Issue ages 0 - 44

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with <u>every</u> application)

Agent Information		
Agent ID	Agent Name (Print)	Agent Phone ( )
Agent Email		Agent Fax ( )
Case Manager Name	Case Manager Phone ( )	
Case Manager Email Address		

Proposed Insured Information	
Insured's name (Print)	Last 4 digits of Insured's social security #

Required Disclosures with Application:

❑ HIPAA Authorization Form ❑ Beneficiary/Additional Insured Information Form

Other Disclosures (if applicable):

❑ Accelerated Death Benefit Disclosure Form ❑ Replacement Form(s)

Submitting Applications: ***(Faxing is the preferred method)***

If faxing, fax to **1-866-834-0437** and enter date faxed_____ . **Do Not** mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

4333 Edgewood Road NE, Cedar Rapids, IA 52499

If a case manager is listed, please follow your General Agency's submission process with sending the signed application packet.

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

LIFE APPLICATION

Part A1 – Producer

Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

Part A2 – Plan & Rider Information

Plan	Face Amount	Total Premium
	$	$

Rate Class applied for:

❑ Preferred Non-Tobacco ❑ Preferred Tobacco ❑ Preferred Juvenile
❑ Standard Non-Tobacco ❑ Standard Tobacco ❑ Standard Juvenile
❑ Graded

Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) ❑ Yes ❑ No

Child / Grandchild Rider? $_____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) ❑ Yes ❑ No

Part A3 – Proposed Insured

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

D.O.B. (MM/DD/YYYY)	U.S. State or Country of Birth	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.

Gender	Height	Weight	SSN

Driver's License Number State	Phone Number for Interview	Best time to call	Occupation
	( )	a.m. p.m.	

Part A4 – Owner (If Other Than Proposed Insured)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Phone Number	D.O.B. (MM/DD/YYYY)	Gender	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.
( )			

SSN	Relationship to Insured

Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)

Primary Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured
Contingent Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured

Part A6 – Existing Insurance

Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? ❑ Yes ❑ No

Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? ❑ Yes ❑ No

If yes, submit the state required forms and please provide company name and policy number. _____

Is this to be a 1035 exchange? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

Part B1 – Initial Premium Payment Method

❑ By check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual.
Is the check for initial premium payment on the same account as monthly EFT payments? ❑ Yes ❑ No

❑ By payroll deduction or allotment.

❑ Draft initial premium upon receipt from the account below.

❑ Draft initial premium at future date from the account below. Please indicate the month and day (mm/dd): _____/_____
Month **Day (1st thru 28th only)**

If you select an initial premium draft date in the future, it may not be greater than 30 days after the application date and the recurring draft date below must be the same day of the month as the initial premium draft 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.

Part B2 – Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Transamerica Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

❑ Checking ❑ Savings Financial Institution Name: _____ City/State: _____

Account #: | | | | | | | | | | | | | | | | | | |

Routing #: | | | | | | | | | |

No debit card numbers please

Recurring Draft Date (1st-28th):_____ If no recurring draft date is selected, the draft date will be the same day of the month as the Policy Date.

Payor Signature (if other than proposed Insured or Owner)_____ Date:_____

Part B3 – Recurring Payment Method

EFT

❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Payroll Deduction

Special Frequency _____

❑ List Bill ❑ Civil Service Allotment ❑ Military Allotment

Requested Effective Date _____

Automatic Premium Loan provision (if available)? ❑ Yes ❑ No

Part B4 – Payor Information

The Payor is the ❑ Proposed Insured ❑ Owner ❑ Other (If Other, please provide the following information:)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)	
SSN	Relationship to Insured	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part B5 – Secondary Addressee

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Last Name and Last 4 Digits of SSN: _____

Part C1

Within the last 12 months has the proposed Insured used tobacco products in any form? ❑ Yes ❑ No

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

Part C2 – If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.

1) Is the proposed insured currently:
   a. Hospitalized or bedridden? ❑ Yes ❑ No
   b. On parole or probation? ❑ Yes ❑ No
2) Within the **past 2 years** has the proposed insured:
   a. Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for cancer (other than Basal Cell carcinoma)? ❑ Yes ❑ No
   b. Had a stroke (CVA), transient ischemic attack (TIA), heart attack, cardiovascular surgery including bypass, angioplasty, stent implant or pacemaker implant; or had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for congestive heart failure? ❑ Yes ❑ No
   c. Used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance. ❑ Yes ❑ No
   d. Used oxygen to assist in breathing (including oxygen use for Sleep Apnea)? ❑ Yes ❑ No
   e. Used illegal drugs (other than marijuana); or been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for alcoholism, alcohol use/abuse or drug use/abuse (including prescription drugs)? ❑ Yes ❑ No
   f. Undergone testing by a medical professional for which the results have not been received; or been advised by a member of the medical profession to have any surgical operation, diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been completed? ❑ Yes ❑ No
   g. Resided in a nursing home, assisted or long term care facility; or received hospice or home health care? ❑ Yes ❑ No
   h. Been diagnosed with Crohn's disease, Multiple Sclerosis or Parkinson's disease? ❑ Yes ❑ No
   i. Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for Hepatitis C, Tuberculosis (TB) or Lupus? ❑ Yes ❑ No
   j. Been incarcerated; or been convicted of a felony or misdemeanor; or been convicted of 2 or more DUI's/DWI's or 3 or more moving violations? ❑ Yes ❑ No
3) Has the proposed insured:
   a. Within the past 10 years, been diagnosed with, been treated for or been advised by a member of the medical profession to receive treatment for Alzheimer's, dementia, memory loss, any cognitive disorder, organic brain disease, mental incapacity, Lou Gehrig's (ALS), Downs Syndrome, Huntington's, Spina Bifida not surgically corrected, Sickle Cell anemia, Cystic Fibrosis or Cerebral Palsy? ❑ Yes ❑ No
   b. 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
   c. Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ Yes ❑ No
   d. Within the past 10 years, been in a diabetic coma or had or been advised by a member of the medical profession to have an amputation due to disease or disorder? ❑ Yes ❑ No
   e. Received or been advised by a member of the medical profession to receive an implanted defibrillator or an organ transplant (other than corneal)? ❑ Yes ❑ No

Part C3 - For All Questions Answered "Yes" In This Section Give Details On The Supplemental Information To The Application.

1) Does the proposed Insured take any prescription medication? ❑ Yes ❑ No
2) Within the last **10 years**, has the proposed Insured had or received medical treatment for any of the following conditions:
   Any disease or disorder of the blood, heart or circulatory system such as heart attack, stroke or transient ischemic attack (TIA) ❑ Yes ❑ No
   Respiratory Disease ❑ Yes ❑ No
   Kidney/Liver/Digestive Disorder ❑ Yes ❑ No
   Epilepsy/Seizures ❑ Yes ❑ No
   Mental/Nervous Disorder ❑ Yes ❑ No
   Cancer/Leukemia ❑ Yes ❑ No
   High Blood Pressure ❑ Yes ❑ No
   If yes, last reading: _____/_____ Medication: _____
   Diabetes ❑ Yes ❑ No
   If yes, age at onset: _____ Medication: _____ Avg. blood sugar reading: _____
3) Within the last **5 years**, has the proposed Insured:
   a) Had one or more DUI(s), been charged with, or convicted of a felony OR been on probation/parole? ❑ Yes ❑ No
   b) Illegally used any drug or controlled substance or been treated/counseled for drug or alcohol abuse? ❑ Yes ❑ No

Part C4 – Nursing Home Option - If The Following Question Is Answered "Yes", The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

AGREEMENT / AUTHORIZATION

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) except as provided in the Conditional Receipt, if issued with the same proposed 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 proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; 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 the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt.

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 the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 24 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

I 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.

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.

Signed Date _____ Signed at City _____ State _____

_____
Proposed Insured Signature
(Insured age 15 and over must sign)

_____
Signature of Parent or Legal Guardian
(if Proposed Insured is Under 18 years of age)

_____
Owner Signature (If Owner other than Insured)

_____
Producer Signature

If the EFT premium payment method is chosen, please tape a voided check in this box.

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to the Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to the Company.

TRANSAMERICA LIFE INSURANCE COMPANY
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

MIB DISCLOSURE NOTIFICATION

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

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

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

01/13

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.

Agent Instructions: Please leave this page with the Proposed Insured/Owner

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name:____________________ Social Security Number: ________________

Additional Information

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

Additional Information

Child / Grandchild Rider Information

Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN
Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	Gender	Relationship to Insured	SSN

Contingent Owner

Name (First, M.I., Last, Suffix)	SSN	Gender	Relationship to Insured	Phone Number ( )	D.O.B. (MM/DD/YYYY)

Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Signed Date____________ Signed at City____________ State ____________

Proposed Insured Signature
(Insured age 15 and over must sign)

Signature of Parent or Legal Guardian
(if Proposed Insured is Under 18 years of age)

Owner Signature (If Owner other than Insured)

Producer Signature

Last Name and Last 4 Digits of SSN: _____

Agent's Report

Existing insurance? ❑ Yes ❑ No

Is the policy applied for in this application intended to replace any insurance or annuity now in force? ❑ Yes ❑ No

I represent that:

1) I have personally seen the proposed Insured. ❑ Yes ❑ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ❑ Yes ❑ No

Is the person proposed for insurance related to you? ❑ Yes ❑ No Relationship _____

_____

Producer Signature

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

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

OWNER - if other than Primary Insured

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

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

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

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

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

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

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

AGENT

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

Date

Producer or Agent Signature

Owner Signature

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA 52499
Administrative Office:
4333 Edgewood Rd NE
Cedar Rapids, IA 52499
(800) 238-4302

(Referred to as the Company, we, our or us)

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

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 of 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 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

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 Financial Life Insurance Company**
440 Mamaroneck Avenue, Harrison, NY 10528
☐ **Transamerica Life Insurance Company**
☐ **Transamerica Premier Life Insurance Company**
Administrative Office: 4333 Edgewood Road N.E.
Cedar Rapids, IA 52499

SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM

POLICY NUMBER_____

SOCIAL SECURITY BENEFIT PAYMENT PAID ON:

Box A - Required

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

☐ Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)
☐ Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)
☐ Benefit paid on Second Wednesday (Option C)
☐ Benefit paid on Third Wednesday (Option D)
☐ Benefit paid on Fourth Wednesday (Option E)

Initial Draft Month_____ (Cannot exceed one benefit payment cycle past application date)

INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)

Box B - Bank Withdrawal Account

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____
☐ Survivor Account

_____ _____
Financial Institution Name, Office or Branch — Financial Institution Address City, State, Zip

_____ Check One: ☐ Checking ☐ Savings $ _____
List All Authorized Account Holders — Premium amount

_____ _____ _____
Transit Routing Number — Account Number — Account Holder Signature

Box C - Direct Express MasterCard

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____
☐ Survivor Account

5332 48 __ __ __ __ __ __ __ __ __ __ __ __
Direct Express MasterCard Account Number

_____ $ _____
Cardholder Signature — Date — Premium amount

_____ _____
Card Expiration Date Mo/Yr — Cardholder Name (Please Print)

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. 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 charge or withdrawal is not honored for payment, 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 MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

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

_____ _____
Signature of Authorized Account Holder — Date