**
(619) 296-3400

**San Francisco**
(415) 863-2437

**San Joaquin County AIDS Project**
(209) 468-3821

**San Luis Obispo County - HIV Prevention Project**
(800) 544-6016 or (805) 781-5540

**San Mateo County AIDS Program**
(650) 573-2588

**Santa Barbara County Public Health Department**
(805) 681-5120

**Santa Clara - HIV/AIDS Prevention Program**
(408) 494-7870

**Santa Cruz County - AIDS Project Program**
(831) 427-3900

**Solano County Public Health**
Fairfield (707) 428-1131
Vallejo (707) 553-5331

**Sonoma County**
(707) 545-4551

**Stanislaus County HIV/STD Program**
(209) 558-8866

**Ventura County Public Health Services**
(805) 652-6583

TRANSAMERICA
LIFE INSURANCE COMPANY

**CALIFORNIA DISCLOSURE**

## DISCLOSURE FOR UNIVERSAL LIFE POLICIES WITH NO-LAPSE GUARANTEES OR ANY SIMILAR CONFIGURATION

This policy is guaranteed to stay in force for a number of years as long as you have paid at least as much as the required premiums and met other policy requirements. This is called a no-lapse guarantee.

Even though it contains a no-lapse guarantee, this policy may provide nonforfeiture benefits (such as cash surrender values) which are less than those that would be provided if the no-lapse guarantee were issued as a separate policy (for example, as a term policy). However, the premiums for the term policy might be higher than those for the no-lapse guarantee in this policy.

When considering the purchase of this policy, you should consider the value to you of higher nonforfeiture benefits versus the level of the premiums required to keep your insurance coverage in force.

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
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** |
|---|---|---|
| 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 (except HIV status)? | ☐ | ☐ |
| 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 (except HIV 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. Diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | ☐ | ☐ |

Details:

| 7. | **Yes** | **No** |
|---|---|---|
| a. Within the past ten years, have you 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 (not including HIV tests)? | ☐ | ☐ |
| 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? | ☐ | ☐ |

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. 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 best of my knowledge and belief. 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: 4333 Edgewood Road NE
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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **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 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

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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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
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**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.**

## 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