

**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:

- 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 Company noted above (the "Company")], 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.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
- 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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Company, 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 Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in its 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 Company 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 Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's 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 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.**

**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:

- 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 Company noted above (the "Company")], 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.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
- 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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Company, 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 Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in its 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 Company 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 Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's 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 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

GA # \_\_\_\_\_  
**Individual Life Insurance  
Application For One Life  
Part 1**

**Proposed Insured:** \_\_\_\_\_  
First Middle Last Suffix Mr./Mrs./Ms./Dr.  
Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Birth Place: \_\_\_\_\_ Male ☐ Female ☐  
Mo. Day Yr.  
Soc. Sec. No.: \_\_\_\_\_ U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire  
Employer: \_\_\_\_\_ Area Code & Work Phone \_\_\_\_\_  
Occupation: \_\_\_\_\_  
Annual Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_  
Residence: \_\_\_\_\_  
No. & Street (Cannot be a P.O. Box) City State Zip Country Area Code & Home Phone \_\_\_\_\_  
Owner's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
(If other than Proposed Insured) Mo. Day Yr.  
If Trust, provide name and date of Trust: \_\_\_\_\_  
Relationship to Proposed Insured: \_\_\_\_\_  
Address: \_\_\_\_\_  
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No. \_\_\_\_\_  
U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: \_\_\_\_\_ E-mail: \_\_\_\_\_  
(Not for Policy/Billing Notices)  
Beneficiary's Name and Relationship to Proposed Insured: \_\_\_\_\_

Address: \_\_\_\_\_  
No. & Street (Cannot be a P.O. Box) City State Zip Country Date of Trust, if Applicable \_\_\_\_\_

1. Plan Applied For: \_\_\_\_\_ Kind Code: \_\_\_\_\_
2. Risk Classification: Preferred Plus/Select ☐ Preferred ☐ Standard Plus ☐ Standard ☐  
Extra Rating of ☐ \_\_\_\_\_ Other ☐ \_\_\_\_\_
3. Nicotine Classification: Nicotine ☐ Non-Nicotine ☐
4. Amount Applied For \$ \_\_\_\_\_
5. Additional Benefits by Rider: ☐ Waiver of Premium/Waiver Provision ☐ Accident Indemnity \$ \_\_\_\_\_ ☐ Other \_\_\_\_\_ \$ \_\_\_\_\_
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Other \_\_\_\_\_  
☐ PAC ☐ Direct Bill
7. Complete for Flexible Premium Plans:  
Required Premium Per Year (RAP) \$ \_\_\_\_\_  
Planned Periodic Premium \$ \_\_\_\_\_  
+ Initial Lump Sum \$ \_\_\_\_\_  
= Total Initial Premium \$ \_\_\_\_\_
8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ☐ Yes ☐ No (APL will be in effect unless no is checked.)
9. Do you have any existing life insurance or annuities? If none, check this box ☐. If yes, please list the policies below.
- a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.
- | Type of Coverage (Personal / Business / Employer Provided / Group) | Company/Policy Number | Face Amount | Replacement?   |
|--|-----------------------|-------------|--|
|  |                       | \$          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |                       | \$          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|  |                       | \$          | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- b. Total Accidental Death insurance inforce with all companies: \$ \_\_\_\_\_



10. Is any application for life insurance pending with any other company? ☐ Yes ☐ No  
If yes, give company name, amount applied for and total amount to be placed. \_\_\_\_\_
11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? ☐ Yes ☐ No If yes, give insurance company name, owner's name, and amount of insurance of each policy.  
\_\_\_\_\_

12. Mail Additional Premium Notices To: \_\_\_\_\_  
Address: \_\_\_\_\_  
No. & Street City State Zip Country

**Yes No "You" means any person proposed to be insured.**

- ☐ ☐ 13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
- ☐ ☐ 14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
15. Have you used nicotine at any time? Date Last Used
- ☐ ☐ Cigarettes \_\_\_\_\_
- ☐ ☐ Cigar/Pipe/Chewing Tobacco \_\_\_\_\_
- ☐ ☐ Other \_\_\_\_\_
16. Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_  
In the past five years, have you been convicted of or pleaded guilty to:
- ☐ ☐ a. Moving violations? If yes, give dates and type. \_\_\_\_\_
- ☐ ☐ b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. \_\_\_\_\_
- ☐ ☐ c. Reckless driving? If yes, give dates. \_\_\_\_\_
- ☐ ☐ 17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
- ☐ ☐ 18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
- ☐ ☐ 19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
- ☐ ☐ 20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

**Remarks:** Give details for any questions answered yes

---

---

---

---

---

---

---

---

**I, the Proposed Insured, and I, the Owner if different, hereby represent** that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief. **I/we agree:** (1) this application shall consist of Part 1, Part 2, and any required application supplement(s)/ amendment(s), and shall be the basis for any contract issued on this application; (2) except as otherwise provided in the conditional receipt, if issued, with the same Proposed Insured as on this application, any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.



\* D T O O 9 \*

## NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to you under Section 101(j) of the Internal Revenue Code to the extent it exceeds the premiums and other considerations paid by you for the policy unless the written Notice and Consent is obtained **prior to policy issue** and certain other requirements of such section are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

## AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 26 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 acknowledge** receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. ☐ Yes ☐ No

**PLEASE MAKE CHECKS PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.**

Amount paid with this Application \$ \_\_\_\_\_ ☐ Check # \_\_\_\_\_ ☐ Credit Card (Complete Credit Card Order Confirmation Form)

**Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.**

Signed at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
City-State Date

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
City-State Date

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Owner (if other than Proposed Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner, give corporate title and full name of corporation below.

\_\_\_\_\_  
X \_\_\_\_\_  
Signature of Licensed Producer

(NOT PART OF APPLICATION)

**REPORT BY AGENCY OFFICE**

DATE: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_ OFFICE ID#: \_\_\_\_\_

CASE MANAGER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PRODUCER 1: \_\_\_\_\_ SHARE %: \_\_\_\_\_  
LAST FIRST

OFFICE ID #: \_\_\_\_\_ PRODUCER ID #: \_\_\_\_\_ PRODUCER PROFILE #: \_\_\_\_\_  
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 2: \_\_\_\_\_ SHARE %: \_\_\_\_\_  
LAST FIRST

OFFICE ID #: \_\_\_\_\_ PRODUCER ID #: \_\_\_\_\_ PRODUCER PROFILE #: \_\_\_\_\_  
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 3: \_\_\_\_\_ SHARE %: \_\_\_\_\_  
LAST FIRST

OFFICE ID #: \_\_\_\_\_ PRODUCER ID #: \_\_\_\_\_ PRODUCER PROFILE #: \_\_\_\_\_  
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

Indicate City/County Code as required in AL, GA, KY, LA, & SC \_\_\_\_\_

What is the purpose for insurance? \_\_\_\_\_

Are you related to the Proposed Insured? ☐ Yes ☐ No Relationship \_\_\_\_\_

How long have you known the Proposed Insured? \_\_\_\_\_

Proposed Insured is: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Yes ☐ No To the best of your knowledge, does the applicant have any existing life insurance or annuities?

☐ Yes ☐ No To the best of your knowledge, could replacement be involved?

X

Signature of Producer

**PRE-AUTHORIZED CHECK/WITHDRAWAL PLAN ("PAC")**

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 Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

- ☐ **MONTHLY** (This will be elected if no box is checked)  
☐ **QUARTERLY**  
☐ **SEMI-ANNUAL**  
☐ **ANNUAL**

- ☐ **PREMIUM**  
☐ **LOAN REPAY**  
☐ **SAVINGS**  
☐ **CHECKING**

- ☐ **NEW AUTHORIZATION**  
☐ **BANK CHANGE**  
☐ **ADD TO EXISTING POLICY**  
☐ **OTHER** \_\_\_\_\_

**PICK A DATE TO DRAFT (1-28)** \_\_\_\_\_

**NAME OF FINANCIAL INSTITUTION:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**ACCOUNT NUMBER:** \_\_\_\_\_

**NAME(S) ON BANK ACCOUNT:** \_\_\_\_\_

**ROUTING#:** \_\_\_\_\_

**AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM**

I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements or riders), or as agreed to by me, and for such other payments as I may authorize the Company to make. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on the earliest due date. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this authorization in no way affects the terms of the policy, other than the mode of payment, and I understand that if the premiums are not paid within the grace period allowed by a policy, as in the event any such withdrawal being dishonored, or for any reason, then the policy shall terminate subject to any nonforfeiture provisions in the policy.

**AUTHORIZATION TO HONOR PAC WITHDRAWALS**

As a convenience to me, I hereby request the financial institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company and/or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these authorizations.

\_\_\_\_\_  
BANK SIGNATURE(S) OF DEPOSITOR(S)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR

TAPE VOIDED CHECK HERE



\* D T O 8 4 \*  
TG-NF

## NOTICE OF DISCLOSURE OF INFORMATION

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](http://www.mib.com).

**Notice to Persons Applying for Insurance:** Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

**Notice of Insurance Information Practices:** The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499.



## INSTRUCTIONS FOR CONDITIONAL RECEIPT

### DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

1. any Proposed Insured has been treated for or experienced, within the last 12 months, any disorder of the heart, stroke, or other vascular disease, cancer, or HIV infection, or
2. any Proposed Insured is under the age of 16 or over the age of 75, or
3. the amount applied for under the attached application exceeds \$2,000,000.

IF ANY PROPOSED INSURED IS NOT DISQUALIFIED BY ONE OR MORE OF THE FACTORS LISTED IN 1 - 3 ABOVE, YOU MAY COLLECT MONEY AT THE TIME THE APPLICATION PART 1 IS COMPLETED.

**Make all checks payable to Transamerica Life Insurance Company. Do not make checks payable to the insurance producer or leave the payee blank, otherwise this Receipt cannot become effective. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application (2 months' premium for Monthly Pre-Authorized Withdrawal Plan). For credit card payments, complete a Credit Card Order Confirmation Form.**

**CONDITIONAL RECEIPT**  
**PLEASE READ THIS CAREFULLY**

Received from \_\_\_\_\_, the sum of \$\_\_\_\_\_ for the life insurance application dated \_\_\_\_\_, with \_\_\_\_\_ as the Proposed Insured.

**This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.**

**This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.**

**CONDITIONAL COVERAGE:** Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

**CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT:** Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete to the best of my knowledge and belief; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

**60-DAY LIMIT OF CONDITIONAL COVERAGE:** If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

**DOLLAR LIMITS OF CONDITIONAL COVERAGE:** The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or \$1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, \$400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or \$100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

**IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT.** If one or more of this Receipt's conditions have not been met exactly, or if a Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

**Except as provided in this Conditional Receipt,** no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

**ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT**

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

X _____ Signature of Proposed Owner If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust below.	_____, 20____ Date If Proposed Owner is a Corporation, an authorized officer, other than the Proposed Insured must sign as Owner. Give corporate title and full name of corporation below.
--	--

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

**Submit this completed and signed original with the application and payment.**

Original



**CONDITIONAL RECEIPT  
PLEASE READ THIS CAREFULLY**

Received from \_\_\_\_\_, the sum of \$ \_\_\_\_\_ for the life insurance application dated \_\_\_\_\_, with \_\_\_\_\_ as the Proposed Insured.

**This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.**

**This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.**

**CONDITIONAL COVERAGE:** Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

**CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT:** Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete to the best of my knowledge and belief; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

**60-DAY LIMIT OF CONDITIONAL COVERAGE:** If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

**DOLLAR LIMITS OF CONDITIONAL COVERAGE:** The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or \$1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, \$400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or \$100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

**IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT.** If one or more of this Receipt's conditions have not been met exactly, or if a Proposed Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the Proposed Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

**Except as provided in this Conditional Receipt,** no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at \_\_\_\_\_ on \_\_\_\_\_, 20\_\_\_\_ ☒ \_\_\_\_\_  
City, State Date Insurance Producer or other Company Authorized Rep

---

**ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT**

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

**Leave this page with the proposed Owner if money is submitted with application**

Proposed Owner



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

## Beneficiary/Additional Insured Information Form

<b>PRIMARY INSURED</b>				
1. Last Name		First Name		2. SS# Last 4 Digits
<b>OWNER - if other than Primary Insured</b>				
1. Last Name		First Name		2. TIN/SS# Last 4 Digits
<b>ADDITIONAL/OTHER PROPOSED INSURED - if applicable</b>				
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	
<b>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.</b>				
Name / Address		DOB	Percent	Relationship
				Phone # SSN / Tax ID#
<b>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.</b>				
Name / Address		DOB	Percent	Relationship
				Phone # SSN / Tax ID#
<b>AGENT</b>				
<input type="checkbox"/> 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	

---

---

**YOU HAVE THE RIGHT TO NAME A SECONDARY ADDRESSEE  
ON YOUR LIFE INSURANCE POLICY TO RECEIVE NOTICE  
OF LAPSE OR TERMINATION OF THIS POLICY  
WHEN DUE TO NONPAYMENT OF PREMIUM.**

Please complete the following information to add a secondary addressee on your policy.

**SECONDARY ADDRESSEE:**

Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone Number \_\_\_\_\_

Signature of  
Secondary Addressee \_\_\_\_\_

Date \_\_\_\_\_

**POLICY INFORMATION:**

Insured \_\_\_\_\_

Owner \_\_\_\_\_

Owner's Address \_\_\_\_\_  
\_\_\_\_\_

Policy Number(s) \_\_\_\_\_

Signature of Owner \_\_\_\_\_

Date \_\_\_\_\_

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

**Notice and Consent for  
HIV-Related Testing  
CALIFORNIA**

---

---

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. It may take a few weeks to many years for symptoms to appear but they usually include fever, diarrhea, tiredness and enlarged lymph glands.

To evaluate your insurability, the Insurer designated above (the “Insurer”) has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of HIV antibodies. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body’s way of fighting the infection. By signing and dating this Consent, you agree that this test may be done.

### **The HIV Antibody Test**

A series of tests will be performed by a licensed laboratory through a medically accepted procedure. The most commonly used tests are the ELISA or “EIA” and the Western blot. If the ELISA shows the sample is positive for HIV, then the Western blot is done to confirm that initial result.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally the test may be negative in persons who are infected with HIV.

### **Meaning of Test Results**

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

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

### **Counseling**

Many public health organizations have recommended that before taking an HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your physician or health care provider. A list of counseling resources is provided for your information. Other counseling services may also be available to you.

**Notice and Consent for  
HIV-Related Testing  
CALIFORNIA**

**Confidentiality of Test Results**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting or claims decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer. Negative test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date you sign this Consent.

**Notification of Test Results**

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your physician or health care provider so that the Insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked "Personal & Confidential", at your residence address.

\_\_\_\_\_  
Name of Health Care Provider

\_\_\_\_\_  
Street

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
City, State, Zip Code

**Other Sources of Information**

As required by California law, the following list of counseling resources is being provided to you.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross for further information.

**HIV/AIDS HOTLINE - National**

(800) 342-2437 English  
(800) 222-9432 Spanish  
(800) 243-7889 TTY/TDD users

**AIDS HOTLINE WEB SITE**

<http://www.aidshotline.org>

**HIV/AIDS HOTLINE - California**

(800) 367-2437 English, Spanish & Filipino  
(888) 225-2437 TTY users

**Consent**

**I have read and I understand this *Notice and Consent for HIV-Related Testing* which may include AIDS Virus (HIV) Antibody/Antigen testing. I voluntarily consent to provide a sample of my bodily fluid(s), the testing of my bodily fluid(s) for HIV antibodies, and disclosure of the test results as described.**

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Proposed Insured (*Please Print*)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date Signed

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. It may take a few weeks to many years for symptoms to appear but they usually include fever, diarrhea, tiredness and enlarged lymph glands.

To evaluate your insurability, the insurer named above (the "Insurer") has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of HIV antibodies. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body's way of fighting the infection. By signing and dating this Consent, you agree that this test may be done.

## **The HIV Antibody Test**

A series of tests will be performed by a licensed laboratory through a medically accepted procedure. The most commonly used tests are the ELISA or "EIA" and the Western blot. If the ELISA shows the sample is positive for HIV, then the Western blot is done to confirm that initial result.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally the test may be negative in persons who are infected with HIV.

## **Meaning of Test Results**

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

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

## **Counseling**

Many public health organizations have recommended that before taking an HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your physician or health care provider. A list of counseling resources is provided for your information. Other counseling services may also be available to you.



# Notice and Consent for HIV-Related Testing California

## Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting or claims decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer. Negative test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date you sign this Consent.

## Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your physician or health care provider so that the Insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked "Personal & Confidential", at your residence address.

Name of physician or health care provider:

\_\_\_\_\_

Street

\_\_\_\_\_

City, State, Zip Code

\_\_\_\_\_

## Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing*. I voluntarily consent to provide a sample of my bodily fluid(s), the testing of my bodily fluid(s) for HIV antibodies, and disclosure of the test results as described.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Name of Proposed Insured (*Please Print*)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date Signed



## Counseling Resources List

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Transamerica Life Insurance Company (TLIC). Therefore, TLIC makes no representations or warranties that this information is accurate as of the date you receive this list. Also, TLIC makes no representations or warranties about the quality or nature of any services these resources may provide.

This is not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross for further information.

### **HIV/AIDS HOTLINE — National**

(800) 342-2437 English  
(800) 222-9432 Spanish  
(800) 243-7889 TTY/TDD users

### **HIV/AIDS HOTLINE - California**

(800) 367-2437 English, Spanish & Filipino  
(888) 225-2437 TTY users

### **California Dept. of Health Services**

(916) 449-5905

### **Alameda County HIV/AIDS Services**

(510) 873-6500

### **Contra Costa County AIDS Program**

(925) 313-6771

### **Fresno County Human Health Services**

(559) 445-3434

### **Kern County Dept. of Health**

(661) 868-0503

### **Los Angeles County**

(213) 351-8000  
Long Beach (562) 570-4320  
Pasadena (626) 794-6025

### **Marin County HIV Services**

(415) 499-7804

### **Monterey County Dept. of Health**

(831) 647-7932

### **Orange County Health Care**

(714) 834-7700

### **Riverside County HIV/AIDS Hotline**

(800) 243-7275 or (909) 358-5307

### **Sacramento County Department**

(916) 874-7720

### **San Bernardino County Health Department**

(800) 255-6560 or (909) 383-3060

### **San Diego County Office of AIDS Coordination**

(619) 296-3400

### **San Francisco**

(415) 863-2437

### **San Joaquin County AIDS Project**

(209) 468-3821

### **San Luis Obispo County - HIV Prevention Project**

(800) 544-6016 or (805) 781-5540

### **San Mateo County AIDS Program**

(650) 573-2588

### **Santa Barbara County Public Health Department**

(805) 681-5120

### **Santa Clara - HIV/AIDS Prevention Program**

(408) 494-7870

### **Santa Cruz County - AIDS Project Program**

(831) 427-3900

### **Solano County Public Health**

Fairfield (707) 428-1131  
Vallejo (707) 553-5331

### **Sonoma County**

(707) 545-4551

### **Stanislaus County HIV/STD Program**

(209) 558-8866

### **Ventura County Public Health Services**

(805) 652-6583



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

## Terminal Illness Accelerated Death Benefit Disclosure

You may request an accelerated death benefit when the Insured has been diagnosed with a Terminal Illness. A Terminal Illness is a medical condition, resulting from injury or disease which, as diagnosed by a Physician, has reduced life expectancy to not more than 12 months from the date of the Physician's diagnosis. We must receive written proof of the Insured's Terminal Illness before we make an accelerated death benefit payment. We reserve the right to seek a second medical opinion or have the Insured examined at our expense by a Physician we choose.

We will pay an accelerated death benefit upon due proof that the Insured has a Terminal Illness, subject to the following conditions:

1. The Terminal Illness is first diagnosed on or after the Endorsement Date; and
2. The policy and endorsement are in force at the time of the accelerated death benefit request; and
3. The Face Amount of the policy at the time the accelerated death benefit request is received is at least \$25,000; and
4. At the time you request to exercise the accelerated death benefit, there must be at least two (2) years remaining before the Expiry Date of the policy;
5. We receive written proof of the Insured's Terminal Illness satisfactory to us, including a Physician's certification; and
6. We receive a consent form signed by all irrevocable beneficiaries and all assignees in a form acceptable to us.

An administrative fee will be deducted from the present value of each accelerated death benefit amount requested. As of the Endorsement Date, the administrative charge is \$350. The administrative charge will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index (CPI) since 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used.

The maximum death benefit you may accelerate is equal to the lesser of:

1. 100% of the Face Amount of the policy; or
2. \$1,500,000, including all other accelerated death benefit amounts previously elected or currently under review under all policies, endorsements or riders issued by us on the life of the Insured.

The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the accelerated death benefit is paid will also be reduced. The reduced premium will equal the appropriate premium rate applied to the reduced Face Amount plus any applicable policy fee. We will provide you with information showing the reduced Face Amount resulting from the accelerated death benefit payment.

### RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE AND YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.

By signing below, you agree that you have read the above and received a copy of this disclosure form.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner's (Applicant's) Signature

\_\_\_\_\_  
Agent's Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**



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

## Chronic Illness and Critical Illness Accelerated Death Benefit Disclosure

This disclosure form provides a brief description of the accelerated death benefit options available under your policy. For details regarding your rights and obligations under the policy, please read your policy carefully. Accelerated benefits are payments made to you during the lifetime of the Insured in lieu of payment of the full death benefit of the policy.

*Chronically Ill* means the Insured:

- (a) Is unable to perform without Substantial Assistance from another person for a period of at least 90 days, at least two out of six Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or
- (b) Requires Substantial Supervision by another person, for a period of at least 90 consecutive days, to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

*Critically Ill* means the Insured has been diagnosed with a medical condition that would, in the absence of treatment, result in the Insured's death within 12 months.

**Conditions Under which Accelerated Benefits May be Elected:** If the Insured becomes Critically Ill or Chronically Ill while this policy is In Force, you may elect to receive an Accelerated Death Benefit payment subject to the provisions of the policy and the following conditions:

1. You must provide us with the required certification applicable to the requested form of Accelerated Death Benefit.
2. This policy must be In Force at the time of your Accelerated Death Benefit request; and
3. The Face Amount of this policy at the time the Accelerated Death Benefit request is received must be at least \$25,000; and
4. The waiting period must have expired; and
5. We must receive the consent of all irrevocable beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

**Amount of Benefit:** The Accelerated Death Benefit payment we make to you will be less than the amount of the death benefit which you request to accelerate. The Accelerated Death Benefit payment for the amount of the death benefit which you request to accelerate will be calculated as  $A - B - C - D$  where A, B, C, and D are determined as follows:

- A. The present value of the amount of the death benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your rider(s) form.
- B. Any due or unpaid premium if we make payment during the grace period.
- C. The actuarial present value of future premiums, excluding rider premiums that would otherwise be payable to keep this policy In Force during the period of the Insured's remaining lifetime at time of the acceleration, using the applicable rated age, mortality table, and interest rate.
- D. An administrative charge for each Accelerated Death Benefit request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2014 is \$350, but will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index for All Urban Consumers (CPI) since January 1, 2014. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used.

If we approve your request for a Chronic Illness Accelerated Death Benefit or Critical Illness Accelerated Death Benefit, the amount that may be payable will be based in part on the Insured's remaining life expectancy at the time of the acceleration. The longer the Insured's remaining life expectancy, the lower the payment amount will be. The shorter the Insured's remaining life expectancy, the higher the payment amount will be.

**Maximum Benefit:** The maximum death benefit you may accelerate over the lifetime of the Insured is equal to the lesser of:

- 1. 90% of the Face Amount of this policy; or
- 2. \$1,500,000 including all other Accelerated Death Benefits previously elected or currently under review under all policies, endorsements or riders issued by us or our affiliates on the life of the Insured.

The maximum death benefit you may accelerate in any 12 month period because the Insured is Chronically Ill is 24% of the Face Amount of the policy at the time of the initial acceleration.

**Effect of Benefit on Policy:** The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the Accelerated Death Benefit is paid will be adjusted. The adjusted premium will equal the appropriate premium rate applied to the reduced Face Amount plus any applicable policy fee. We will provide you with information showing the reduced Face Amount resulting from the Accelerated Death Benefit payment.

As an example of the impact that election of an Accelerated Death Benefit has on policy values, consider the following situation:

Prior to Election		Upon Partial Election of 50% of Face Amount		Upon Full Election	
Face Amount	= \$200,000	Remaining Face Amount	= \$100,000	Face Amount	= \$20,000
Annual Premium	= 4,000	Remaining Annual Premium	= 2,000	Annual Premium	= 400

**Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.**

By signing below, you agree that you have read the above and received a copy of this disclosure form.

\_\_\_\_\_

Date

\_\_\_\_\_

Owner's (Applicant's) Signature

\_\_\_\_\_

Agent's Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**

**Transamerica Life Insurance Company  
Transamerica Financial Life Insurance Company**

**Consent to do Business Electronically and Electronic Delivery of  
and/or Access to Policy Documents**

**What is the purpose of this Consent and Disclosure?**

You are applying for an insurance policy ("Policy") from either Transamerica Life Insurance Company or Transamerica Financial Life Insurance Company (either individually or collectively, "Transamerica") and have expressed your desire to conduct business electronically and for electronic delivery and access, with regard to the Policy, as well as documents related to the Policy. To conduct business electronically, receive documents applicable to the Policy in electronic format, and access documents electronically via a hyperlink contained in an electronic mail ("email") or attached to an email, you must provide Transamerica, and its authorized designees and agents, with your consent. If you indicated your consent by electronically signing this document where indicated below, you will be providing Transamerica and its authorized designees and agents, with your consent:

1. To have the information described in this document (Consent to do Business Electronically and Electronic Delivery of and/or Access to Policy Documents, hereinafter referred to as "Consent") made available and delivered to you electronically;
2. To execute via electronic means the documents that are described in this Consent;
3. To submit, via electronic means, your application for an insurance product; and
4. To all of the terms and conditions set forth in this Consent.

**What does this Consent cover once I consent?**

This Consent covers your agreement to all of the terms and conditions of this Consent, including your agreement to:

1. **Permit the Owner of the Policy to receive via electronic means the documents that Transamerica is required by law or regulation to provide or make available to you in writing ("Required Documents"), as well as other information and documents (collectively, "Other Documents");**
2. **Permit the Owner of the Policy to receive via electronic means privacy notices from Transamerica, including those companies on whose behalf Transamerica sends privacy notices, including World Group Securities, Inc. and Transamerica Financial Advisors, Inc., as well as from any affiliate or subsidiary companies administering or supporting any Policy issued as part of your application (collectively "Privacy Notices");**
3. **Permit the Owner and Insured (and Third Party, if applicable) to submit via electronic means your application for an insurance product;**
4. **Permit the Owner and Insured (and Third Party, if applicable) to execute via electronic means certain Required Documents and Other Documents; and**
5. **Be bound with the same force and effect as if you had signed your name on paper by hand when you electronically sign this Consent where indicated below and click "OK" or otherwise apply your electronic signature to Required Documents or Other Documents.**

**NOTE: IF THE OWNER IS NOT THE INSURED, THEN BOTH WILL NEED TO SIGN THE CONSENT BELOW**

**What is the Scope of this Consent?**

This Consent applies to all documents related to your Policy, including, but not limited to, the following: Privacy Notices, prospectuses, prospectus supplements, annual and semiannual reports, annual and quarterly statements, confirmation statements, statements of additional information, proxy solicitation materials, conditional receipts, application, application supplements and addendums, Policy contract, illustrations, amendments, riders, replacement notices, customer correspondence, and any other Required Documents and Other Documents when available (collectively, "Policy Documents"). These Policy Documents will generally be accessible through a hyperlink delivered via email to the Owner's email address(es) written below when electronic access to the various Policy Documents is available from Transamerica.

Even though you have provided Transamerica with this Consent, Transamerica may, at its option, or as required by law: (a) deliver Policy Documents to you on paper, and (b) require that certain communications from you be delivered to Transamerica on paper.

**Can I get paper copies of the Policy Documents?**

Yes. You may obtain paper copies of any of the Policy Documents at any time and without charge by contacting Transamerica at the address provided below. If you do not wish to access all Policy Documents electronically, please call Transamerica's Customer Service Department at the telephone number provided below.

**Should I maintain copies of the Policy Documents?**

Yes. You agree to print or save this Consent and all Policy Documents, and to keep printed or electronic copies of them for your records. If you have any trouble with printing or saving, you should contact Transamerica.

**How long will this Consent remain in effect?**

This Consent shall become effective once you sign below and remains in effect for so long as your Policy remains in effect, or until you withdraw your consent (as described in the next section), whichever occurs first.

**What if I change my mind?**

**If at any time you would like to cease doing business electronically with Transamerica with respect to your Policy, you will need to provide Transamerica with written notice of your withdrawal of your consent to do so, which will then terminate this Consent. You may withdraw consent at any time and without charge by contacting Transamerica. Your withdrawal of consent and the termination of this Consent will become effective two (2) business days after Transamerica's receipt of your withdrawal. Thereafter, all Policy Documents will be provided to you on paper and you will no longer be able to conduct business with us electronically, unless you provide your consent again.**

**What if my contact information changes?**

You must keep Transamerica informed of any changes to your email address(es) and all other contact information by contacting Transamerica at the contact information provided below. You agree to hold Transamerica harmless with respect to any emails sent to the incorrect email address due to your failure to provide Transamerica with a current or valid email address.

**You can contact Transamerica as follows:**

For all products except Financial Foundation IUL:

Mail: 6400 C Street SW  
Cedar Rapids, IA 52499  
Telephone: 1-800-852-4678  
Internet: [www.transamerica.com](http://www.transamerica.com)

For Financial Foundation IUL:

Mail: 6400 C Street SW  
Cedar Rapids, IA 52499  
Telephone: 1-800-851-9777  
Internet: [www.premier.transamerica.com](http://www.premier.transamerica.com)

**Are there any hardware or software requirements?**

Yes. To access, receive, and retain the Policy Documents sent or made available to you electronically by Transamerica, you must have access to a computer with an Internet connection. You must have a valid email address, be able to send and receive emails, and be able to save the Policy Documents to a storage device for later reference or have the computer connected to a printer so you can print out such documents. Unless notified otherwise, Transamerica will be providing or making available these documents to your agents and insurance representatives. The minimum hardware and software requirements are:

**Computer Compatibility**

Item		Minimum	
Memory (RAM)		2 GB	
Hard Drive Space		1 GB available for storage of electronic documents	
Operating System		Windows Vista with Service Pack 2 or a later version MAC OS 10.x or higher	
Screen Resolution		1060 x 800 pixels at 16-bit color resolution	
Screen Display Size		12 inches measured diagonally	
Browser Application		Internet Explorer 9.0 or higher with all critical updates Mozilla Firefox: Google Chrome Safari 5 or higher  *** We will <u>not</u> support beta versions of any browsers.	
PDF Reader		Adobe Acrobat Reader 6.0 or higher	
Speed		DSL or broadband service	

**Mobile Device Compatibility**

Operating Systems	Apple Devices: iOS7 or higher Android Devices: Android 4 or higher
-------------------	---

You should check the Technical Requirements periodically for updates on supported software and browsers. From time to time we may offer services or features that require a certain type of browser or configuration. If we detect that your browser is not properly configured, we may provide you with a notice on how to properly update your browser. Also, the browsers we support may change over time. We reserve the right to discontinue supporting a certain browser or operating system if we believe that it suffers from a security flaw or other flaw that makes it unsuitable for use with the insurance products.

**What else should I know about this Consent?**

Your consent is voluntary. If you consent, you are consenting to conduct business electronically and to receive and access Policy Documents electronically. You cannot consent to receive or access Policy Documents electronically without consenting to conduct business electronically. However, if you wish to consent to conduct business electronically but do not wish to receive or access Policy Documents electronically, you need to sign this Consent and call Transamerica's Customer Service Department at the telephone number provided above to opt-out of electronic delivery and/or access and to receive Policy Documents by mail.

There is no charge for electronic delivery of Policy Documents, although your internet provider may charge for internet access. Unless required by law, you will NOT receive electronic copies in addition to papercopies.

For California Only: An additional consent for electronic delivery may be required before Required Documents are delivered to you electronically. Absent an additional consent, Policy Documents other than Required Documents may be delivered electronically under this Consent or Transamerica may elect to deliver all Policy Documents by mail.



By signing below, I attest that I: (i) have carefully read this Consent using computer hardware and software that meet the minimum hardware and software requirements described above; (ii) agree to conduct business electronically; (iii) agree to receive all mailings and communications, which may even include cancellation or nonrenewal notices, electronically; (iv) agree to receive Policy Documents in electronic format; (v) agree to access Policy Documents electronically; and (vi) accept and sign this Consent voluntarily and with full knowledge and understanding of its terms and conditions. I will save a copy of this Consent.

\_\_\_\_\_  
Name of Insured

\_\_\_\_\_  
Insured Email Address

\_\_\_\_\_  
Signature of Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number of Insured

Please check the box below or complete Owner information. Complete Additional Owner information, if applicable.

☐

Owner is same as Insured

\_\_\_\_\_  
Name of Owner, if other than Insured

\_\_\_\_\_  
Owner Email Address

\_\_\_\_\_  
Signature of Owner, if other than insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone Number of Owner, if other than insured

\_\_\_\_\_  
Name of Additional Owner, if applicable

\_\_\_\_\_  
Additional Owner Email Address

\_\_\_\_\_  
Signature of Additional Owner, if applicable

\_\_\_\_\_  
Date

**Note: If there are more than two (2) Additional Insureds, please complete additional forms.**

\_\_\_\_\_  
**Name of Additional Insured (if any)**

\_\_\_\_\_  
**E-mail Address of Additional Insured (if any)**

\_\_\_\_\_  
**Signature of Additional Insured (if any)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Additional Insured (if any)**

\_\_\_\_\_  
**Email address of Additional Insured (if any)**

\_\_\_\_\_  
**Signature of Additional Insured (if any)**

\_\_\_\_\_  
**Date**

**IF THERE ARE THIRD PARTIES SIGNING REQUIRED DOCUMENTS OR OTHER DOCUMENTS, PLEASE HAVE THEM COMPLETE THE INFORMATION BELOW. FOR ADDITIONAL THIRD PARTIES, PLEASE COMPLETE ADDITIONAL FORMS.**

\_\_\_\_\_  
**Name of Third Party**

\_\_\_\_\_  
**Status of Third Party (e.g., Guardian, Payor, etc.)**

\_\_\_\_\_  
**Signature of Third Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Additional Third Party**

\_\_\_\_\_  
**Status of Third Party (e.g., Guardian, Payor, etc.)**

\_\_\_\_\_  
**Signature of Additional Third Party**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Trustee**

\_\_\_\_\_  
**Signature of Trustee**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Authorized Person**

\_\_\_\_\_  
**Signature of Authorized Person**

\_\_\_\_\_  
**Date**



## eDelivery Terms and Conditions of Use

The Transamerica company using this form is:

☐ Transamerica Life Insurance Company

☐ Transamerica Financial Life Insurance Company

As used herein, "the Company", "we", "our", or "us" means the Transamerica company checked above.

**ELECTRONIC INFORMATION CONSENT** – I consent to receive documents and notices applicable to the Eligible Policy/Policies accessed through the Company website or portal, or websites or portals operated on behalf of the Company. These include, but are not limited to: Policy contracts, applications, application supplements and addendums, illustrations, amendments, riders, replacement notices, statements of additional information, conditional receipts, customer correspondence, prospectuses, prospectus supplements, annual and semiannual reports, quarterly statements and immediate confirmations, privacy notices, other notices, and documentation, permitted by law to be sent electronically, in electronic format, when available instead of receiving paper copies of these documents by U.S. mail.

**Important Information Concerning Electronic Document Delivery:**

- Your consent is voluntary. Documents will only be transmitted to you electronically if you consent.
- There is no charge for electronic delivery, although your internet provider may charge for Internet access.
- You are confirming that you have access to a computer with internet capabilities and an active email account to receive information electronically.
- This Electronic Document Delivery applies only to Eligible Policies accessed through the Company website or portal, or websites or portals operated on behalf of the Company.
- After consenting to Electronic Document Delivery, we will send an email to confirm that the email address you provided is correct. If we are unable to confirm an email address or have reasonable suspicion that an email address is incorrect, we will not activate the consent for electronic delivery, in which case you will continue to receive paper copies of your documents.
- Email filters must be updated to ensure you received email notifications from us.
- Not all contract documentation and notifications may currently be available in electronic format.
- You can request the Company provide paper copies of documents at any time for no charge.
- If an email address changes, you may notify us at any time by contacting us at the phone number listed below or editing your profile on the appropriate website.
- This consent will remain in effect until revoked. You may opt out of receiving records electronically at any time.
- If you choose to revoke your consent, withdrawal of this consent will become effective within two business days after the Company receives your request.

Please call 1-800-851-9777 or visit the Company website at [www.transamerica.com](http://www.transamerica.com) if you would like to revoke your consent, wish to receive a paper copy of the information above, or need to update your email address.

☐ By checking this box, I consent to receive electronic transmission of documents and agree to the terms and conditions as described above.

Policy Owner: \_\_\_\_\_  
Email Address Printed Name

Policy Number(s): \_\_\_\_\_



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](http://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  
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](http://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

## 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](http://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](http://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](http://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](http://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](http://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](mailto:consumerdatarequest@transamerica.com).



Transamerica Life Insurance Company  
Home Office: 4333 Edgewood Road N.E.  
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



1. <b>Proposed Insured:</b> <i>(Print Full Name)</i> _____	2. <b>Date of Birth:</b> Month _____ Day _____ Year _____	3. <b>Social Security #</b> _____
--	--	-----------------------------------

4. **Name/Address/Phone of primary care physician:**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ City/St/Zip: \_\_\_\_\_

Date and reason for last visit: \_\_\_\_\_

5. **Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_

Give complete details of all yes answers to questions 6 - 9, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

6. <b>HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:</b>	Details:																																							
<table style="width: 100%;"> <tr> <th></th> <th style="text-align: center;">Yes</th> <th style="text-align: center;">No</th> </tr> <tr> <td>a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood (except HIV status)? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>e. Sugar, protein or blood in urine, sexually transmitted disease (except HIV disease), stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>h. Any disease or abnormality of the eyes, ears, nose, throat or skin? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>i. Cancer, tumor, polyp or cyst? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>j. Any physical deformity or amputation? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>l. Diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </table>		Yes	No	a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain? .....	<input type="checkbox"/>	<input type="checkbox"/>	b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood (except HIV status)? .....	<input type="checkbox"/>	<input type="checkbox"/>	c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>	d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? .....	<input type="checkbox"/>	<input type="checkbox"/>	e. Sugar, protein or blood in urine, sexually transmitted disease (except HIV disease), stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>	f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands? .....	<input type="checkbox"/>	<input type="checkbox"/>	g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones? .....	<input type="checkbox"/>	<input type="checkbox"/>	h. Any disease or abnormality of the eyes, ears, nose, throat or skin? .....	<input type="checkbox"/>	<input type="checkbox"/>	i. Cancer, tumor, polyp or cyst? .....	<input type="checkbox"/>	<input type="checkbox"/>	j. Any physical deformity or amputation? .....	<input type="checkbox"/>	<input type="checkbox"/>	k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	l. Diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/>	<input type="checkbox"/>	
	Yes	No																																						
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood (except HIV status)? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
e. Sugar, protein or blood in urine, sexually transmitted disease (except HIV disease), stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
h. Any disease or abnormality of the eyes, ears, nose, throat or skin? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
i. Cancer, tumor, polyp or cyst? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
j. Any physical deformity or amputation? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
l. Diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/>	<input type="checkbox"/>																																						
7. <b>Yes No</b> a. Within the past ten years, have you used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician? <input type="checkbox"/> <input type="checkbox"/> b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse? <input type="checkbox"/> <input type="checkbox"/>																																								
8. <b>OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:</b> <b>Yes No</b> a. Consulted, been examined or been treated by any physician or practitioner?..... <input type="checkbox"/> <input type="checkbox"/> b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study (not including HIV tests)? .....																																								
c. Had observation or treatment at a clinic, hospital or other medical facility?..... <input type="checkbox"/> <input type="checkbox"/> d. Had or been advised to have a surgical procedure? .....																																								
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever? <input type="checkbox"/> <input type="checkbox"/> f. Had any injury requiring treatment? .....																																								



9. **Yes No**
- a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? ..... ☐ ☐
- b. Has your weight changed by more than 15 pounds in the past year? ..... ☐ ☐
- c. Are you now pregnant? ..... ☐ ☐

10. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** ☐ Yes ☐ No *If yes, list all and indicate why.*

11. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father				
Mother				
Brothers # _____				
Sisters # _____				

12. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** ☐ Yes ☐ No *If yes, indicate type, frequency and date last used.*

13. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** ☐ Yes ☐ No *If no, provide complete details.*

14. Do you participate in regular weekly exercise?..... ☐ Yes ☐ No
15. Do you participate in athletics (*Team or Individual*)?..... ☐ Yes ☐ No
16. Have you ever used any tobacco products? ..... ☐ Yes ☐ No
17. Do you get regular examinations by your health care provider? ..... ☐ Yes ☐ No
18. Do you get regular annual dental checkups? ..... ☐ Yes ☐ No
19. Do you clean your house or do yard work?..... ☐ Yes ☐ No
20. Do you have a pet? ..... ☐ Yes ☐ No
21. Are you a member of a social group or volunteer for charity work?..... ☐ Yes ☐ No

It is represented that the statements and answers given above are true, complete, and correctly recorded to the best of my knowledge and belief. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_

**AGENT'S STATEMENT:** I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Insured.

\_\_\_\_\_  
Signature of Proposed Insured

X \_\_\_\_\_  
Signature of Witness/Agent/Registered Representative

\_\_\_\_\_  
Print name of Proposed Insured

**NON-MEDICAL**

**PRE-AUTHORIZED CHECK/WITHDRAWAL PLAN ("PAC")**

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 Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

- ☐ **MONTHLY** (This will be elected if no box is checked)  
☐ **QUARTERLY**  
☐ **SEMI-ANNUAL**  
☐ **ANNUAL**

- ☐ **PREMIUM**  
☐ **LOAN REPAY**  
☐ **SAVINGS**  
☐ **CHECKING**

- ☐ **NEW AUTHORIZATION**  
☐ **BANK CHANGE**  
☐ **ADD TO EXISTING POLICY**  
☐ **OTHER** \_\_\_\_\_

**PICK A DATE TO DRAFT (1-28)** \_\_\_\_\_

**NAME OF FINANCIAL INSTITUTION:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**ACCOUNT NUMBER:** \_\_\_\_\_

**NAME(S) ON BANK ACCOUNT:** \_\_\_\_\_

**ROUTING#:** \_\_\_\_\_

**AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM**

I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements or riders), or as agreed to by me, and for such other payments as I may authorize the Company to make. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on the earliest due date. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this authorization in no way affects the terms of the policy, other than the mode of payment, and I understand that if the premiums are not paid within the grace period allowed by a policy, as in the event any such withdrawal being dishonored, or for any reason, then the policy shall terminate subject to any nonforfeiture provisions in the policy.

**AUTHORIZATION TO HONOR PAC WITHDRAWALS**

As a convenience to me, I hereby request the financial institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company and/or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these authorizations.

\_\_\_\_\_  
BANK SIGNATURE(S) OF DEPOSITOR(S)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR

TAPE VOIDED CHECK HERE



\* D T O 8 4 \*