Transamerica Life Insurance Company
New Business Cover Sheet

Fax to: 866.297.3607

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

Special Instructions: _____

Office ID# 14610

For illustration software go to 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

☐ APPS ☐ ExamOne ☐ Other
☐ EMSI ☐ Portamedic

Lab Slip/Bar Code #:_____ Date Taken:_____

Tips! To speed processing...

- *Submit initial application and forms ONLY ONCE, either via fax, 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

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 $ _____ ☐ Monthly Disability Income Rider
   ☐ Estate Protection Rider ☐ Guaranteed Split Option Rider
   ☐ Children's Insurance _____ Units
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: $ _____

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. **Special Information for Premium Notices:** A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.
Name: _____ Billing Address: _____

Yes	No	**"You" means any person proposed to be insured.**
☐	☐	13. In the past two years have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, ballooning, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding? 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. To the best of your knowledge and belief, 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 within the next two years 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 within the next two years? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	20. To the best of your knowledge and belief, 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.

Subject to the incontestabililty provison of the policy, 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.

NOTICE TO CONSUMER

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

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

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

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

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

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

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

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

FRAUD WARNING: 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.

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 Agent/Broker

_____
Printed Name of Licensed Agent/Broker

_____ _____
Agent/Broker# Florida License ID#

1. To the best of your knowledge, does the applicant have any existing life insurance or annuities? ☐ Yes ☐ No
2. To the best of your knowledge, could replacement be involved? ☐ Yes ☐ No

_____
Signature of Licensed Agent/ Broker

(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**

PICK A DATE TO DRAFT (1-28) _____

☐ **PREMIUM**
☐ **LOAN REPAY**
☐ **SAVINGS**
☐ **CHECKING**

☐ **NEW AUTHORIZATION**
☐ **BANK CHANGE**
☐ **ADD TO EXISTING POLICY**
☐ **OTHER** _____

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 AIDS, 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, 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.

FRAUD WARNING: 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.

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.

Original

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, 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.

FRAUD WARNING: 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.

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: 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

OWNER - if other than Primary Insured

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

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

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

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

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

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

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

AGENT

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

Date

Producer or Agent Signature

Owner Signature

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

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

SA-ADINFO 0805

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 BEEN TREATED OR DIAGNOSED BY A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR:**	**Yes**	**No**	Details:
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	☐	☐	
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	☐	☐	
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐	☐	
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	☐	☐	
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	☐	☐	
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐	☐	
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	☐	☐	
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	☐	☐	
i. Cancer, tumor, polyp or cyst?	☐	☐	
j. Any physical deformity or amputation?	☐	☐	
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition?	☐	☐	
7. Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐	
8.	**Yes**	**No**	
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP except as prescribed by a physician?	☐	☐	
b. Have you ever been treated or counseled or been advised to seek treatment or counseling by a licensed medical professional for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	☐	☐	
9. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU BEEN TREATED OR DIAGNOSED BY A LICENSED MEMBER OF THE MEDICAL PROFESSION FOR:**	**Yes**	**No**	
a. An X-ray, electrocardiogram, laboratory test or other diagnostic study?	☐	☐	
b. Observation or treatment at a clinic, hospital or other medical facility?	☐	☐	
c. Or been advised to have a surgical procedure?	☐	☐	
d. Dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	☐	☐	
e. Any injury requiring treatment?	☐	☐	

File # _____

10.

	Yes	No
a. To the best of your knowledge and belief, 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. Have you been told by a licensed member of the medical profession that you are now pregnant?	☐	☐

11. **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.*

12. **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 # _____				

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

14. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK (EXCLUDING VACATION & TEMPORARY LEAVE OTHER THAN FOR DISABILITY OR SICKNESS) ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** ☐ Yes ☐ No *If no, provide complete details.*

15. Do you participate in regular weekly exercise? ☐ Yes ☐ No
16. Do you participate in athletics *(Team or Individual)?* ☐ Yes ☐ No
17. Have you ever used any tobacco products? ☐ Yes ☐ No
18. Do you get regular examinations by your health care provider? ☐ Yes ☐ No
19. Do you get regular annual dental checkups? ☐ Yes ☐ No
20. Do you clean your house or do yard work? ☐ Yes ☐ No
21. Do you have a pet? ☐ Yes ☐ No
22. 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.

FRAUD WARNING: 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.

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

☐ **Transamerica Life Insurance Company** ☐ **Transamerica Premier Life Insurance Company**

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

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer or insurers by placing your initials in the appropriate box below.

☐ YES ☐ NO

DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.

I have read this notice and received a copy of it.

_____ _____

Applicant's Signature Date

_____ _____

Agent's Signature Date

_____

Agent's Name (Printed or Typed)

_____

Agent's Address (Printed or Typed)

_____

Agent's Company (Printed or Typed)

Information on Policies which may be replaced:

Company Name	Policy Number	Name of Insured

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

Notice and Consent for HIV-Related Testing FLORIDA

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

Pre-Testing Considerations

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.

Meaning of a Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results will adversely affect your application for insurance.

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 decisions on behalf of the Insurer; or may be disclosed to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results may be reported to an insurance medical information exchange under procedures that are designed to assure confidentiality. This might include the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS. Information might also be reported for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health. A trained person should deliver that information so that you can understand clearly what the test result means. Please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name and address of physician for reporting a positive test result:

Name _____ Address _____

Phone Number _____ City, State, Zip Code _____

Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing*. I voluntarily consent to providing a sample of bodily fluid(s), the testing of my bodily fluid(s) and the disclosure of the test results as described above.

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

Proposed Insured (Please Print) _____ Date of Birth _____

Signature of Proposed Insured or Parent/Guardian _____ State of Residence _____

Date _____

Transamerica Life Insurance Company

TERMINAL ILLNESS, CRITICAL ILLNESS, and CHRONIC ILLNESS ACCELERATED DEATH BENEFIT DISCLOSURE FORM

Accelerated Benefits are payments made to the Owner during the lifetime of the Insured. Such benefits will be paid in lieu of payment of the full Death Benefit of the Policy upon death of the Insured. The conditions under which accelerated benefits may be elected vary–as described below.

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT OPTION

Benefits may be elected under this option if the Insured becomes Terminally Ill after the later of the Date of Issue or the Policy Date. Terminally Ill means that the Insured has been diagnosed by a Physician as having a medical condition, resulting from bodily injury or disease, or both, with is expected to result in the death of the Insured within 12 months of diagnosis.

The maximum death benefit you may accelerate because the Insured is Terminally Ill is equal to the lesser of:

1. 100% of the Face Amount of the policy; or
2. $500,000, including all other Accelerated Death Benefits previously elected or currently under review under the policy on the life of the Insured.

CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

Benefits may be elected under this Rider if the Insured is Chronically Ill. Chronically Ill means that the Insured has been certified, by a Licensed Health Care Practitioner as:

1. Being unable to perform, without substantial assistance from another person, at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or
2. Requiring substantial supervision for protection from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

No Chronic Illness Accelerated Benefit will be paid during the first 2 years the Rider is in effect.
The maximum Death Benefit accelerated in any year is the lesser of 24% of the life insurance coverage on the initial Election Date or $240,000. This amount will be prorated over other periods of time, such as 2% each month, 6% every 3 months, or 12% every 6 months. The maximum Death Benefit accelerated over the lifetime of the Insured is the lesser of 90% of the Initial Face Amount or $500,000.

CRITICAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

Benefits may be elected under this Rider if the Insured has experienced a covered Qualifying Event while the Policy and Rider are in force. The Qualifying Events covered under this Rider are:

1. **Heart attack (myocardial infarction)** - The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous Heart Attack. The diagnosis of heart attack must be based on the presence of all of the following:
    a. Chest pain;
    b. Associated new EKG changes which support the diagnosis; and
    c. Elevation of cardiac (heart) enzymes above standard laboratory levels.

2. **Stroke** - A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis lasting more than 24 hours and producing measurable neurological deficit which persists for at least 30 consecutive days following the occurrence of the Stroke. Stroke does not include transient ischemic attacks.

3. **Diagnosis of Cancer**. Cancer means a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Cancer does not include:
    a. Any skin cancer, except invasive malignant melanoma into the dermis or deeper;
    b. Pre-malignant lesions, benign tumors, or polyps; and
    c. Carcinoma in-situ.

4. **Diagnosis of End Stage Renal Failure**. End Stage Renal Failure means an irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.

5. **Major Organ Transplant** - The receipt by transplant of any of the following organs or tissues: heart, lungs, liver, kidney, pancreas, or bone marrow.

6. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis)** by a qualified Physician.

No Accelerated Benefit will be paid under the Critical Illness Accelerated Benefit Rider for any Qualifying Event that occurs on or before the 30th day following the Effective Date of the Rider unless such Qualifying Event directly resulted from accidental injury.

No Accelerated Benefit will be paid under the Critical Illness Accelerated Death Benefit Rider for any Qualifying Event that directly or indirectly results from self-inflicted injury or attempted suicide.

The Owner may elect to accelerate all or a portion of the Insured's Death Benefit in force under the Policy on the Election Date. **We reserve the right to set a maximum amount that we will pay under any of the Accelerated Benefits Riders on the life of any Insured person. If we do so, the lifetime maximum will be no more than $500,000. If the Insured becomes eligible for benefits under the Chronic Illness Accelerated Death Benefit Rider, the Death Benefit that may be accelerated in any year will also be subject to a maximum amount.**

Accelerated Benefits are paid as a lump sum, provided, however, payments under the Chronic Illness Accelerated Death Benefit Rider may be prorated as described above. The following factors may be used by us in the determination of the amount payable under the Chronic Illness Accelerated Death Benefit Rider and the Critical Illness Accelerated Death Benefit Rider:

1. The Death Benefit accelerated;
2. Future Premiums payable under the Policy;
3. Our assessment of the future expected lifetime of the Insured;
4. Any administrative fee assessed; and
5. The Accelerated Benefits Interest Rate in effect.

The Insured's Death Benefit in force will be reduced each time an Accelerated Benefit is paid. The Face Amount will be reduced in the same proportion as the reduction in the Insured's Death Benefit. The new premiums and charges for the remaining portion will be reduced to those appropriate for the reduced Face amount.

As an example of the impact that election of Accelerated Benefits has on Policy values, consider the following situation:

Prior to Election	Upon Partial Election of 50% of Death Benefit	Upon Full Election
Death Benefit = $200,000 Annual Premium = 4,000	Remaining Death Benefit = $100,000 Remaining Annual Premium = 2,000	Death Benefit = $0 Annual Premium = 0

Dollar values showing the specific impact that acceleration will have on your Policy benefits and values will be provided when you apply for Accelerated Benefits.

Payment of Accelerated Benefits will reduce the Death Benefit otherwise payable under the Policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under these Riders.

Date

Owner's (Applicant's) Signature

Agent's Signature

TRANSAMERICA® LIFE INSURANCE COMPANY

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

Application Supplement for Children's Insurance Rider

File # _____

FOR INFORMATION OR TO MAKE A COMPLAINT, CALL 1-800-852-4678

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 or treated by a licensed member of the medical profession?**
☐	☐	Congenital Heart Abnormalities, Heart Disorder, Epilepsy, Cancer, Malignancy, Blood Disorder, Leukemia, Diabetes, Cystic Fibrosis, Kidney Disease, Brain or Neurological Disorder?
☐	☐	Asthma or other lung disease or injury or illness requiring hospitalization?

Remarks

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

FRAUD WARNING: 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.

Signed at _____
(city-state)

_____
Signature of Proposed Insured

Signed at _____
(city-state)

_____
Signature of Owner (if other than Proposed Insured)

_____
Witness of Proposed Insured Signature

_____
(date)

_____
Witness of Owner Signature

Date: _____

_____
Signature of Licensed Agent/Broker

_____
Printed Name of Licensed Agent/Broker

_____
Agent/Broker# Florida License ID#

TRANSAMERICA
LIFE INSURANCE COMPANY

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

_____ _____

_____ _____

_____
Agent# Florida License ID#

TRANSAMERICA
LIFE INSURANCE COMPANY

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

_____ _____

_____ _____

_____
Agent# Florida License ID#

☐ **Stonebridge Life Insurance Company**
☐ **Transamerica Life Insurance Company**
☐ **Transamerica Premier Life Insurance Company**

Illustration Certification Form

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

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

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 _____ (APPLICANT) on this date. An illustration conforming to the requirements of the _____ (STATE) state regulation on illustrations will be delivered to this applicant no later than the policy delivery date.

_____ 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 _____ (APPLICANT). An illustration conforming to the requirements of _____ (STATE) state regulations on illustrations shall be delivered to this applicant no later than the policy delivery date.

_____ 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