Reset Form

Reset Form

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

Reset Form

TRANSAMERICA®

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

Transamerica Life Insurance Company

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

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

1

Proposed Primary Insured Personal Information

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

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

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

Place of Birth (State / Territory, Country)

Gender
☐ **Male** ☐ **Female**

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

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

City | U.S. State / Territory

Zip Code | Country | Years at Address

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

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

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

Preferred Phone Number ☐ **Mobile**

Alternate Phone Number ☐ **Mobile**

Best Time to Call
☐ **AM** ☐ **PM**

Time Zone

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

Email Address

Occupation

2 U.S Citizenship

If yes, go to next section.

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** → Green Card Number and Expiration

Country of Citizenship

3 Other Insurance

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

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

If yes ☐ **Yes** ☐ **No**

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

If yes ☐ **Yes** ☐ **No**

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

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

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

If yes ☐ **Yes** ☐ **No**

Anticipated Cash Value Transfer

$

4

Owner

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

Is the owner a Person or a Trust?

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

If person, complete through Country of Citizenship.

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

U.S. Social Security Number

__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Email Address

Gender

☐ **Male** ☐ **Female**

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

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

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

Country | Years at Address | Preferred Phone Number

☐ **Mobile**

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

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

Owner's relationship to Proposed Primary Insured

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

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

Is the owner a U.S. citizen?

If yes, go to next section. → ☐ **Yes** ☐ **No** →

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

__ __ / __ __ / __ __ __ __

United States citizens and valid Green Card holders are eligible.

Country of Citizenship

Complete this section only if the owner is a Trust.

If owner is a trust, complete a Trust Certification.

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

__ __ / __ __ / __ __ __ __

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

5 Primary Beneficiaries

Primary Beneficiary 1 Percentage of Death Benefits

_____ %

Total shares between all primary beneficiaries must equal 100%.

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

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

Business Entity or Trust (if applicable)

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

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

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

Mailing Address ☐ Same as Proposed Primary Insured | City

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

Relationship to the Proposed Primary Insured

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

Continued on next page

5

Primary Beneficiaries

continued

Total shares between all primary beneficiaries must equal 100%.

Primary Beneficiary 2 Percentage of Death Benefits

%

Total shares between all primary beneficiaries must equal 100%.

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

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

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

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

Mailing Address ☐ Same as Proposed Primary Insured | City

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

Relationship to the Proposed Primary Insured

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

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

Primary Beneficiary 3 Percentage of Death Benefits

%

Total shares between all primary beneficiaries must equal 100%.

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

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

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

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

Mailing Address ☐ Same as Proposed Primary Insured | City

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

Relationship to the Proposed Primary Insured

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

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

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

6 Contingent Beneficiaries

Total shares between all contingent beneficiaries must equal 100%.

Contingent Beneficiary 1 Percentage of Death Benefits

___ %

Total shares between all contingent beneficiaries must equal 100%.

If beneficiary is a trust, complete a Trust Certification.

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

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

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

Mailing Address ☐ Same as Proposed Primary Insured | City

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

Relationship to the Proposed Primary Insured

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

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

Contingent Beneficiary 2 Percentage of Death Benefits

___ %

Total shares between all contingent beneficiaries must equal 100%.

If beneficiary is a trust, complete a Trust Certification.

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

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

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

Mailing Address ☐ Same as Proposed Primary Insured | City

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

Relationship to the Proposed Primary Insured

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

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

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

7 Secondary Addressee

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

Legal First Name	Middle Name	Legal Last Name	Suffix

Mailing Address

City	U.S. State / Territory	Zip Code

Email Address	Phone Number
	☐ **Mobile**

8 Product Details

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

Rate Class Applied for:

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

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

☐ **Graded**

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

☐ **Yes** ☐ **No**

If yes

Adjust face amount to premium?

☐ **Yes** ☐ **No**

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

☐ **Elect** ☐ **Do Not Elect**

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

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

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

9 Premium

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

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

Total Premium

$

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

__ __ / __ __ ☐ **Current Date**

Recurring Payment Frequency

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

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

10 Premium Payor

A person or Trust paying the premium

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

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

U.S. Social Security Number

__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Trust

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

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

City | U.S. State / Territory

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

Continued on next page

10 Premium Payor *continued*

Email Address

Premium Payor's relationship if other than the Proposed Insured

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

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

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

If yes, go to next section.

Country of Citizenship

11 Primary Care Physician

Physician, Hospital or Health Care Provider Name

Phone Number

Address

Date of last visit (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Check this box if you do not have a physician.

☐

12 Lifestyle

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

☐ **Yes** ☐ **No**

B. Height (feet and inches)

__ ' __ __ "

C. Current Weight (pounds)

D. Approximate weight a year ago (pounds)

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

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

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

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

_____ **pounds**

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

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

☐ **Exercise** ☐ **Illness**

13

Medical History Part 1

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

D. To the best of your knowledge and belief, within the **last 10 years** have you been diagnosed by a member of the medical profession as having a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS Related Complex)?

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

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

☐ **Yes** ☐ **No**

G. Diabetic coma?

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

13

Medical History Part 1

continued

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

J. Cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

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

14

Medical History Part 2

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

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

☐ **Yes** ☐ **No**

E. Hepatitis C?

If yes, proceed to E1 & E2. →

☐ **Yes** ☐ **No**

E1. Has the Hepatitis C been cured?

☐ **Cured** ☐ **Not Cured**

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

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

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

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

14

Medical History Part 2

continued

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

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

☐ **Yes** ☐ **No**

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

If yes, proceed to I1. →

☐ **Yes** ☐ **No**

I1. If yes, provide details regarding use:

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

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

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

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

If yes for angina, proceed to M1. →

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

☐ **Yes** ☐ **No**

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

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

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

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

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

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

15

Medical History Part 3

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

☐ **Yes** ☐ **No**

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

B. Bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

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

☐ **Yes** ☐ **No**

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

15

Medical History Part 3

continued

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

If yes for angina, proceed to I1.

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

☐ **Yes** ☐ **No**

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

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

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

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

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

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

16 Authorization to Obtain and Disclose Information

Each of the undersigned hereby certifies and represents as follows:

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

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

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

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

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

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

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

TAXPAYER IDENTIFICATION CERTIFICATION

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

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

16 Authorization to Obtain and Disclose Information

continued

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

The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

__ __ / __ __ / __ __ __ __

Signature of Proposed Insured	Date (mm/dd/yyyy)	City	U.S. State / Territory

__ __ / __ __ / __ __ __ __

Signature of Parent or Legal Guardian (Of children under age 16)	Date (mm/dd/yyyy)	City	U.S. State / Territory

__ __ / __ __ / __ __ __ __

Signature of Applicant/Owner (If other than Proposed Insured)	Date (mm/dd/yyyy)	City	U.S. State / Territory

Title of Trust (If owner is trust)	Trustee First Name	Trustee Last Name

Print Producer 1 Name	Producer 1 Number	Producer 1 Signature

Print Producer 2 Name	Producer 2 Number	Producer 2 Signature

17 Other Insurance (to be completed by the Producer)

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No** Explain

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

Producer Signature

NOTICE OF DISCLOSURE

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

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

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

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

MIB GROUP, INC. (MIB) PRE-NOTIFICATION

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

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

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

NOTICE OF INSURANCE INFORMATION PRACTICES

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

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

CONDITIONAL RECEIPT

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

Conditions of Coverage

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

Effective Date

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

Agent's Report

1

	Writing Agent Name	Agent Number	Profile Number	Percent of Agent's Split
Producer 1 →				
Producer 2 →	Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split
Producer 3 →	Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split
Producer 4 →	Split Agent Name	Agent Number	Profile Number	Percent of Agent's Split

2

Agent Disclosure

How long have you known the Proposed Primary Insured?

Relationship to Proposed Primary Insured

Are you financially responsible for the Proposed Primary Insured?

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

If yes →

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

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

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

☐ **Yes** ☐ **No**

If yes →

Name and address of Broker/Dealer

City	U.S. State / Territory	Zip Code

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

☐ **Yes** ☐ **No** ☐ **N/A**

Please indicate how this sale was taken:

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

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

☐ **Yes** ☐ **No**

Type of Government issued photo ID

Issuer of Identification Document	Number	Expiration Date

3 Correspondence Information

Case Manager Name (if applicable)

Agent/Case Manager Email	Office ID

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

4 Signature

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

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

__ __ / __ __ / __ __ __ __

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

Reset Form

TRANSAMERICA®

Payment Authorization Form

Introduction

Instructions:
Use this form to choose the initial premium payment method on your application for insurance or to update how you pay for an existing policy. Take care to fill in each field accurately so letters and numbers cannot be misinterpreted and attach a separate sheet if there is more than one policy number. Note that not all payment options are available on all products.

Return Completed Form To:
Transamerica Life Insurance Company
Transamerica Financial Life Insurance Company
6400 C St. SW
Cedar Rapids, IA 52499

Or fax it to us at:
1-800-235-4782

Questions?

Contact your Financial Professional

Visit us at:
transamerica.com

Call us at:
1-800-pyramid

Policy Number (for existing policies only)

Insured First Name

Insured Last Name

Draft Date (MM/DD, 1st through 28th only)

__/__

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

Total Premium

$___,___.___

Recurring Payment Frequency (choose one)

☐ **Monthly** ☐ **Quarterly** ☐ **Semiannually** ☐ **Annually**

Please select your preferred payment type/s by checking the box for initial and/or recurring payments next to the option you favor. (Ex: I want to make my initial payment by check and recurring payments with my credit card.)

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/ EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Social Security Benefits Billing (SSB)	☐ **Initial** ☐ **Recurring**	Complete the SSB Option info on the next page. To pay by SSB Card, tokenize the card # and fill out the Credit Card Payment section; or for direct SSB account draft, fill out the Bank Draft Payment section.
Credit Card	☐ **Initial** ☐ **Recurring**	Tokenize your card number, and complete the Credit Card Payment section below
Check	☐ **Initial**	No additional form required; mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	No additional form required; this method only available quarterly, semiannually, or annually. Bills are generated 30 days prior to due date.

If using Social Security Benefits for either form of payment, please enter payer date of birth and then select one:

Payer date of birth

__/__/__

☐ Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)

☐ Benefit 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)

Credit Card Payment Information

Credit Card Type: ☐ **VISA** ☐ **MasterCard**

PCI Token #

Create your PCI token at: creditcardtoken.transamerica.com *(Reminder: When you enter your credit card information on the Token website, your unique number will start with a "T". Be sure to write the full number, including the T, on the line at left.)*

Cardholder First Name

Cardholder Last Name

Card Exp.Date __/__

Payment Amount $___,___.___

The cardholder is the (choose one):

☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

X _____

By signing I acknowledge that I have read and agreed to all of the following consents that pertain to my preferred premium payment method.

Bank Draft (ACH/EFT) Payment Information

Account Type: ☐ **Checking** ☐ **Savings**

Account Holder First Name

Account Holder Last Name

Trust or Entity (if entity, add the title of officer and name of entity; if trust, add trustee's name)

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

The account holder is the (choose one):

☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Account Holder Signature:

X _____

By signing I acknowledge that I have read and agreed to all of the following consents that pertain to my preferred premium payment method.

Consents

If a conditional receipt was issued along with this authorization, initial premium will be withdrawn/cashed upon receipt of the application by the Company. Unless a conditional receipt was issued along with this authorization, I/we agree this authorization shall not become effective for payment of the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in the application have been met.

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

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

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

Distributions Will Be Subject to Identity Verification
To help ensure the security of your funds, if bank account information is provided, the Company may obtain a consumer report from a Consumer Reporting Agency (“CRA”) to help verify the validity and accuracy of the account information provided. If I have provided the company with bank account information, I authorize the Company to obtain a consumer report from the CRA as described above, and acknowledge that I: (1) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA; and (2) consent to such sharing, retention, and use.

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Website (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax advisor.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

Date	Applicant Signature
Date	Agent Signature

TRANSAMERICA®
LIFE INSURANCE COMPANY
Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road N.E.
Cedar Rapids, IA 52499

Notice To Applicant Regarding Replacement Of Long-Term Care Insurance Or Life Insurance Including Accelerated Death Benefits

According to information you have furnished, you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by Transamerica Life Insurance Company. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

(1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.

(2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____ _____

Date Applicant's Signature

Note: One copy of notice shall be retained by the applicant and one signed copy shall be retained by the Company.

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

❑ Additional or different benefits (please specify) _____ .
❑ No change in benefits, but lower premiums.
❑ Fewer benefits and lower premiums.
❑ Other (please specify) _____ .

_____ _____

Date Applicant's Signature

_____ _____

Date Signature of Agent/Insurance Producer, Broker or Other Representative

_____ _____

Date Type or print Name & Address of Agent/Insurance Producer, Broker

TRANSAMERICA®

Revised April 30, 2021

CALIFORNIA CONSUMER PRIVACY ACT NOTICE

At Transamerica, it is important to us that you understand how we use and share your personal information. This California Consumer Privacy Act ("CCPA") notice ("Notice") outlines our use and disclosure of personal information. This Notice identifies the categories of personal information we collect, describes how we use and share personal information, and explains how California residents can make certain requests regarding their personal information.

Categories of Information Collected

The categories of personal information we collect about you depend on what you share with us, the product(s) you have purchased from us, and the service(s) you receive from us. Below, we describe the categories of personal information we have collected in the last 12 months and how we disclose this information to third parties:

- Identifiers such as name, postal address, date of birth, email address, social security number, driver's license number, passport number, or other information that identifies you
- Demographic and other information considered to be protected classifications under federal or California law, such as age, race, disability, criminal history, marital status or medical condition
- Personal information as defined in the California customer records law such as signature; insurance or other policy number; financial information, including as submitted by you related to your specific financial condition, accounts or assets, or which relate to a product sold, serviced or issued by us; and health, prescription or medical information you have provided to us or authorized us to access
- Commercial information, such as transaction information and purchase history, and information relating to your business and property interests
- Biometric information such as a voice recording; Internet or network activity information, such as search and browsing history, login credentials, IP address, and device and advertising identifiers
- Geolocation data
- Audio information such as a voice recording
- Professional or employment-related information, such as past and present work history, affiliations, education and employment
- Inferences which we may generate or acquire relating to your preferences, attitudes, characteristics or behaviors

Sources from Which Personal Information is Collected

We collect these categories of personal information from a variety of sources, including yourself and other sources authorized by you either on this Site or via processing/servicing a product or an application for a product, for example, from your doctor, financial advisor, or credit reporting agency, or other sources needed to underwrite or issue a product or complete a transaction. Internet information may be collected from devices you use to access our websites and services (including through cookies and similar technologies). Inferences and other categories of personal information may be collected from third parties such as social media providers, advertising networks, marketing and analytics providers, and data brokers. More details may be found in our Online Privacy Statement (www.transamerica.com/privacy-policy) (see "What Data We Collect About You and How").

Business or Commercial Purposes of Use of Personal Information

We may use personal information for business or commercial purposes including: i) evaluating eligibility for products or services; ii) administering our products, providing services, and delivering content; iii) product pricing, development, and quality assurance; iv) actuarial and research studies, and other technological development and analytics; v) legal and regulatory filings, auditing, and compliance; vi) identity verification, fraud prevention, and information security; vii) supporting, debugging, and maintaining information systems; viii) marketing, advertising, promotions, and sales; and, ix) other operational purposes compatible with the uses related to your initial disclosure. More details may be found in our Online Privacy Statement (see "How We May Use the Data We Collect").

To Which Categories of Third Parties is Information Disclosed or "Sold"?

Information included under the categories listed above is disclosed to affiliates, to service providers, as authorized by you, or as required by law. This includes: companies who help us process claims, maintain accounts, and support marketing and sales; credit bureaus; insurance regulators, law enforcement, government authorities and third parties in response to legal

processes or to determine eligibility for public benefits; health care professionals (e.g., to verify coverage or provide information relating to a medical condition); other insurance companies (including successor insurers), agents and insurance support organizations to coordinate benefits or in connection with insurance transactions involving you; group policyholders (e.g., regarding claims experience, benefits administration or service audits); certificate or policyholders (e.g., regarding the status of an insurance transaction); those with a legal or beneficial interest in your assets (e.g., a creditor); employer or plan sponsor (e.g., to support administration of employee accounts as permitted by law); your representatives and lawyers; to prevent or prosecute fraud or crime; to researchers or professional advisers (such as for actuarial or research studies); and to a purchaser, underwriter, or others in connection with the sale or merger of all or part of our business. Some information in the following categories may be "sold", as defined under California law, to third-party marketing and analytics partners, including to other financial institutions for joint marketing, including via cookies or similar technologies, and in connection with targeted advertising efforts: identifiers, protected classifications, geolocation data, and inferences.

Sales of Minors' Personal Information

We do not sell the personal information of individuals we know to be under the age of 16.

Your California Consumer Privacy Rights

As a California resident, you have certain rights to make requests regarding your personal information ("Consumer Requests"):

1) Right to Know: You have the right to request that we disclose what personal information we collect, use, disclose, and sell, including: i) specific pieces of information that we have collected about you; ii) categories of personal information we have collected about you; iii) categories of sources from which the personal information is collected; iv) categories of personal information about you that we sold or disclosed for a business purpose; v) categories of third parties to whom the personal information was sold or disclosed for a business purpose; and vi) the business or commercial purpose for collecting or selling personal information. You may make a request to know by going to: www.transamerica.com/show-me-my-info.

2) Right to Delete: You have the right to request that we delete personal information we have collected about you, subject to Transamerica's legal rights or obligations to retain such personal information. You may make a deletion request by going to: www.transamerica.com/delete-my-info.

3) Right to Opt-Out: You have the right to opt out of the "sale" of your personal information. You may opt-out by going to: www.transamerica.com/do-not-sell-my-info.

You can also make a Consumer Request by calling Transamerica, toll-free, at 877-247-2401.

Transamerica publishes its response metrics related to Consumer Requests at the following link: www.transamerica.com/CCPA-metrics.

Verification Process & Authorized Agents

Upon receipt of a Consumer Request, we will seek to verify your identity to our reasonable satisfaction before responding. This may require you to submit personal information to us during the verification process. You may authorize another individual to submit a Consumer Request on your behalf through the means indicated above. We may require the authorized agent to provide proof of your signed permission to submit the request and may require you to do one of the following: i) verify your identity directly with the us; or ii) directly confirm to us that you have provided the authorized agent permission to submit the request.

Non-Discrimination

You have the right to be free from unlawful discrimination for exercising your privacy rights under the CCPA. In response to your exercise of your rights, we may not: i) deny goods or services; ii) charge different prices or rates for goods or services, including through discounts or other benefits, or imposing penalties; iii) provide a different level of quality of goods or services; or iv) suggest that you will receive a different price or rate for goods or services, or a different level or quality of goods or services. We may, however, charge different prices or rates, or provide a different level or quality of goods or services, if that difference is reasonably related to the value provided to us by your personal information. We may limit our response to your rights as permitted by applicable law.

Contact Us

If you have questions or any concerns, please call our toll-free number: 877-247-2401 or reach out to us via email: consumerdatarequest@transamerica.com.

TRANSAMERICA®
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: 6400 C Street SW
Cedar Rapids, IA 52499

Accelerated Death Benefit Rider Replacement Question

Section I - Proposed Owner

First	Middle	Last	Soc. Sec. No.
			- -

Section II - Proposed Insured

First	Middle	Last	Soc. Sec. No.
			- -

Section III - Replacement Question

You are applying for a life insurance policy with accelerated death benefit riders. By applying for this policy, do you intend to replace any stand-alone long term care (LTC) insurance policy or any life insurance policy with a LTC Insurance rider currently in force?
❑ Yes ❑ No

I, the Proposed Insured, and I, the Proposed Owner if different, hereby represent that the statements and answers given in this supplement form are true and complete to the best of my/our knowledge and belief.

Signed at _____ on _____ / _____ / _____
(City and State) (Month) (Date) (Year)

_____
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor)

Signed at _____ on _____ / _____ / _____
(City and State) (Month) (Date) (Year)

_____
Signature of Owner (if other than proposed Insured)

Signed at _____ on _____ / _____ / _____
(City and State) (Month) (Date) (Year)

_____
Signature of Licensed Producer

Schedule of Social Security Benefit Payments 2022

JANUARY 2022						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

FEBRUARY 2022						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28					

MARCH 2022						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL 2022						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2022						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 2022						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2022						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

AUGUST 2022						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2022						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2022						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER 2022						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER 2022						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

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

Supplemental Security Income (SSI)

If you received Social Security before May 1997 or if receiving both Social Security & SSI, Social Security is paid on the 3rd and SSI on the 1st.

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

Securing today and tomorrow

SSA.gov

Social Security Administration
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