TRANSAMERICA
LIFE INSURANCE COMPANY

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

CLAIMANT'S STATEMENT

Date: _____

To the above Insurance Company: I hereby make claim under the policy/certificate or policies/certificates of the Company, numbered as follows: _____ Claim # _____

1. a. Name of deceased in full: _____
   b. Last known address of deceased: _____
   c. Occupation at death: _____
2. a. Date of death: _____ b. Place of death: _____
   c. Cause of death: _____ d. If death was due to suicide, homicide, or accident, state which and describe briefly: _____
3. Name and address of attending mortician: _____
4. On what date did deceased first complain of or give other indications of last illness? _____
5. a. BIRTH date of deceased: _____ State of Birth: _____
   b. From what source was the above date of birth obtained (from family record, certificate of birth, or otherwise)? _____
6. a. What is the beneficiary's date of birth? _____
   b. What is the beneficiary's Social Security /Trust Identification/Estate Identification No.? _____
   c. What is the beneficiary's phone number? _____
   d. What is the beneficiary's relationship to the deceased? _____
   e. State the amount of the claim: _____

Remarks: _____

I have not been notified by the Internal Revenue Service that I am subject to back-up withholding as a result of failure to report all interest or dividends. **Cross out this statement if you have been so notified.**

I certify, under penalty of perjury, that the Social Security or Taxpayer Identification Number and Back-up Withholding status information are correct. I further certify that I am a U.S. person, including a U.S. resident alien (non-U.S. person must complete form W-8BEN).

All of the above answers and statements are true and complete, and correctly recorded. I understand that the furnishing of forms by the Company does not constitute an admission that there is any insurance coverage in force or payable.

The policy/certificate IS / IS NOT (circle one) attached. (See Instructions (5) on back)

_____	_____
Personal Signature of Witness	Personal Signature of Claimant
_____	_____
Printed Name of Witness	Printed Name of Claimant
_____	_____
Address of Witness	Address of Claimant
_____	_____
City, State, ZIP of Witness	City, State, ZIP of Claimant

TRANSAMERICA
LIFE INSURANCE COMPANY

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

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

Note to claimant/personal representative: This authorization must be signed for us to receive medical records under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Although we may not need to obtain medical records to process your claim, we must obtain this form to avoid possible delays if medical information is needed.

I authorize all physicians, medical professionals, staff members, hospitals, clinics and other medical care institutions, medically related facilities, medical or hospital service and prepaid health plans, employers and group policy holders, contract holders and benefit plan administrators, state and federal governmental agencies (including law enforcement agencies), Social Security Administration, Internal Revenue Service and Veteran Administration facilities, coroners, medical examiners and any other person or entity that has any health information relating to the insured/patient named below (collectively, the "Providers") to disclose the **entire medical record** and any other protected health information concerning the insured/patient to the companies referenced at the top of this authorization (the "Companies"), their affiliates and reinsurers, and any agent, employee, representative, investigator, benefit plan administrator, consumer reporting agency or independent claim administrator acting on behalf of any of the Companies. This authorization includes release of any oral, written, or electronic information, records, documents, or knowledge concerning any medical care, medical advice, treatment or supplies, including psychiatric or mental health records (excluding psychotherapy notes), substance abuse records, medical records, medical notes, and medical recordings. This also includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, to the extent permitted by state law.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization and I instruct the Providers to release and disclose the **entire medical record** without restriction.

The protected health information is to be disclosed under this Authorization at my request, as permitted by § 164.508(c)(1)(iv) of the HIPAA Privacy Rule.

This authorization shall remain in force for 24 months (12 months in Kansas) following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Companies at Attention: Claims Department, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that the Companies have a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Companies will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and their own privacy policies.

I understand that Providers that are subject to the HIPAA Privacy Rule (not including the Companies) may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I do understand that if I refuse to sign this authorization to release the **entire medical record** of the insured/patient, the Companies may not be able to make any benefit payments. I acknowledge that (1) I am legally permitted to sign this authorization as the personal representative of the insured/patient, and (2) that I have received a copy of this authorization.

_____ _____

Name of insured/patient (please print) Date of birth

_____

Signature of Insured/Patient or Personal Representative of the Insured/Patient Date

_____

Description of Personal Representative's Authority or Relationship to Insured/Patient

_____

Policy or Contract Number

For use in claims processing

SIGN AND RETURN THIS COPY

821353459

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P = partnership) ▶ .....
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- Any estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

REQUEST FOR VERIFICATION OF POLICY PROCEEDS
FAX# 410-385-5971

NOTICE - Transamerica's receipt of this form shall not be construed as our acceptance and recognition of an assignment on the policies provided below.

FAX this information to:

618-252-2226

Funeral Home Name Chase National Corporation

Address 105 S. Commercial St., Suite 2

Harrisburg, IL 62946

Phone# 618-252-2824

Fax # **618-252-2226**

Deceased's Name _____ Date of Death _____

Cause of Death Natural ( ) Accident ( ) Other ( )

Date of Birth _____ Social Security Number _____

Policy Number	Issuing Company

I Authorize Transamerica to furnish to the above named Funeral Home any information that I would be entitled to receive about the policies provided on this form insuring the deceased person named above, including, but not limited to, the amount of the death benefit, other Beneficiaries if any and other information requested by the Funeral Home relating to the insurance policy(ies); I am authorized to sign this form, and hereby release Transamerica from any liability it may incur by releasing this information.

Signature of Beneficiary/Executor _____

Date:_____