TRANSAMERICA®

Accelerated Death Benefit Rider Disclosure

Transamerica Life Insurance Company

Home Office: 4333 Edgewood Road NE Cedar Rapids, IA 52499

Receipt of the Accelerated Death Benefit may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of the Accelerated Death Benefit may be taxable and assistance should be sought from a personal tax advisor.

Description of Benefit: Upon receipt of proof acceptable to us of the Insured's Qualifying Event, the Owner may choose to receive the Accelerated Death Benefit while the Insured is alive and the Rider is In Force.

Qualifying Event: An event defined in the Rider, which allows for payment of the Accelerated Death Benefit.

Accelerated Death Benefit Amount: The Accelerated Death Benefit shall be equal to:

1. the Policy Death Benefit that would be In Force at the end of the 12 month period following the Acceleration Date, before deduction of any outstanding Loan Balance; less

2. a discount on the Accelerated Death Benefit calculated for the 12 month period using the current interest rate; less

3. any outstanding policy loans, including accrued interest until the end of the 12 months following the Acceleration Date; less

4. any premiums which would be required to keep the Policy In Force for the 12 month period following the Acceleration Date for the Policy Amount of Insurance reduced by an appropriate discount using the current interest rate.

Termination of Coverage: The Accelerated Death Benefit Rider will automatically terminate when the Policy to which it is attached terminates or lapses or matures or is continued under one of the nonforfeiture options; or when the Accelerated Death Benefit is paid; whichever occurs first.

Impact on the Policy's Death Benefit: The Policy to which the Rider is attached will terminate on the date the Accelerated Death Benefit is paid.

By signing below, you agree that you have read and received a copy of this summary and disclosure statement at the time of application.

Date	Owner's (Applicant's) Signature
Date	Agent's Signature

Reset Form

Reset Form

HIPAA Authorization for Release of Health-Related Information

○ **Transamerica Life Insurance Company** ○ **Transamerica Premier Life Insurance Company**

Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

Reset Form

TRANSAMERICA®

HIPAA Authorization for Release of Health-Related Information

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Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

Reset Form

TRANSAMERICA®

Individual Life Insurance Application

Transamerica Life Insurance Company

Home Office: 4333 Edgewood Road NE Cedar Rapids, IA 52499

Unless otherwise stated, "You" refers to the Proposed Primary Insured.

1

Proposed Primary Insured Personal Information

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number
__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Place of Birth (State / Territory, Country)

Gender
☐ **Male** ☐ **Female**

Marital Status
☐ **Single** ☐ **Married (including common law)** ☐ **Registered Domestic Partner**

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Years at Address

Mailing Address **(If different from Physical Address)**

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

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

Preferred Phone Number ☐ **Mobile**

Alternate Phone Number ☐ **Mobile**

Best Time to Call
☐ **AM** ☐ **PM**

Time Zone

Preferred method of communication
☐ **Mail** ☐ **Phone** ☐ **Email**

Email Address

Occupation

2 U.S Citizenship

If yes, go to next section.

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

Country of Citizenship

3 Other Insurance

If you are doing an Internal Replacement, please fill out the Full Surrender form.

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

If yes ☐ **Yes** ☐ **No**

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

If yes ☐ **Yes** ☐ **No**

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

Type of Coverage	Company	Policy #	Face Amount	Replacement?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

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

If yes ☐ **Yes** ☐ **No**

Anticipated Cash Value Transfer

$

4 Owner

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

Is the owner a Person or a Trust?

☐ **Person** ☐ **Trust - (go to the Trust questions below)**

If person, complete through Country of Citizenship.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number

__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Email Address

Gender

☐ **Male** ☐ **Female**

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

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

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

Country | Years at Address | Preferred Phone Number

☐ **Mobile**

Mailing Address **(If different from Physical Address)**

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

Owner's relationship to Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Domestic Partner**

☐ **Child** ☐ **GrandParent** ☐ **Other** _____

If yes, go to next section. →

Is the owner a U.S. citizen?

☐ **Yes** ☐ **No** →

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

__ __ / __ __ / __ __ __ __

United States citizens and valid Green Card holders are eligible.

Country of Citizenship

Complete this section only if the owner is a Trust.

If owner is a trust, complete a Trust Certification.

Trust | Original Trust Date (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

5

Primary Beneficiaries

Primary Beneficiary 1 Percentage of Death Benefits

___ %

Total shares between all primary beneficiaries must equal 100%.

If beneficiary is a trust, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable)

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

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

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

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**
☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

Continued on next page

5

Primary Beneficiaries

continued

Total shares between all primary beneficiaries must equal 100%.

Primary Beneficiary 2 Percentage of Death Benefits

___ %

Total shares between all primary beneficiaries must equal 100%.

If beneficiary is a trust, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**
☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

Primary Beneficiary 3 Percentage of Death Benefits

___ %

Total shares between all primary beneficiaries must equal 100%.

If beneficiary is a trust, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**
☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

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

6 Contingent Beneficiaries

Total shares between all contingent beneficiaries must equal 100%.

Contingent Beneficiary 1 Percentage of Death Benefits

___ %

Total shares between all contingent beneficiaries must equal 100%.

If beneficiary is a trust, complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

Contingent Beneficiary 2 Percentage of Death Benefits

___ %

Total shares between all contingent beneficiaries must equal 100%.

If beneficiary is a trust, complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

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

7 Secondary Addressee

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

Legal First Name	Middle Name	Legal Last Name	Suffix

Mailing Address

City	U.S. State / Territory	Zip Code

Email Address	Phone Number
	☐ **Mobile**

8 Product Details

Product Name	Coverage Amount	
	$	*This is the amount of life insurance coverage you are applying for.*

Rate Class Applied for:

☐ **Preferred Non-Tobacco** ☐ **Preferred Tobacco** ☐ **Preferred Juvenile**

☐ **Standard Non-Tobacco** ☐ **Standard Tobacco** ☐ **Standard Juvenile**

☐ **Graded**

If a policy cannot be issued as applied for, would you accept a rated policy if available?

☐ **Yes** ☐ **No**

If yes →

Adjust face amount to premium?

☐ **Yes** ☐ **No**

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

☐ **Elect** ☐ **Do Not Elect**

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

Benefit	Amount
☐ **Accidental Death Benefit Rider**	Coverage amount equal to policy face amount
☐ **Child/Grandchild Rider**	**$**

Complete the **Child/ Grandchild Rider Supplement Application**

9 Premium

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

If the initial draft date is prior to the application date, please complete the Back Date to Save Age Form.

Total Premium

$

Initial Draft Date (MM/DD) *1st thru 28th only*

__ __ / __ __ ☐ **Current Date**

Recurring Payment Frequency

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

Payment Option	Initial / Recurring	Form Information
☐ **EFT**	☐ **Initial** ☐ **Recurring**	For EFT, please complete the Electronic Payment Form.
☐ **Social Security Billing Benefits**	☐ **Initial** ☐ **Recurring**	For Social Security Benefits Billing, please complete the Social Security Benefits Billing Form.
☐ **Check**	☐ **Initial** ☐ **Recurring**	For monthly, please complete the Electronic Payment form for recurring payments.
☐ **1035 Exchange**	☐ **Initial** ☐ **Recurring**	For 1035 Exchange, please complete the 1035 Exchange Form.

10 Premium Payor

A person or Trust paying the premium

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

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number

__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Trust

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Phone Number ☐ **Mobile**

Continued on next page

10 Premium Payor *continued*

Email Address

Premium Payor's relationship if other than the Proposed Insured

☐ **Spouse** ☐ **Child** ☐ **Domestic Partner** ☐ **Other** _____

☐ **Parent** ☐ **Trust** ☐ **Grandparent**

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

If yes, go to next section.

Country of Citizenship

11 Primary Care Physician

Physician, Hospital or Health Care Provider Name

Phone Number

Address

Date of last visit (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Check this box if you do not have a physician.

☐

12 Lifestyle

A. Within the last 12 months have you used nicotine replacement, smoking or tobacco products in any form including, but not limited to the following: nicotine gum, patch or pills; cigarettes; cigars; pipe; chew; snuff; e-cigarettes; vape; hookah; or have you used marijuana more than 12 times in the last 12 months?

☐ **Yes** ☐ **No**

B. Height (feet and inches)

__ ' __ __ "

C. Current Weight (pounds)

D. Approximate weight a year ago (pounds)

☐ **1-14 lbs. more than current** ☐ **1-14 lbs. less than current** ☐ **Same as current**

☐ **15 lbs. more than current** ☐ **15 lbs. less than current**

If 15 lbs. more or less, proceed to the following two questions.

E. If your weight gain or loss is greater than 15 lbs in the last year, what is the difference in pounds?

_____ **pounds**

F. Explain your weight gain or loss of greater than 15 lbs in the last year. Check all that apply.

☐ **Diet** ☐ **Lifestyle Change** ☐ **Other** _____

☐ **Exercise** ☐ **Illness**

13

Medical History Part 1

Have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

A. Currently under the age of 18 with autism, depression, bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

B. Prior to the age of 45 with Heart Failure or Congestive Heart Failure?

☐ **Yes** ☐ **No**

C. Are you **currently** hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care; or been advised or planning to have surgery requiring general anesthesia?

☐ **Yes** ☐ **No**

Home Health Care is defined as: Medical care provided by a medical professional, friends or family member including, but not limited to arranging medications, taking blood pressure or sugar readings, administering medications, wound care, feeding tube, etc.

D. Have you **ever** been diagnosed by a member of the medical profession or tested positive for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or tested positive on an AIDS/HIV-related test?

☐ **Yes** ☐ **No**

E. Have you **ever** been the recipient or been given medical advice by a member of the medical profession to be a recipient of stem-cell, tissue, bone marrow, or organ transplant (other than corneal)?

☐ **Yes** ☐ **No**

Have you **ever** been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

F. Alzheimer's, dementia, memory loss, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, pulmonary fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?

☐ **Yes** ☐ **No**

G. Diabetic coma?

☐ **Yes** ☐ **No**

H. Amputation other than at the time of an accident or trauma?

☐ **Yes** ☐ **No**

I. Metastatic cancer, recurrent cancer, multiple cancers or cancer with lymph node involvement?

☐ **Yes** ☐ **No**

13

Medical History Part 1

continued

During the **last 2 years** have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

J. Cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

During the **last 2 years** have you:

K. Had testing by a medical professional for which the results have not been received, been non-compliant with physician orders regarding treatment plans, or been advised to have any diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been done?

☐ **Yes** ☐ **No**

L. Attempted suicide; been incarcerated, on probation, on parole, or convicted of or awaiting trial for a felony?

☐ **Yes** ☐ **No**

M. Been convicted for or plead no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) or had 3 or more moving violations?

☐ **Yes** ☐ **No**

If all questions in Part 1 are answered "No," proceed to Part 2.

If any question in Part 1 is answered "Yes", you are not eligible for any coverage.

14

Medical History Part 2

Have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

A. Prior to the age of 20 with Diabetes (other than gestational diabetes)?

☐ **Yes** ☐ **No**

B. Prior to the age of 26 with Crohn's Disease?

☐ **Yes** ☐ **No**

C. Prior to the age of 45 with Parkinson's Disease; Coronary Artery Disease, Peripheral Vascular Disease, or Cerebral Vascular Disease; Heart Attack, Transient Ischemic Attack (TIA), or Stroke; Cardiac Surgery, Bypass Surgery, Stent Implant, Angioplasty, Pacemaker or Defibrillator Implant, or Heart Valve Replacement?

☐ **Yes** ☐ **No**

Have you **ever** been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

D. Cirrhosis, heart failure, or congestive heart failure (CHF); or an aneurysm that has not been surgically corrected (still present)?

☐ **Yes** ☐ **No**

E. Hepatitis C?

If yes, proceed to E1 & E2. →

☐ **Yes** ☐ **No**

E1. Has the Hepatitis C been cured?

☐ **Cured** ☐ **Not Cured**

E2. If cured, when was the last blood test (RNA PCR Titer) showing the Hepatitis C was cured?

☐ **0-24 months after treatment ended**

☐ **More than 24 months after treatment ended**

If the answer to E2 is 0-24 months, then the best rate class is Graded. If the answer is more than 24 months, then the best rate class is Standard and the answer counts as a "No" when referring to directions below.

F. During the **last 4 years** have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

G. During the **last 2 years** have you used illegal drugs or been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs), muscular dystrophy, or systemic lupus erythematosus (SLE)?

☐ **Yes** ☐ **No**

If SLE has been in remission and there has been no treatment for more than two years, you may then answer this question "No" in regard to only the SLE.

14

Medical History Part 2

continued

During the **last 2 years** have you:

H. Required assistance with activities of daily living (ADL's) such as bathing, dressing, eating, toileting, getting in and out of chair or bed, or do you have ongoing neurological incontinence or, has a medical professional recommended that you be confined to a Nursing Home?

☐ **Yes** ☐ **No**

If "Yes", you are not eligible for the Nursing Home Option on the Accelerated Death Benefit Rider.

I. Used a wheelchair, electric scooter or electric cart?

☐ **Yes** ☐ **No**

If yes, proceed to I1.

I1. If yes, provide details regarding use:

☐ **Currently use or use occasionally at facilities such as, but not limited to, the grocery store, department stores, warehouse stores, airports**

☐ **Reason for use is expected to resolve in the next 3 months or the reason for use has resolved**

If the answer to I1 is "Reason for use...", count I as a "No" when referring to directions below.

During the **last 1 year** have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

J. More than 6 seizures; or been diagnosed with, been treated for or advised to receive treatment for any liver disease (including but not limited to autoimmune hepatitis) other than cirrhosis or Hepatitis C that should have been noted in a prior question?

☐ **Yes** ☐ **No**

K. Heart attack, stroke (CVA) or transient ischemic attack (TIA)?

☐ **Yes** ☐ **No**

L. Used oxygen to assist in breathing (including for Sleep Apnea); received kidney dialysis; kidney failure or chronic kidney disease (stage 4 or 5); encephalitis; or have you been unemployed or disabled and been diagnosed with, treated for or been given medical advice by a member of the medical profession for chronic pain?

☐ **Yes** ☐ **No**

Chronic Pain is defined as: Pain lasting more than 6 months or requiring 6 or more fills of narcotic pain prescriptions in any 12 month period.

If yes for angina, proceed to M1.

M. Angina (chest pain); or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or had an aneurysm surgically corrected?

☐ **Yes** ☐ **No**

M1. When was the angina (chest pain) first diagnosed?

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

If the answer to M1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count M as a "No" when referring to directions below.

If all questions in Part 2 are answered "No," proceed to Part 3.

If one question in Part 2 is answered "Yes," you are potentially eligible for the Graded Death Benefit product.

If two or more questions in Part 2 are answered "Yes," you are not eligible for any coverage.

15

Medical History Part 3

A. Prior to the age of 45, have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for cancer (other than Basal Cell)?

☐ **Yes** ☐ **No**

Have you **ever** been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

B. Bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

C. Parkinson's disease, multiple sclerosis, systemic lupus erythematosus (SLE), sarcoidosis, Crohn's disease, ulcerative colitis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?

☐ **Yes** ☐ **No**

Chronic Asthma is defined as: Using inhalers year round on a daily or weekly basis, or filling prescriptions 6 or more times in any 12 month period.

During the **last 4 years** have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

D. Kidney disease (stage 1, 2 or 3) or other kidney disorder?

☐ **Yes** ☐ **No**

E. Used illegal drugs; alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs)?

☐ **Yes** ☐ **No**

During the **last 4 years** have you:

F. Been convicted for or plead no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) or had 3 or more moving violations?

☐ **Yes** ☐ **No**

During the **last 2 years** have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

G. Heart attack, stroke (CVA) or transient ischemic attack (TIA)?

☐ **Yes** ☐ **No**

H. Used insulin; had more than 6 seizures; spina bifida cystica, pancreatitis, tuberculosis; hepatitis B or other liver disease?

☐ **Yes** ☐ **No**

15

Medical History Part 3

continued

If yes for angina, proceed to I1.

During the **last 2 years** have you been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

I. Angina (chest pain); cardiomyopathy; vascular, circulatory or blood disorder (including anemia other than iron deficiency); heart surgery of any kind including bypass surgery, angioplasty, stent implant; irregular heart rhythm such as atrial fibrillation or heart murmur; had an aneurysm surgically corrected; or do you currently have a pacemaker/ defibrillator?

☐ **Yes** ☐ **No**

I1. When was the angina (chest pain) first diagnosed?

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

If the answer to I1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count I as a "No" when referring to directions below.

If all questions in Part 3 are answered "No," you are potentially eligible for the Preferred product.

If one question in Part 3 is answered "Yes," you are potentially eligible for the Standard product.

If two or more questions in Part 3 are answered "Yes," you are potentially eligible for the Graded Death Benefit product.

16 Authorization to Obtain and Disclose Information

Each of the undersigned hereby certifies and represents as follows:

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

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

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

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

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

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

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

TAXPAYER IDENTIFICATION CERTIFICATION

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

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

16 Authorization to Obtain and Disclose Information

continued

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

Signature of Proposed Insured	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory
Signature of Parent or Legal Guardian (Of children under age 18)	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory
Signature of Applicant/Owner (If other than Proposed Insured)	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory

Title of Trust (If owner is trust)	Trustee First Name	Trustee Last Name
Print Producer 1 Name	Producer 1 Number	Producer 1 Signature
Print Producer 2 Name	Producer 2 Number	Producer 2 Signature

17 Other Insurance (to be completed by the Producer)

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements? If **no**, explain.

☐ **Yes** ☐ **No** Explain

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

Producer Signature

NOTICE OF DISCLOSURE

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

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

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

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

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

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

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

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

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our producer may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Transamerica Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

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

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium rates or amount of coverage.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or $50,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies prior to a future date selected for draft of the initial premium or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

Reset Form

Agent's Report

1

Producer 1 →

Writing Agent Name	Agent Number	Profile Number	Percent of Agent's Split

Producer 2 →

Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

Producer 3 →

Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

Producer 4 →

Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

2

Agent Disclosure

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

Are you financially responsible for the Proposed Primary Insured?

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

If yes →

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

If yes →

Name and address of Broker/Dealer

City	U.S. State / Territory	Zip Code

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

☐ **Yes** ☐ **No** ☐ **N/A**

Please indicate how this sale was taken:

☐ In person ☐ Phone or Video Call (Skype, FaceTime, etc.) ☐ Other _____

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

☐ **Yes** ☐ **No**

Type of Government issued photo ID

Issuer of Identification Document	Number	Expiration Date

3 Correspondence Information

Case Manager Name (if applicable)

Agent/Case Manager Email	Office ID

Agent/Case Manager Phone Number	Agent/Case Manager Fax Number

4 Signature

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

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

__ __ / __ __ / __ __ __ __

Signature of Writing Agent/ Registered Representative Date (mm/dd/yyyy)

Reset Form

TRANSAMERICA®

Electronic Payment

○ **Transamerica Financial Life Insurance Company**
Home Office: Harrison, New York
○ **Transamerica Life Insurance Company**
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
○ **Transamerica Premier Life Insurance Company**
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Policy/Certificate Information

If you have more than five policies, please attach an additional sheet.

Policy/Certificate Number	Insured Name	Premium Payment	Loan Payment (If Applicable)
		$	$
		$	$
		$	$
		$	$
		$	$

Initial Payment (ONLY for new policy applications, otherwise skip this section)

☐ **Check:** Check this box if you are submitting a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company. Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

☐ **Automatic Withdrawal:** Check this box to have the initial premium paid through the account specified in the "Account Information" section below. By checking this box, you agree to have the amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium may not equal the amount reflected in the chart above. Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below. You further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Future Recurring Payment

Select Mode: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

☐ Withdraw on day of the month matching the policy's effective date. This will be the default election if no box is checked.

☐ Withdraw on this day of the month (choose a day between 1 and 28): _____

If you need to change or cancel your bank draft, please notify us five (5) business days before your withdrawal date so we can process your request. Visit www.transamerica.com for details on how to contact us.

Past Due Premium

By signing this form, you authorize the Company to bring your policy current, which will pull past premiums due from your bank account. (Note: You can call us to verify the total overdue premiums.)

☐ Check here if you are providing us with a separate premium payment. Please write the policy/certificate number on the check.

Check amount: $_____ Date: _____

Continued on next page

Payor's Authorization to Insurance Company

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

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

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

Bank Account Information

Please enclose a voided check or complete this section with your financial institution information.

Please select the type of account: ☐ **Checking** ☐ **Savings**

Account Holder First Name	Account Holder Last Name

Trust or Entity *If entity, show title of officer and name of entity. If trust, show trustee's name.*

Financial Institution Name

Location City	State	Zip Code

Routing Number	Account Number

Account Holder Relationship to Insured	Insured Name

Account Holder(s) Signature(s) Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Complete pages 1 and 2, and <u>return both pages</u> to the Company

Reset Form

TRANSAMERICA

Important Notice Replacement of Life Insurance or Annuities

○ **Transamerica Life Insurance Company** ○ **Transamerica Premier Life Insurance Company**

Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

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

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

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

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

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

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

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ☐ YES ☐ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO**

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

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

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

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

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

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

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

PREMIUMS:

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

POLICY VALUES:

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

INSURABILITY:

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

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

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

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

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

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

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

30 DAY RIGHT TO CANCEL

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

Schedule of Social Security Benefit Payments 2019

JANUARY 2019						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY 2019						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28		

MARCH 2019						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

APRIL 2019						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

MAY 2019						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

JUNE 2019						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

JULY 2019						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

AUGUST 2019						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

SEPTEMBER 2019						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

OCTOBER 2019						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

NOVEMBER 2019						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

DECEMBER 2019						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Benefits paid on	Birth date on
Second Wednesday	1st – 10th
Third Wednesday	11th – 20th
Fourth Wednesday	21st – 31st

- Supplemental Security Income (SSI)
- Social Security benefits prior to May 1997; or if receiving both Social Security and SSI, Social Security is paid on the third

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

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