RESET

APPLICATION FOR INSURANCE

[ ]

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

PROPOSED INSURED INFORMATION

1. Name (First, M.I., Last)	2. Mailing Address			
3. Home Telephone No. ( )	4. Work Telephone No. ( )	5. Birth Date	6. Birth State / Country	7. E-mail Address (optional)

8. Height	9. Weight	10. Marital Status	11. Sex ☐ Male ☐ Female	12. U.S. Citizen ☐ Yes ☐ No	13. If no, give immigration status/type of visa:

14. Occupation & Duties

15. Annual Income Current Year	16. Social Security No. or Tax I.D. No.	17. Drivers License No. and State

18. Have you used any tobacco or nicotine products within the last 5 years? ☐ Yes ☐ No If yes, list type and when used last

BENEFICIARY AND RELATIONSHIP TO PROPOSED INSURED

(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed insured.)

19. Primary	Relationship	20. Contingent	Relationship

OWNER

(Unless otherwise noted, the Owner will be the Insured.)

21. Name	a. Relationship to Proposed Insured	b. Social Security Number
c. Address	d. Birth Date	e. Phone ( )

POLICY INFORMATION

22. Plan: _____ ☐ Level ☐ Increasing Term Period _____	23. Amount of Insurance $	24. Planned Premium $

25. Mode of Payment (for bank draft, complete Check-O-Matic authorization, and collect initial payment.)

☐ Monthly Bank Draft ☐ Annual ☐ Other _____

26. ADDITIONAL BENEFITS and AMOUNTS

☐ Additional Insured Rider (AIR) $_____
☐ Base Insured Rider (BIR) $_____
☐ Children's Benefit Rider (CBR) $_____
☐ Guaranteed Insurability Rider (GIR) $_____
☐ Accidental Death Benefit (ADB) $_____

☐ Waiver of Premium Benefit (WP)
☐ Monthly Disability Income Rider (DIR)
☐ 2 Year ☐ 5 Year $_____
☐ Other _____ $_____
☐ Other _____ $_____

27. Name of Proposed Additional Insured(s) including any children applying	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last
							☐ No ☐ Yes _____
							☐ No ☐ Yes _____
							☐ No ☐ Yes _____
							☐ No ☐ Yes _____

28. LIFE INSURANCE IN FORCE

If none check this box ☐

Insured's Name	Company (only need if replacing)	Policy Number (only need if replacing)	Face Amount
			$
			$

29. DISABILITY INCOME - INSURANCE IN FORCE

If none check this box ☐ Complete if applying for disability income and have current coverage.
Please include any salary continuation program or employer paid benefits you may be eligible for should you become ill or injured over an extended period of time.

Insured's Name	Company	Policy Number	Monthly Amount	Benefit Period	Elimination Period

GENERAL QUESTIONS Complete the following. For YES answers, give full details in the space provided in Section 52.

30. Will the insurance applied for replace or change any existing insurance or annuity? ☐ Yes ☐ No

Have you or any Proposed Additional Insured (including any children applying),

31. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? ☐ Yes ☐ No
32. Within the past 5 years,
    a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? ☐ Yes ☐ No
    (If yes, provide state and drivers license number.) _____
    b. Been or is now fully or partially disabled? ☐ Yes ☐ No
    c. Been charged with or convicted of any felony or has been or is currently on probation or parole? ☐ Yes ☐ No
33. Within the past 2 years, (If any YES answer, complete the Avocation, Aviation, Foreign Travel Questionnaire.)
    a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? ☐ Yes ☐ No
    b. Flown other than as a passenger, or plan to? ☐ Yes ☐ No
    c. Had a foreign residence, traveled to a foreign country or are you planning to travel to a foreign country in the next two years? ☐ Yes ☐ No
34. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ☐ Yes ☐ No

Questions 35 to 38 apply to you or any Proposed Additional Insured:

35. Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60? ☐ Yes ☐ No
36. Do you exercise? If yes, describe type, how often per week and how long per session. ☐ Yes ☐ No
37. Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. ☐ Yes ☐ No
38. Have you had any weight change in the past year? ☐ Yes ☐ No
39. Do you or any Proposed Additional Insured (including any children applying) have any health, disability or life insurance pending or contemplated with another company? ☐ Yes ☐ No

MEDICAL QUESTIONS Each question must be individually asked and answered. For YES answers, give full details in the space provided in Section 52.

40. Have you or any Proposed Additional Insured (including any children applying) EVER been diagnosed as having or been treated, by a member of the medical profession for AIDS, or AIDS Related Complex (ARC)? ☐ Yes ☐ No

(Questions 41 to 51) Within the past 10 years, have you or any Proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having:

41. A heart attack, heart disease, palpitations, heart murmur, chest pain, high blood pressure, stroke, anemia or any other disease or disorder of the blood or circulatory system? ☐ Yes ☐ No
42. Emphysema, asthma, shortness of breath, chronic cough, sleep apnea or any other disease or disorder of the respiratory system? ☐ Yes ☐ No
43. Seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia, Alzheimer's disease or any other disease or disorder of the brain or nervous system? ☐ Yes ☐ No
44. Sugar, albumin, blood in urine, or any other disease or disorder of the kidneys, bladder, or urinary system? ☐ Yes ☐ No
45. Prostate problems, breast problems, a sexually transmitted disease or any other disease or disorder of the reproductive system? ☐ Yes ☐ No
46. Stomach, intestine, liver disorder or any other disease or disorder of the gastrointestinal system (such as: ulcer, colitis, Crohn's disease or hepatitis)? ☐ Yes ☐ No
47. Diabetes, thyroid disorder or any other disease or disorder of the endocrine system? ☐ Yes ☐ No
48. Lupus, arthritis, back, bone, joint, or any other disease or disorder of the muscle or bone? ☐ Yes ☐ No
49. Tumor(s), polyp(s), cancer, melanoma or other malignancy? ☐ Yes ☐ No
50. Or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? ☐ Yes ☐ No
51. Or are you currently under the observation of a physician or taking medication? ☐ Yes ☐ No

52. ADDITIONAL INFORMATION If additional space required, use Supplemental Form SA-ADINFO.

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

53. PERSONAL PHYSICIAN(S) If additional space required, use Supplemental Form SA-ADINFO.

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

ILLUSTRATION CERTIFICATION The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT presented an illustration of the policy applied for or discussed any non-guaranteed elements of the policy with the Applicant/Owner. Upon or prior to delivery, I will provide an illustration and explain any non-guaranteed elements of the policy.

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) – Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent 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) no policy applied for shall take effect until all of the following conditions have been met: 1) the first full premium must be received by the Company; 2) during the lifetime of any proposed insured, the proposed owner must have personally received and accepted the policy which was applied for; 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, and there must have been no change in the insurability of any proposed insured. Unless otherwise stated the undersigned applicant 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, 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 Premier Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Premier 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 expire 30 months from the date signed. Either my authorized representative or I may receive a copy of the authorization upon request.

The Company shall have sixty 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 applicant 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 (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. 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.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

Please make checks payable to Transamerica Premier Life Insurance Company. Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with application: $ _____ Best time to call for a personal history interview: _____ a.m. / p.m. Okay to contact at work? ☐ Yes ☐ No

Dated at _____ (City) _____ (State) this _____ day of _____ (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

TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER 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 I am not subject to backup withholding because I am an exempt recipient; 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.

Signature of Proposed Owner _____ **Date** _____

AGENT INFORMATION & SIGNATURE

Signature of Agent	(Print First and Last Name)	Agent #
( ) Telephone Number	( ) Agent Fax #	Agent E-mail Address
Split Agent Signature (If Applicable)	(Print First and Last Name)	Agent #
( ) Telephone Number	( ) Agent Fax #	Agent E-mail Address

- Did you ask all questions on the application in the presence of all proposed insureds, record the answers as given, and witness all signatures? ☐ Yes ☐ No
  If not, please provide details. _____
- Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? ☐ Yes ☐ No
  (If yes, submit the state required forms.)

CONDITIONAL RECEIPT

(Detach and leave with applicant if money is submitted with application. If within the past 12 months the proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.)

PLEASE READ THIS CAREFULLY

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from _____, the sum of $_____ for the insurance or annuity application dated _____, with _____ as the proposed insured(s) or annuitant. The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application and must be received at our Home Office within the lifetime of the proposed insured;
4. All medical examinations, tests, and other screenings required of any proposed insured by the Company are completed and the results received at our Home Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Home Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other conditional receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or additional benefits, if any, for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, 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(s) you have made upon return of this Receipt to the Company.

This Receipt is not valid unless all blanks are completed above and this Receipt is signed by an agent or authorized Company representative. This Receipt does not provide any conditional insurance until all of the conditions and requirements are met as outlined above.

Dated at _____ this _____ day of _____, _____
City State Month Year

_____
Signature of Agent

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE
REGARDING INVESTIGATIVE REPORT

To proposed insureds: 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.

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential. Transamerica Premier 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 Premier 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 OF INSURANCE INFORMATION PRACTICES

To proposed insureds: 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 agent 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 Premier Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

AGENT'S REPORT

How well do you know proposed insured? _____

	Yes	No
Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance? (If "yes", explain in Remarks Section)	☐	☐
Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?) (If "yes", explain relationship _____)	☐	☐
Did you see all of those to be insured on the date the application was written? (If "no", explain in Remarks Section)	☐	☐

Rate Class:

Universal and Term

- ☐ Preferred Choice (Term Only)
- ☐ Standard Plus Non-Tobacco
- ☐ Standard Non-Tobacco
- ☐ Standard Plus Tobacco
- ☐ Standard Tobacco

Other Term and IUL

- ☐ Preferred Elite
- ☐ Preferred Plus
- ☐ Preferred
- ☐ Non-Tobacco
- ☐ Preferred Tobacco
- ☐ Tobacco

1. Agent's Name	Agent No.	% if Split
2. Agent's Name	Agent No.	% if Split

COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED

What is the relationship of the Owner to the primary insured (please explain)?

_____

What is the relationship of the Payor to the primary insured (please explain)?

_____

ADDITIONAL REMARKS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed insured not fully set forth herein. I will not deliver the policy if the health of the insured has changed.

_____

Signature of Writing Agent

RESET

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

Transamerica Premier 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

RESET

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

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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.

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

Notice and Consent for HIV-Related Testing GEORGIA

Notice And Consent For FDA Approved Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the Insurer designated above ("the Insurer") has requested that you provide a sample of your blood, urine and/or other bodily fluid(s) for FDA approved testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the insurer is a member of MIB, Inc. (MIB), and if the test results for HIV antibodies/antigens are other than normal, the insurer will report to MIB, a generic code which signifies only a nonspecific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to MIB. Other test results may be reported to MIB in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

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

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

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 provide a sample of blood, urine and/or bodily fluid(s), the FDA approved testing of that sample and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

Proposed Insured (Please Print) _____ Date of Birth _____

Signature of Proposed Insured or Parent/Guardian _____ Date Signed _____

State of Residence _____

Life Insurance Buyer's Guide

This guide can show you how to save money when you shop for life insurance. It helps you to:

— Decide how much life insurance you should buy,

— Decide what kind of life insurance policy you need, and

— Compare the cost of similar life insurance policies.

Prepared by the National Association of Insurance Commissioners

Reprinted by

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

May 2012

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers. You are urged to use this Guide in making a life insurance purchase.

This Guide Does Not Endorse Any Company or Policy.

Buying Life Insurance

When you buy life insurance, you want a policy which fits your need without costing too much. Your first step is to decide how much you need, how much you can afford to pay and the kind of policy you want. Then, find out what various companies charge for that kind of policy. You can find important differences in the cost of life insurance by using the life insurance cost indexes which are described in this guide. A good life insurance agent or company will be able and willing to help you with each of these shopping steps.

If you are going to make a good choice when you buy life insurance, you need to understand which kinds are available. If one kind does not seem to fit your needs, ask about the other kinds which are described in this Guide. If you need more information than is given here, you may want to check with a life insurance agent or company or books on life insurance in your public library.

Choosing the Amount

One way to decide how much life insurance you need is to figure how much cash and income your dependents would need if you were to die. You should think of life insurance as a source of cash needed for expenses of final illnesses, paying taxes, mortgages or other debts. It can also provide income for your family's living expenses, educational costs and other future expenses. Your new policy should come as close as you can afford to making up the difference between (1) what your dependents would have if you were to die now, and (2) what they would actually need.

Choosing the Right Kind

All life insurance policies agree to pay an amount of money if you die. But all policies are not the same. There are three basic kinds of life insurance.

1. Term Insurance

2. Whole Life Insurance

3. Endowment Insurance

Remember, no matter how fancy the policy title or sales presentation might appear, all life insurance policies contain one or more of the three basic kinds. If you are confused about a policy that sounds complicated, ask the agent or company if it combines more than one kind of life insurance.

The following is a brief description of the three basic kinds:

Term Insurance:

Term Insurance is death protection for a "term" of one or more years. Death benefits will be paid only if you die within that term of years. Term insurance generally provides the largest immediate death protection for your premium dollar.

Some term insurance policies are "renewable" for one or more additional terms even if your health has changed. Each time you renew the policy for a new term, premiums will be higher. You should check the premiums at older ages and the length of time the policy can be continued. Some term insurance policies are also "convertible." This means that before the end of the conversion period, you may trade the term policy for a whole life or endowment insurance policy even if you are not in good health. Premiums for the new policy will be higher than you have been paying for term insurance.

Whole Life Insurance:

Whole life insurance gives death protection for as long as you live. The most common type is called "straight life" or "ordinary life" insurance, for which you pay the same premiums for as long as you live. These premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term insurance policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher than for ordinary life insurance since the premium payments are squeezed into a shorter period.

Although you pay higher premiums, to begin with, for whole life insurance than for term insurance, whole life insurance policies develop "cash values" which you may have if you stop paying premiums. You can generally either take the cash, or use it to buy some continuing insurance protection. Technically speaking, these values are called "nonforfeiture benefits." This refers to benefits you do not lose (or "forfeit") when you stop paying premiums. The amount of these benefits depends on the kind of policy you have, its size, and how long you have owned it.

A policy with cash values may also be used as collateral for a loan. If you borrow from the life insurance company, the rate of interest is shown in your policy. Any money which you owe on a policy loan would be deducted from the benefits if you were to die, or from the cash value if you were to stop paying premiums.

Endowment Insurance:

An endowment insurance policy pays a sum or income to you — the policyholder — if you live to a certain age. If you were to die before then, the death benefit would be paid to your beneficiary. Premiums and cash values for endowment insurance are higher than the same amount of whole life insurance. Thus, endowment insurance gives you the least amount of death protection for your premium dollar.

Finding a Low Cost Policy

After you have decided which kind of life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "non-participating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be. The premiums and cash values of a participating policy are guaranteed, but the dividends are not.

Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums

2. Cash Values

3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies.

1. *Life Insurance Surrender Cost Index.* This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.

2. *Life Insurance Net Payment Cost Index.* This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's Equivalent Level Annual Dividend to its cost index allows you to compare total costs of similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a non-participating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the non-participating policy will not change.

How Do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for *all* types of insurance at *all* ages and for *all* amounts of insurance, it is important that you get the indexes for the actual policy, age and amount which you intend to buy. Just because a "Shopper's Guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.

(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for a while, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.

IMPORTANT THINGS TO REMEMBER — A SUMMARY

The first decision you must make when buying a life insurance policy is choosing a policy whose benefits and premiums most closely meet your needs and ability to pay. Next, find a policy which is also a relatively good buy.

If you compare Surrender Cost Indexes and Net Payment Cost Indexes of similar competing policies, your chances of finding a relatively good buy will be better than if you do not shop. REMEMBER, LOOK FOR POLICIES WITH LOWER COST INDEX NUMBERS. A good life insurance agent can help you to choose the amount of life insurance and kind of policy you want and will give you cost indexes so that you can make cost comparisons of similar policies.

Don't buy life insurance unless you intend to stick with it. A policy which is a good buy when held for 20 years can be very costly if you quit during the early years of the policy. If you surrender such a policy during the first few years, you may get little or nothing back and much of your premium may have been used for company expenses.

Read your new policy carefully, and ask the agent or company for an explanation of anything you do not understand. Whatever you decide now, it is important to review your life insurance program every few years to keep up with changes in your income and responsibilities.

❑ **Transamerica Life Insurance Company**

❑ **Transamerica Premier Life Insurance Company**

Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499-0001

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 or Additional Insured Rider upon death of the Insured. The conditions under which accelerated benefits may be elected vary by Rider as described below.

NOTE: Your Policy may not be eligible for coverage under all the Accelerated Death Benefit Riders described below. Please check your Policy and the Riders for details on each Accelerated Death Benefit Rider that is included with your Policy and the Insured's coverage under each Rider.

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

Benefits may be elected under this Rider if the Insured has a Terminal Condition. Terminal Condition means a condition resulting from injury or illness that with reasonable medical certainty, as determined by a Physician, will result in death within 24 months from the date of the Physician's Statement.

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, within the last 24 months, 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; or
2. Requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

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

No Application for Election of Accelerated Benefits will be accepted under the Chronic Illness Accelerated Benefits Rider during the first two years that it 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. 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, that 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:

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

The benefit will first be used to pay a pro-rata share of any outstanding debt to us. The benefit will never exceed 90% of the Death Benefit accelerated for the Critical Illness or Chronic Illness Accelerated Death Benefit Riders, 100% for the Terminal Illness Accelerated Death Benefit Rider. It will never be less than the Cash Surrender Value, if any, corresponding to the portion of the Death Benefit accelerated.

The Insured's Death Benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the Death Benefit that is accelerated on the Election Date. The Face Amount or Coverage Amount, and if applicable, the Cash Value, Cash Surrender Value, Accumulated Value, Surrender Charge, and outstanding debt under the Policy 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 as if the contract had been originally issued at the reduced 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	Remaining Death Benefit	= $100,000	Death Benefit	= $0
Cash Value or Cash Surrender Value	= 80,000	Remaining Cash Value or Cash Surrender Value	= 40,000	Cash Value or Cash Surrender Value	= 0
Outstanding Debt	= 50,000	Remaining Outstanding Debt	= 25,000	Outstanding Debt	= 0
Annual Premium	= 4,000	Remaining Annual Premium	= 2,000	Annual Premium	= 0

Dollar values showing specific impact that acceleration will have on your Policy 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