RESET

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

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

OWNER - if other than Primary Insured

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

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

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

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

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

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

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

AGENT

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

Date

Producer or Agent Signature

Owner Signature

Transamerica Life Insurance Company

California Fraud Language Endorsement

It is hereby understood and agreed that the form to which this Endorsement is attached is amended as follows:

For your protection California law requires the following to appear on this form.

Fraud Warning: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

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TRANSAMERICA®

Supplemental Application
Death Benefit Option Election Form

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

This Supplemental Application replaces and supercedes SECTION 8. DEATH BENEFIT OPTION, on the application. Please elect one of the following death benefit options below:

- ☐ Level Benefit
- ☐ Increasing Benefit
- ☐ Graded Death Benefit

I acknowledge and agree that this Supplemental Application together with the original application and any amendments thereto shall be the basis for any insurance issued. This Supplemental Application shall form a part of the original application and of the policy issued thereunder, if any, and they shall be binding on any person who shall have or claim any interest under such policy.

Print Name of Owner

Signature of Owner

Signature of Agent

Date

Transamerica Life Insurance Company

California Fraud Language Endorsement

It is hereby understood and agreed that the form to which this Endorsement is attached is amended as follows:

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RESET

TRANSAMERICA LIFE INSURANCE COMPANY

Administrative Office: 6400 C Street SW, Cedar Rapids, IA 52499

Supplemental Application for Index Universal Life Policy

Supplement to Application Dated: _____

Premium Amount: $ _____

Indicate your premium allocation percentages below. Total must equal 100%.

_____.0%	Global Index Account
_____.0%	Index Account
_____.0%	Basic Interest Account
_____**100%**	**Total**

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and correct. I acknowledge and agree that this Supplemental Application together with the original application and any amendments thereto shall be the basis for any insurance issued. This Supplemental Application shall form a part of the original application and of the policy issued thereunder, if any, and they shall be binding on any person who shall have or claim any interest under such policy.

Dated at_____ this _____day of _____, _____

_____ _____

Signature Of Owner if other than Proposed Insured Signature Of Proposed Insured

Transamerica Life Insurance Company

California Fraud Language Endorsement

It is hereby understood and agreed that the form to which this Endorsement is attached is amended as follows:

For your protection California law requires the following to appear on this form.

Fraud Warning: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Supplemental Application for Long Term Care Rider (LTCR)

This is a supplement to the Application for Life Insurance for the proposed Insured. Please complete if LTC Rider is being elected.

☐ **New Application** ☐ **Reinstatement** (Check the applicable box.)

Section 1 Proposed Insured and Owner Information

	First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)
Proposed Insured:				
Owner: (if other than the proposed Insured)				

Section 2 Protection Against Unintended Lapse

I, the Owner, understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. (Check the applicable box.)

☐ I designate the following person to receive notice prior to cancellation of my rider for nonpayment of premium (complete information below):

☐ I elect **NOT** to designate a person to receive this notice. I may change my election at a future date.

First Name	M.I.	Last Name

Address (Cannot be a P.O.Box)	City	State	Zip Code

Section 3 Health Questions - In this section, "You" means the proposed Insured.

1. During the last 12 months, have you ever:
   a) required assistance or supervision of any kind to perform any every day activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring or toileting? ☐ Yes ☐ No
   b) used a catheter, chair lift, crutches, dialysis, motorized scooter, oxygen equipment, quad or three-pronged cane, respirator, walker or wheelchair? ☐ Yes ☐ No
   c) been advised to enter or resided in a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), or rehabilitation facility, or attended an adult day care facility, or required home health care? ☐ Yes ☐ No
2. During the last 3 years, have you ever used insulin to treat Diabetes, or have you ever been diagnosed or treated for Diabetes WITH COMPLICATIONS (such as Neuropathy, Retinopathy, Nephropathy, Heart Disease, Stroke or Peripheral Vascular Disease)? ☐ Yes ☐ No
3. Have you EVER been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following condition(s):

Alzheimer's disease or Dementia	☐ Yes	☐ No
Amputation due to disease	☐ Yes	☐ No
ALS (Lou Gehrig's disease)	☐ Yes	☐ No
Arthritis with narcotic pain medication	☐ Yes	☐ No
Multiple Strokes/CVA's/TIA's	☐ Yes	☐ No
Organ Transplant (other than Corneal)	☐ Yes	☐ No
Multiple Sclerosis	☐ Yes	☐ No
Huntington's Chorea	☐ Yes	☐ No
Muscular Dystrophy	☐ Yes	☐ No
Myasthenia Gravis	☐ Yes	☐ No
Organic Brain Syndrome	☐ Yes	☐ No
Osteoporosis with fractures	☐ Yes	☐ No
Parkinson's disease	☐ Yes	☐ No
Polymyositis	☐ Yes	☐ No
Scleroderma	☐ Yes	☐ No
Memory loss	☐ Yes	☐ No
Unplanned weight loss greater than 15 pounds within the last 2 years	☐ Yes	☐ No

4. Do you have a parent or sibling diagnosed or treated by a member of the medical profession for Huntington's Chorea or Polycystic Kidney Disease? ☐ Yes ☐ No

If Questions 1, 2, 3 or 4 were answered yes, the rider is not available for the proposed Insured and this application supplement should not be completed or submitted.

5. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions:

Disorientation	☐ Yes	☐ No
Used a Straight Cane	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No
Transient Ischemic Attack (TIA)	☐ Yes	☐ No
Loss of Balance	☐ Yes	☐ No
Loss of Strength	☐ Yes	☐ No
Tremors	☐ Yes	☐ No
Dizziness	☐ Yes	☐ No

6. Do you have a handicap sticker, handicap placard, or handicap license plate? (Give reason below.) ☐ Yes ☐ No

7. In the last 24 months, have you had to limit or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies? (Give reason below.) ☐ Yes ☐ No

Give details for all yes answers to questions 5, 6, & 7. For every medication there should be a condition and for most conditions there should be a medication or treatment.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/Medication Taken	Name of Physician Seen/Physician's Address

8. Within the past 5 years, have you ever received any long term care benefits, disability income benefits or Social Security Disability benefits? If the answer is yes, provide details in Section 5, Remarks. ☐ Yes ☐ No

9. Within the past 5 years, have you ever been declined for long term care insurance including long term care insurance provided by rider to a life insurance or other policy? List company name, date and reason in Section 5, Remarks. ☐ Yes ☐ No

Section 4 Existing and Pending Coverage - In this section, "You" means the proposed Insured. (Provide details of yes answers below.)

1. Are you covered by Medicaid? ☐ Yes ☐ No
2. Are you covered under any other long term care insurance policy, contract or rider in force? ☐ Yes ☐ No
3. Has any of your long term care insurance, including coverage by riders, lapsed, been surrendered or otherwise terminated in the past 24 months? ☐ Yes ☐ No
4. Is the coverage applied for intended to replace any long term care, medical or health or disability insurance coverage ? ☐ Yes ☐ No
5. Are there any other life insurance policies currently in force on your life which provide similar long term care or accelerated death benefit coverage? ☐ Yes ☐ No
6. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)? If yes, please give details in Section 5, Remarks. ☐ Yes ☐ No
7. Did you have a long term care insurance policy or certificate in force in the last 12 months? ☐ Yes ☐ No
   If yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in Section 5, Remarks.
8. Do you intend to replace any in force medical or health insurance coverage with this policy? If yes, please provide details in Section 5, Remarks and complete the required replacement form. ☐ Yes ☐ No

If yes to questions 5-8, please provide details. If more space is needed, please use the Supplemental Information form.

Name and Address of Insurance Company	Policy/Certificate Number	Type and Amount of Benefits	Lapse Date	Currently In Force? Yes	Currently In Force? No	Being Replaced? Yes	Being Replaced? No
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐
				☐	☐	☐	☐

Section 5 Remarks

I, the proposed Insured, and I, the Owner if different, hereby represent that I/we have read this application and that all statements and answers given in this application supplement are true and complete to the best of my/our knowledge and belief. **I/we agree** that: (1) this application supplement, and the Application shall be the basis for any contract issued; (2) the coverage I/we are applying for provides benefits for the proposed Insured only; and (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.

Caution: If your answers on this application supplement and/or on the Application for the life insurance policy to which the LTC Rider will be attached are incorrect or untrue, Transamerica Life Insurance Company may have the right to deny benefits or rescind coverage.

I understand that benefits under the Long Term Care Rider are provided through an accelerated death benefit option, and that if I exercise the accelerated death benefit option, any beneficiary I designate will receive a reduced death benefit.

I certify that I have received the Outline of Coverage, HIPAA Privacy Notice, the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

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

X _____ _____

Signature of proposed Insured — Date (MM/DD/YYYY)

X _____ _____

Signature of Owner (if other than proposed Insured) — Date (MM/DD/YYYY)

X _____ _____

Signature of Licensed Agent/Insurance Producer — Date (MM/DD/YYYY)

AGENT/INSURANCE PRODUCER'S REPORT

Insurance Producer's Report

1. Did you personally interview the proposed Insured, ask all the questions and witness the signatures? ☐ Yes ☐ No
2. Did you see or hear or were you advised of any physical impairment of the proposed Insured with regard to walking, speaking, any form of tremor or any signs of confusion or disorientation? ☐ Yes ☐ No
3. Did you review the current long term care, medical or health or disability insurance coverage of the proposed Insured and find that the coverage applied for is appropriate for the applicant's needs? ☐ Yes ☐ No
4. To the best of your knowledge, is the insurance applied for intended to replace any other long term care, medical or health or disability insurance coverage in force with this or any other company? ☐ Yes ☐ No
5. To the best of your knowledge, is the information provided in this application true and complete? ☐ Yes ☐ No
6. Does the proposed Insured live alone? ☐ Yes ☐ No

LIST ANY OTHER HEALTH INSURANCE COVERAGE YOU HAVE SOLD ON THE PROPOSED INSURED

(1) List policies or other coverage sold that are still in force; and

(2) List policies or other coverage sold within the last five (5) years that are no longer in force.

Insurance Company	Policy/Certificate Number	Type and Amount of Benefits	In Force	Lapse Date
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Licensed Agent/Insurance Producer: _____
Last First

Licensed Agent/Insurance Producer ID #: _____
(Up to 10 Digits)

_____ _____
Signature of Licensed Agent/Insurance Producer Date (MM/DD/YYYY)

TRANSAMERICA
® LIFE INSURANCE COMPANY

HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Division
PO Box 159
Cedar Rapids, IA 52406-0159
1-800-227-3740
LTCQuestions@Transamerica.com

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy to be issued by Transamerica Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new policy carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long-term care insurance policy is a wise decision.

STATEMENT TO THE APPLICANT BY AGENT/INSURANCE PRODUCER, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original coverage.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent/insurance producer 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.

4. If, after due consideration, you still wish to terminate your present coverage and replace it with this new policy, 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 policy 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.

_____ _____

Signature of Agent/Insurance Producer, Broker or Other Representative

_____

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

_____ _____

Applicant's Signature

The "Notice to Applicant" was delivered to me on the above date

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office:
6400 C Street SW
Cedar Rapids, IA 52499
1-800-TLC-HOST
www.transamerica.com

LONG TERM CARE INSURANCE
OUTLINE OF COVERAGE
Rider Form ICC12 LTCR03

Notice to buyer: The captioned Long Term Care rider may not cover all of the costs associated with long-term care incurred during the period of coverage. You are advised to review all rider terms, conditions and limitations carefully.

Caution: The issuance of the Long Term Care rider is based on our issuance of the policy to which the rider is attached; and on your responses to the questions on your application for the policy and the application supplement for the rider. Copies of the application for the policy and the application supplement are attached to the policy. If your answers to any of the questions on the application or application supplement are incorrect or untrue, the company has the right (in addition to any rescission rights described in the policy) to deny benefits or rescind the rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

1. The Long Term Care rider is attached to an individual life insurance policy.

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the rider. You should compare this outline of coverage to outlines of coverage for other long term care riders or policies available to you. This is not an insurance contract, but only a summary of coverage. Only the underlying life insurance policy and rider contain governing contractual provisions. This means that the life insurance policy and rider set forth in detail the rights and obligations of you, the Insured (if other than yourself) and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY AND RIDER CAREFULLY!

3. **FEDERAL TAX CONSEQUENCES.** The rider is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. If a change to the rider is required in order to conform to changes in the requirements of the Internal Revenue Code, we will send you an amendment describing the change and you will be given a choice of accepting or rejecting the amendment. If you reject such an amendment, you must give us written notice, and your refusal may result in the rider no longer being tax-qualified or other adverse tax consequences. As with any tax matter, you should consult your tax advisor to evaluate any tax impact of rejecting any such amendment.

4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED.** (a) **Renewability** – THE RIDER IS GUARANTEED RENEWABLE. This means we may not, on our own, cancel or reduce the coverage it provides. Subject to the rider's termination provision, this rider will remain in force for as long as the policy remains in force and the required charges for this rider are paid. rider charges are subject to change, but we will not increase the rates above the maximum rates shown in the Policy Data. (b) **Waiver of Rider Charges** – While benefits under the rider, other than the International Coverage Benefit, are being paid, the Long Term Care rider charges will be waived. However, charges for the underlying policy and/or any other riders providing additional benefits will continue to be assessed.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGES.** Rider charges are subject to change. They are based on the policy's amount at risk (as determined for purposes of the Monthly Cost of Insurance) and our table of Long Term Care rider rates then in effect. The table in effect at any time will generally contain rates that increase with the age of

the Insured. We may change the table from time to time, but we cannot increase the rates beyond the maximum rates shown in the policy. We can only change the rider rate table if we change it for everyone under this rider form who is in the same risk class. A risk class includes persons with the same benefits, issue age, and underwriting risk class at issue and whose Long Term Care riders have been in effect for the same length of time. We will give you at least 60 days advance written notice at your last address shown in our records before we change your rider rate table.

6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED.** You have 30 days from the day you receive the rider to review it and return it to us if you decide not to keep it. You do not have to tell us why you are returning the rider. Within 30 days of when it is received, simply return it to us at our Administrative Office or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any rider charge deducted from the Policy Value, within 30 days after our receipt of the returned rider. The rider will be void as if it had never been issued. If you wish to cancel the rider without canceling the policy, you must return the policy and the rider to us so that we can send you back the policy without the rider.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. That booklet is called the "Guide to Health Insurance for People with Medicare." Neither Transamerica Life Insurance Company nor its agents/insurance producers represent Medicare, the federal government or any state government.

8. **LONG TERM CARE COVERAGE.** Contracts of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital such as: (a) a Long Term Care Facility; (2) an Adult Day Care Center; (3) a Hospice Care Facility; or (4) the home.

   The rider provides coverage in the form of a fixed indemnity benefit for long term care expenses, subject to the rider limitations and elimination period requirements.

9. **BENEFITS PROVIDED BY THE RIDER.**

   Subject to the conditions, limitations and exclusions in the rider, the amount of the benefit payable for any Calendar Month is an amount equal to the lesser of A or B where:

   A is 2% of Long Term Care Specified Amount, at commencement of benefits; and
   B is the inflation-adjusted per diem dollar amount specified by section 7702B(d)(4) and (5) of the Internal Revenue Code of 1986, as amended (or applicable successor provision), times the number of days in the Calendar Month.

   You may request a monthly benefit amount less than the above maximum. Choosing a lesser amount could extend the period during which benefits may be payable. You may change your election 30 days before the beginning of any calendar year.

   Long Term Care rider benefits are an acceleration of the policy's death benefit and will reduce any proceeds payable at surrender of the policy or upon the Insured's death.

   ELIGIBILITY FOR THE PAYMENT OF BENEFITS. Long Term Care benefits may be payable under the rider if the Insured is a Chronically Ill Individual and (1) has satisfied the 90-day Elimination Period; (2) has received Qualified Long Term Care Services covered under the rider and such services are specified in a Plan of Care; and (3) a current Plan of Care and written Proof of Loss have been approved by us.

   Elimination Period. The rider has an Elimination Period of 90 days. This means that we will not pay benefits under the rider for any period before the Insured has incurred expenses, on each of 90 separate days during which the rider is in effect, for Qualified Long Term Care Services that would otherwise be covered under the rider. These days of care or services need not be continuous. The Elimination Period has to be satisfied only once while the rider is in effect. You must provide us with Proof of Loss in order to satisfy the Elimination Period.

We will give the Insured credit toward the Elimination Period for days of confinement, care or services covered under the rider, even if they are paid or payable by Medicare.

Care or services received during confinement in a hospital or rehabilitation hospital/facility cannot be used to satisfy the Elimination Period, even if they are paid or payable by Medicare.

Chronically Ill Individual means an individual who has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, at least two out of the six Activities of Daily Living (ADLs) for an expected period of at least 90 days due to a loss of functional capacity; or requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

Severe Cognitive Impairment (including the term "Severely Cognitively Impaired") means a severe loss or deterioration in intellectual capacity that is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:

1. short-term or long-term memory;
2. orientation as to people, places or time;
3. deductive or abstract reasoning; and
4. judgment as it relates to safety awareness.

The evaluation must include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

Activities of Daily Living (ADLs) means the following activities: Bathing, Continence, Dressing, Eating, Toileting and Transferring.

10. **GENERAL EXCLUSIONS AND LIMITATIONS.** Qualified Long Term Care Services do not include care, confinement or services:

    1. resulting from alcoholism, or drug addiction or chemical dependency unless as a result of medication used as prescribed by a Physician;
    2. resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
    3. due to participation in a felony, riot or insurrection;
    4. for which no charge is normally made in the absence of insurance; and
    5. received outside the 50 United States and the District of Columbia, or Canada, unless a claim is filed under the International Coverage Benefit.

    Non-Duplication of Benefits. Qualified Long Term Care Services do not include care, confinement or services:

    1. provided in a government facility (unless otherwise required by law);
    2. paid or payable under Medicare. This includes any amounts that would be covered under Medicare, except that they are subject to a Medicare deductible or coinsurance of some kind. This does not apply when expenses are reimbursable under Medicare solely as a secondary payer;
    3. provided under any governmental programs (except Medicaid); or
    4. paid or payable under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; unless the costs incurred and paid exceed the amount covered by one of these entities, policies or programs.

    A government facility includes a facility administered, covered or reimbursed by the Veteran's Administration.

    We will not pay benefits under the rider if Qualifying Long Term Care Services received by the Insured are not included in the Insured's Plan of Care.

    <u>This policy may not cover all the expenses associated with your long-term care needs.</u>

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of Long Term Care services will likely increase over time, you should consider whether and how the benefits of the rider should be used. The rider does not include inflation protection coverage. Increases and decreases to the policy's death benefit resulting from the exercise of your rights under that policy, including your right to make policy loans and withdrawals, will cause a change in the maximum Monthly Long Term Care Rider Benefit Amount as well as the policy's death benefit.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The rider provides coverage for mental and nervous conditions as long as the Insured is certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in the rider. Covered illnesses include, but are not limited to, Alzheimer's Disease, Parkinson's Disease, senile dementia and related degenerative and dementia-based illnesses.

13. **LONG TERM CARE RIDER CHARGE.** The Guaranteed Maximum Monthly Charge Rates per $1000 of amount at risk are shown in the Policy Data.

14. **ADDITIONAL FEATURES.** Interaction of policy provisions and the rider:

    Medical Information. Issuance of the rider requires that we are provided with and evaluate medical information about the Insured. This is generally known as medical underwriting.

    Policy Face Amount Changes. While this rider is In Force you may not request an increase in the policy's Face Amount. Transactions that increase or reduce the Face Amount of the policy will also result in a dollar-for-dollar change in the Long Term Care Specified Amount.

    Loans and Withdrawals. Loans and withdrawals will not be permitted while benefits are being paid under the rider.

    Long Term Care Rider's Effect on Surrender Values under any endorsement providing an enhanced surrender value. If the policy is surrendered during the option periods provided in such an endorsement, any enhanced surrender value will be reduced by the amount of the Long Term Care rider benefits paid.

    Terminal Illness Accelerated Death Benefit Endorsement Effect on the Rider. If your policy includes an endorsement providing an accelerated death benefit in the event of a terminal illness ("Terminal Illness ADB Endorsement") the Insured may qualify for benefits under both the Terminal Illness ADB Endorsement and the Long Term Care rider. If the Insured qualifies for benefits under both the Terminal Illness ADB Endorsement and the Long Term Care rider and if a claim is made under both the Terminal Illness ADB Endorsement and the Long Term Care rider, a benefit will be paid under the Terminal Illness ADB Endorsement first. A payment under the Terminal Illness ADB Endorsement will reduce the policy face amount and the Long Term Care Specified Amount will be reduced by the same amount. Once payment under the Terminal Illness ADB Endorsement is made, any payments under the Long Term Care rider will be made based on the newly reduced Long Term Care Specified Amount.

    We will not pay benefits under both the Terminal Illness ADB Endorsement and the Long Term Care rider simultaneously. If a claim is made under the Terminal Illness ADB Endorsement while benefits are being paid under the Long Term Care rider, we will stop paying benefits under the Long Term Care rider when we pay benefits under the Terminal Illness ADB Endorsement. The maximum accelerated death benefit used to calculate the amount of the Terminal Illness Accelerated Death Benefit will be reduced by any Long Term Care rider benefits paid out. Once payment under the Terminal Illness ADB Endorsement is made, and the Insured qualifies for benefits under the Long Term Care rider, any payments under the Long Term Care rider will be made based on the newly reduced Long Term Care Specified Amount.

    End of Eligibility. If rider benefit payments cease because the Insured no longer qualifies for benefits under this rider, the following will apply:

    1. If the policy's No Lapse Ending Date has not passed, the test to determine whether the No Lapse Guarantee is in effect will not require a Minimum No Lapse Premium for those months while we were paying benefits under this rider.

2. Any negative Policy Value will be reset to zero.
3. Policy transactions that were restricted while we were paying benefits under this rider will become unrestricted.

15. **CONTACT THE STATE AGENCY LISTED IN *A SHOPPER'S GUIDE TO LONG TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE RIDER.**

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office:
6400 C Street SW
Cedar Rapids, IA 52499
(800) 238-4302

Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

Regulations in your state require the insurance company to fill out part of the information on this worksheet and **ask** you to fill out the rest in order to help you and the company decide if you should buy this long term care rider with your life insurance policy.

Premium Information

Rider Form Number _____

The additional charge for the long term care rider you are considering will be charged monthly and will vary based on the policy's amount at risk on each monthly policy date and the appropriate monthly charge rate as determined by the insured's age, sex, class of risk, substandard rating and length of time since the effective date of the rider.

The initial monthly charge for the long term care rider will be $_____.

Type of Rider (noncancellable/guaranteed renewable): Guaranteed Renewable.

The Company's Right to Increase Rider Charges: The Company has a right to increase charges for the long term care rider in the future, provided it raises long term care rider charges for all riders in the same class.

Rider Charges Rate Increase History

The Company and its affiliates have sold long-term care riders since 2013. The Company has not requested any nationwide rider charge increases for previously sold long term care rider forms (within the last 10 years) providing similar coverage.

Questions Related to Your Income

How will you pay each year's rider charge?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

❑ Have you considered whether you could afford to keep this rider if the rider charge you were initially shown went up, for example, by 20% or more?

What is your annual income? (check one)

❑ Under $10,000 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this rider if the charges will be more than 7% of your income.

Have you considered how you will pay for the difference between future costs and your monthly benefit amount?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

The national average annual cost of care in 2012 was $81,030, but this figure varies across the country. In ten years the national average annual cost would be about $131,989 if costs increase 5% annually.

Are you considering the elimination period?

The long term care rider you are considering has an elimination period of 90 days during which benefits will not be paid. Approximate cost is $_____for that 90-day period of care.

How are you planning to pay for your care during the elimination period? (check one)

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20,000-$30,000 ❑ $30,000-$50,000 ❑ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

❑ Stay about the same ❑ Increase ❑ Decrease

If you are buying this rider to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

❑ The answers to the questions above describe my financial situation. OR ❑ I choose not to complete this information, but I do wish to purchase this coverage. (Check one.)
❑ I acknowledge that the carrier and/or its agent/insurance producer (below) has reviewed this form with me including the rider charge, rider charge rate increase history and potential for rider charge increases in the future. I understand the above disclosures. **I understand that the charges for this rider may increase in the future.** (This box must be checked.)

Signed: _____ _____
(Applicant) (Date)

❑ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent/Insurance Producer) (Date)

Agent's/Insurance Producer's Printed Name: _____

Note: In order for us to process your application, please return this signed statement to Transamerica Life Insurance Company, along with your application.

❑ My agent/insurance producer has advised me that this rider does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

TRANSAMERICA LIFE INSURANCE COMPANY
HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
PO Box 159
Cedar Rapids, IA 52406-0159
1-800-227-3740
LTCQuestions@Transamerica.com

Things You Should Know Before You Buy Long - Term Care Insurance

Long-Term Care Insurance:

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should not buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare:

- Medicare does not pay for most long-term care.

Medicaid:

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should not buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide:

- Make sure the insurance company or agent/insurance producer gives you a copy of a book called the National Association of Insurance Commissioners' "A Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling:

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. For more information about the senior health insurance counseling program in your state, contact the state insurance agency listed in the Directories in the above mentioned Shopper's Guide to Long-Term Care Insurance.

Facilities:

- Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices ("Notice") covers an Affiliated Covered Entity ("ACE"). When this Notice refers to the Transamerica ACE or "we", "our" or "us", it is referring to the health care components of the following affiliated entities; Transamerica Financial Life Insurance Company, and Transamerica Life Insurance Company. Each of the companies listed above is a hybrid covered entity under the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively, "HIPAA"). The combined companies listed are designated as a single covered entity for purposes of compliance with HIPAA and certain covered health care components of such companies. The single covered entity shall be known as the Transamerica Affiliated Covered Entity or the "Transamerica ACE." This designation may be amended from time-to-time to add new covered entities that are under common control and ownership to the Transamerica ACE.

The Transamerica ACE is required under HIPAA to protect the privacy of your protected health information ("PHI"), provide you with notice of our legal duties and privacy practices with respect to PHI and abide by the terms of the Notice currently in effect for the Transamerica ACE. This Notice describes how the Transamerica ACE may use and disclose your PHI and your rights to access and amend your PHI.

This notice is effective September 23, 2013 as revised per the date set forth in the footer below, and provided to you in connection with your health plan from the Transamerica ACE. In some cases, this may include product riders purchased with a product that is not considered a health plan subject to HIPAA. Health plans include, but are not limited to: Dental, Long Term Care, Medicare Supplement, Prescription Drug Coverage, Supplemental Medical Expense, Medical Expense, and TRICARE.

Our Commitment to Your Privacy

We are committed to maintaining the privacy of your PHI. This notice will tell you about the ways in which we may use and disclose your PHI for payment, health care operations, and other circumstances as either required or permitted by law. Permitted uses and disclosures may include use and disclosure between the affiliates within the Transamerica ACE. **Except as outlined below, we will not use or disclose your PHI without your written authorization, which you may revoke as described in the "Your Privacy Rights" section below.** For example, use or disclosure of your PHI for marketing, certain uses or disclosures of psychotherapy notes, or any disclosure that would constitute a sale of your PHI, would require your authorization.

We are required by law to: safeguard your PHI; give you this Notice of our duties and privacy practices; notify you in the event of a breach of your unsecured PHI; and abide by the terms of the Notice of Privacy Practices currently in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this Notice, and to make the new notice effective for all PHI maintained by us. In the event of a material change, a revised notice will be sent to all of our policyholders who are enrolled in a health plan subject to HIPAA.

USES AND DISCLOSURES OF YOUR PHI

1. **Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors, hospitals, long term care facilities, and other health care providers involved in your care.

2. **Payment**. We may use and disclose your PHI as necessary for benefit verification and claims processing purposes. For instance, we may use information regarding health care services you receive from service providers such as physicians, hospitals, pharmacies, nursing homes, assisted living facilities, and home health care agencies to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf. Examples of our payment related purposes also include our collection of premiums, coordinating reinsurance, and care coordination activities.

3. **Health Care Operations.** We will use and disclose your PHI as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, pricing, enrollment, underwriting, reinsurance, compliance, auditing, rating, customer service, fraud prevention and reporting, security, payment of agent commissions, and other functions related to your health plan. With the exception of certain long-term care insurance, we are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. If our long-term care insurance underwriting uses genetic information, it will only be used in a manner allowed by law.

4. **Family and Friends Involved in Your Care.** We may disclose your PHI to certain family, friends, and others who are involved in your care or in the payment for your care based on your authorization or if we inform you and you do not object. We may also share your PHI to individuals or others based on your authorization. If you are unavailable, incapacitated, or facing an emergency medical situation, or if we have determined, based on our professional judgment and review of the circumstances, that you would not object and that a limited disclosure may be in your best interest, we may share limited PHI without your approval. If you have designated a person to help prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited PHI to a public or private entity that is authorized

to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.

5. **Business Associates**. Certain services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, claims investigation and adjudication, underwriting support services, care coordination services, etc. We may disclose your PHI to one or more of these outside persons or organizations that assist us with our operations. We obligate business associates to appropriately safeguard the privacy of your PHI.

6. **Collection of Information.** To properly underwrite, rate, and administer your health plan, we may collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization, we may also collect or verify information by contacting information sources such as: insurance support organizations (like Medical Information Bureau, Inc.); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.

7. **Agents.** Your agent is our business associate. For customer service purposes, your agent may be notified of certain coverage-related matters and information necessary to assist in servicing your coverage. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when there is a change in premium paying status, when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent, and, if applicable, the company the agent represents, may be notified on their commission statement that your policy remains in force for as long as you continue to pay your premium.

8. **Plan Sponsors.** We may also use or disclose PHI to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

9. **Health-Related Products, Benefits and Services.** We or our business associates may contact you regarding health-related benefits, products and services that may be of interest to you.

10. **Mergers and Acquisitions.** Your PHI may also be disclosed as a part of a potential sale, merger or acquisition involving our business.

USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

1. Your PHI may be used or disclosed as applicable without your authorization in the following or similar circumstances:
   - for any purpose when required by law;
   - for public health and/or law enforcement activities consistent with law, including if we suspect child abuse, elder abuse, or neglect or believe you to be a victim of abuse, neglect, domestic violence, or other crimes;
   - as required by law for a governmental oversight agency conducting audits, investigations (such as investigations in to consumer complaints), or civil or criminal proceedings;
   - in a judicial or administrative proceeding, as required by a court or an administrative ordered subpoena, or in response to a subpoena or discovery request;
   - as required by law for certain law enforcement purposes; about deceased persons to coroners, medical examiners, and funeral directors consistent with law;
   - if necessary for organ and tissue donation or transplant;
   - for research purposes as permitted by law;
   - upon reasonable belief to avert a serious threat to health or safety;
   - for specialized government functions (such as military personnel and inmates in correctional facilities);
   - for national security or intelligence activities;
   - to workers' compensation agencies as permitted or required by law;
   - to Non-affiliated organizations or persons as permitted by HIPAA, such as other insurance institutions, agents, insurance support organizations (such as Medical Information Bureau, Inc.), or law enforcement and governmental authority as necessary to prevent or investigate criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage;
   - to our parent company and affiliates in conjunction with health care operation purposes;
   - to the Department of Health and Human Services for HIPAA compliance purposes.

<u>Your Privacy Rights</u>

Your rights are explained below. ***Any written requests to exercise those rights should be directed to the address provided at the end of this notice.***

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations, or with certain persons involved in your care, by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, consistent with HIPAA we are not required to agree to the restriction, unless it is a restriction to a health plan for a specific treatment or service that you, or someone on your behalf, has paid for in full, out of pocket, the disclosure is for payment or health operations purposes, and the disclosure is not otherwise required by law.

We retain the right to terminate an agreed upon restriction, other than a specific restriction as to payment or health care operations mentioned above, if we believe such termination is appropriate. In the event of a termination by us, it will only apply to health information created or received after you have been notified of the termination. You also have the right to terminate a restriction, in writing. You may obtain a Request for Restriction form (or terminate a restriction) by contacting us at the phone number or address listed at the end of this notice.

2. **Confidential Communications.** You may request that we send communications of health information to you by alternative means or to alternative locations. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests. We must accommodate a reasonable request if you inform us that disclosure of some or all of your health information could endanger you. You may obtain a Request for Confidential Communication form by contacting us at the phone number or address listed at the end of this notice.

3. **Access.** You have a right to access certain PHI that we retain on your behalf. This means you may submit a written request, signed by you or your representative, to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you also have the right to request a copy in electronic format. We may charge a reasonable fee for copies, postage, labor and supplies. In certain cases, we may deny your request and you may have the right to appeal that decision. If we approve your request, we are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay and the expected date when the request will be fulfilled. You may obtain a Request for Access form by contacting us at the phone number or address listed at the end of this notice.

4. **Amendment.** You have the right to request that PHI we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we will notify you and we will also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary or as identified by you. You may obtain a Request for Amendment form by contacting us at the phone number or address listed at the end of this notice.

5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your PHI within the six (6) calendar years immediately preceding such a request. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting us at the phone number or address listed at the end of this notice.

6. **Revocation of Authorization**. If you have signed an authorization for uses and disclosures of health information, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance on such authorization or the authorization was obtained as a condition of obtaining insurance coverage, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.

7. **Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time by contacting us at the phone number or address listed below. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

NOTE: The rights granted to you do not extend to information about you relating to or in anticipation of a claim or civil or criminal proceeding.

Complaints

If you believe your privacy rights have been violated, you can file a complaint with us by sending your written complaint to our Consumer Affairs Department at the address given below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

Contacting Us

To file a complaint or to make a request as described in the section entitled "Your Privacy Rights," please send your written request to the company at: 6400 C St SW, Cedar Rapids, IA 52499. Requests should be directed to our Customer Service Department and Complaints should be sent to the attention of our Consumer Affairs Department. Please be sure to include the following information:

- Your full name
- Address
- Date of Birth
- Last four digits of your Social Security Number
- Policy number
- The nature of your request or complaint

FOR FURTHER INFORMATION regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy practices, please write to us at the address shown above or call 1-866-512-7495.

THIS NOTICE IS REQUIRED BY FEDERAL LAW. WE MAKE IT AVAILABLE TO THE GENERAL PUBLIC, APPLICANTS AND POLICYHOLDERS. YOUR RECEIPT OF THIS NOTICE IS NOT EVIDENCE OF COVERAGE.

TRANSAMERICA®

Application for Fixed Life Insurance

Transamerica Financial Foundation IUL®
Transamerica Financial Choice IUL℠

Please be advised the forms contained in this booklet are intended to be used with IUL only. Some forms may not be approved for use with other products.

MAIL TO:
6400 C Street SW
Cedar Rapids, IA 52499
1-800-322-3796

THIS APPLICATION PREPARED FOR

Application Prepared by

U327 0312W TX REV
REV 1022

Application Checklist

Important Reminders	**DO:** ☐ Complete the entire application (front and back). ☐ Print application in blue or black ink. ☐ Have applicant initial all changes. ☐ Obtain all required signatures. ☐ Complete and sign the Agent's Report. ☐ Include certification if a trust or corporation is Owner of the policy. **DON'T:** ☐ Use pencil or whiteout. ☐ Accept or send money for total coverage on the proposed primary Insured over $2,000,000.00. ☐ Accept cash with application if the proposed primary Insured is age 76 and over. ☐ Submit an agent check as the initial premium. ☐ Submit starter checks or checking deposit slips for check-o-matic withdrawals. ☐ If within the past 12 months the proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.

PLEASE MAKE SURE ALL APPLICABLE FORMS WITHIN THE PACKET ARE COMPLETED

Leave with Applicant	**THE FOLLOWING PAGES NEED TO BE LEFT WITH THE CONSUMER:** ☐ Buyer's Guide (Where applicable) ☐ Privacy Notice ☐ Conditional Receipt (If money taken with application) ☐ Notices page (Notice of Investigative Report, Disclosure of Information, and Insurance Information Practices) ☐ HIPAA Authorization for Release of Health Related Information ☐ Replacement Disclosure - REPLDISC 0210 **(Required in CT, DC and ND)**

Agent Comments

RESET

LIFE APPLICATION – Transamerica Life Insurance Company
Mailing Address: 6400 C Street SW, Cedar Rapids, IA 52499
Administrative Office: 6400 C Street SW, Cedar Rapids, IA 52499

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION 1. PROPOSED PRIMARY INSURED/OWNER **Face Amount $**_____

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Employer	Years

15. Employer's Address and Phone Number

16. Occupation & Duties

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used_____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED **Face Amount $**_____

If more than one Additional Insured, please use Additional Information Supplement.

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth MM-DD-YYYY	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED **If owner is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If owner is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.**

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Home Phone ( )	4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female	6. Date of Birth/Trust Date MM-DD-YYYY	7. Relationship to the proposed primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country_____ Type of VISA _____

SECTION 4. CHILDREN'S BENEFIT RIDER **Face Amount $** _____

Name	Relationship	Date of Birth	Height	Weight
		MM—DD—YYYY	ft in	lbs
		MM—DD—YYYY	ft in	lbs
		MM—DD—YYYY	ft in	lbs

Are all children listed? ☐ Yes ☐ No Are all children living with proposed primary Insured? ☐ Yes ☐ No

If not, explain why:_____

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 7. PROPOSED PLAN OF INSURANCE

☐ Transamerica Financial Foundation IUL®

☐ Transamerica Financial Choice IUL℠

SECTION 8. DEATH BENEFIT OPTION (if applicable)

☐ Level Benefit ☐ Increasing Benefit

SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)

☐ Guideline Premium Test ☐ Cash Value Accumulation Test (CVAT)

SECTION 10. ADDITIONAL BENEFITS–PRIMARY INSURED ONLY Not all applicable with all products.

☐ Base Insured Rider..... $ _____

☐ Accidental Death Benefit Rider..... $ _____

☐ Guaranteed Insurability Rider..... $ _____

☐ Disability Waiver of Premium Rider

☐ Disability Waiver of Monthly Deductions Rider

☐ Long Term Care Rider (complete Supplemental Application)

☐ Other _____

SECTION 11. PREMIUMS PAYABLE

Initial Planned Premium..... $ ___,___,___.___

☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly ☐ Other _____

☐ Electronic (bank draft) _____ Draft Date (1st thru 28th) ☐ Direct Bill

A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

_____

Secondary Addressee

_____

Street Address (Cannot be a PO Box) City State Zip

SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)

Indicate your premium allocation percentages below. Total must equal 100% and must be whole percents only. Index disclosures are provided on the Index Disclosure Information page accompanying this application. Available index options vary by product.

_____.0% Global Index Account

_____.0% Global Plus Index Account

_____.0% S&P 500® Index Account

_____.0% S&P 500® Plus Index Account

_____.0% Fidelity SMID Multifactor Index℠ Account

_____.0% Basic Interest Account

100% Total

SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS

Does the proposed Insured have existing life insurance, disability policies, critical illness or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?
					Yes No
					Yes No
					Yes No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ ___,___,___.___

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain._____ ☐ Yes ☐ No

_____

B) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report. ☐ Yes ☐ No

SECTION 14. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed primary Insured, not the Owner.

A) Gross Income Current Yr $ ____ , _____ . _____

B) Gross Income Previous Yr $ ____ , _____ . _____

C) Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange ☐ Other_____

D) Current Net Worth $ ____ , _____ . _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 through 70 and $1,000,000 for ages 71 and up.

SECTION 15. BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

A) Current Estimated Market Value $ _____ , _____ , _____

B) Assets *Liquid* $ _____ , _____ , _____

Nonliquid $ _____ , _____ , _____

C) Liabilities $ _____ , _____ , _____

D) Net Worth $ _____ , _____ , _____

SECTION 16. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to "No" answer for medical question 16A and "Yes" answers to questions 16B-E in Section 17 below:

A) For the last 180 days has the proposed primary Insured been actively at work, on a full time basis, at their usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No
2) Asthma, Emphysema, Chronic Bronchitis, Tuberculosis, or any other Respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No
3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No
4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No
5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

C) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No
2) Sought or been advised to seek treatment, limit or discontinue use of alcohol? ☐ Yes ☐ No
3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No
4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test? ☐ Yes ☐ No
5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Have you ever been diagnosed as having or told by a medical doctor that you have AIDS, HIV, or ARC disorders? ☐ Yes ☐ No

E) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

SECTION 17. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.

A) The proposed Insured is a citizen of ☐ USA ☐ Other Country _____ Type of VISA_____

B) How many years has the proposed Insured resided in the USA?_____

C) Does any proposed Insured travel outside the USA? ☐ Yes ☐ No

If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year.

_____

_____

SECTION 20. DRIVING AND PUBLIC RECORDS –Each question must be individually asked and answered for each proposed Insured.

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

_____

_____

SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

SECTION 22. OTHER INSURANCE–TO BE COMPLETED BY THE AGENT

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No

(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

C) Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

SECTION 23. ILLUSTRATION CERTIFICATION (if applicable) **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

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

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

SECTION 24. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the undersigned applicant is the premium payor and Owner of the policy applied for.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, LLC ("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 30 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.

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

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

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

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

If the product applied for is an Index Universal Life Policy, I understand that the values of the policy may be affected by an external index even though the policy does not directly participate in any stock or equity investments.

TAXPAYER IDENTIFICATION CERTIFICATION

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

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

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

Signed at _____ (city) _____ (state) on MM – DD – YYYY (date)

_____
Signature of proposed primary Insured/Owner
(Child age 16 and over must sign)

_____
Signature of parent or legal guardian for Insured(s) 15 and under

_____
Signature of proposed Additional Insured

_____
Signature of Applicant/Owner if other than the proposed primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

_____
Print Agent Name

_____
Agent #

_____
Signature of Agent/Licensed Rep.

_____
Signature of Split Agent/Licensed Rep.

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CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary 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 on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, 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 not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts 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 (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured 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 Tobacco 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 it, 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 notice and/or 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 the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,000,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance 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. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

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 primary 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 primary 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 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 _____ _____ , 20 _____

Signature of Proposed Owner | Date

_____ _____

If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust.

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

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

Original

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CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary 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 on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, 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 not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts 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 (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured 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 Tobacco 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 it, 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 notice and/or 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 the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,000,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance 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. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

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 primary 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 primary 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 the application have been met.

Dated at _____ on _____ ,20____ X _____

City, State | Date | Insurance Producer or other Company Authorized Rep

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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.

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

Proposed Owner

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NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

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

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

MIB PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any. 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, 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.

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Transamerica Life Insurance Company, Attn: Director of Underwriting, 6400 C Street SW, Cedar Rapids, Iowa 52499.

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

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Additional Information Supplement

SECTION 1. PROPOSED CONTINGENT OWNER **If owner is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If owner is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.**

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Home Phone ( ) | 4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date | 7. Relationship to proposed primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

SECTION 2. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 4. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 5. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 6. DECLARATIONS

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at _____ _____ on MM - DD - YYYY
(city) (state) (date)

sec. 1 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

sec. 3 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

sec. 2 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

sec. 4 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

_____
Signature of Parent or Legal Guardian for Insured(s) 15 and under

_____
Witness (Agent/Licensed Rep.)

_____
Signature of Applicant/Owner, if other than the proposed primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

INDEX DISCLOSURE INFORMATION

S&P 500 Index

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Fidelity SMID Multifactor Index

The Fidelity Small-Mid Multifactor Index℠ 5% ER, also called the Fidelity SMID Multifactor Index℠, (the "Index") is a product of Fidelity Product Services LLC ("FPS"). It is a rules-based index that utilizes a dynamic asset allocation approach which blends multiple factors with the characteristics of stocks of small and mid-capitalization U.S. companies along with U.S. Treasuries, which may reduce volatility over time. Fidelity is a trademark of FMR LLC. The Index has been licensed for use for certain purposes by Transamerica Life Insurance Company ("the Company") on behalf of the Transamerica Financial Choice IUL℠("policy"). The Index is the exclusive property of FPS and is made and compiled without regard to the needs, including, but not limited to, the suitability needs, of the Company, the policy, or the policy owners. The policy is not sold, sponsored, endorsed or promoted by FPS or any other party involved in, or related to, making or compiling the Index.

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FPS disclaims all warranties, express or implied, including all warranties of merchantability or fitness for a particular purpose or use. FPS shall have no responsibility or liability with respect to the policy.

Not all indexes are available with all products.

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____ CASE MANAGER: _____

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

This page intentionally left blank

TRANSAMERICA®

Payment Authorization Form

Policy Number (for existing policies only)

Introduction

Instructions:

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

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

Insured FIrst Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Recurring Draft Day (1st through 27th only)

Initial modal premium is withdrawn upon receipt of the application and a completed Conditional Receipt and not on the day chosen for recurring payment. If a Conditional Receipt is not received with the application, then the initial premium is drafted at policy placement.

_____

Leave the above blank to have recurring premiums drafted on day policy is issued.

Recurring Premium Payment Mode (choose one)

☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Planned Modal Premium

$ _____

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

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Check	☐ **Initial**	Mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	This method only available quarterly, semiannually, or annually.
Lump Sum	☐ **One Time Draft Amount** $ _____	At Issue I approve to have the One Time Draft amount drafted from the account below.

Draft upon Underwriter Approval? ☐ **Yes** ☐ **No**

Wait for acceptance to draft after confirmation from agent? ☐ **Yes** ☐ **No**

One-time ACH Debit Authorization

This section should be completed by the Bank Account Holder (Payor). Some policies may require an adjustment payment to cover a gap in premium when certain billing changes occur. This adjustment payment will keep the policy active until your recurring payments begin.

☐ By checking this box and signing this form, you authorize a one-time ACH debit in an amount needed to put your policy in an active status until your recurring payments begin. If this amount has not already been provided, contact us and we will provide you with the exact amount required. If authorized, this ACH debit will be made to your account on or after the date this request is received in good order.

NOTE: If you do not authorize this debit, and payment is still required, you will be contacted.

Bank Draft (ACH/EFT) Payment Information

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

Account Holder First Name _____ Account Holder Last Name _____

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

_____

Financial Institution Name

_____

Routing Number _____ Account Number _____

The account holder is the (choose one):

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

Account Holder Signature:

X _____ **Date:** _____

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

Consents

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

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

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

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

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

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

Notice and Consent for HIV-Related Testing TEXAS

To evaluate your insurability, the insurer named above ("the Insurer") has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations

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.

Meaning of Positive Test Result

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test. Positive HIV antibody test results will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

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 decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The 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 disclose the identity of any particular person.

Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

_____
Name of physician for reporting a positive test result

_____
Street Address

_____
City, State, Zip Code

_____
Telephone

Notice and Consent for HIV-Related Testing TEXAS

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing*. I voluntarily consent to the withdrawal of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

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*)	Signature of Proposed Insured
Street	Date Signed
City, State, Zip Code	Date Birth

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

For Financial Foundation IUL:

Mail:	6400 C Street SW Cedar Rapids, IA 52499
Telephone:	1-800-851-9777
Internet:	https://tlic.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 not 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 of 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 paper copies.

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**

TRANSAMERICA®

eDELIVERY | SECURE! EASY! ENVIRONMENTALLY FRIENDLY!

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 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): _____

About the NAIC …

The **National Association of Insurance Commissioners** (NAIC) is the oldest association of state government officials. Its members are the chief insurance regulators in all 50 states, the District of Columbia, and five U.S. territories. State regulators' primary responsibility is to protect insurance consumers' interests, and the NAIC helps regulators do this in several different ways. This Shopper's Guide is one example of the NAIC's work to help the states educate and protect consumers.

Another way the NAIC helps state insurance regulators is by giving them a forum to develop uniform public policy when appropriate. It does this through a series of model laws, regulations, and guidelines developed for the states' use. The states may choose to adopt the models intact or change them to meet the needs of their marketplace and consumers. As you read through this Shopper's Guide, you'll find several references to NAIC model laws or regulations related to long-term care insurance. Check with your state insurance department to find out if your state has enacted these NAIC models.

National Association of Insurance Commissioners
1100 Walnut Street
Suite 1500
Kansas City, MO 64106-2197

Phone: (816) 842-3600

www.naic.org
Revised 2019

About This Shopper's Guide

The decision to buy long-term care insurance is an important financial decision that shouldn't be rushed. The **National Association of Insurance Commissioners** (NAIC) wrote this Shopper's Guide to help you understand long-term care and the insurance options that can help you pay for long-term care services. The decision to buy long-term care insurance is very important. You should not make it in a hurry. Most states' laws require insurance companies or agents to give you this Shopper's Guide to help you better understand long-term care insurance and decide which, if any, policy to buy. Some states produce their own shopper's guide.

Take a moment to look at the table of contents and you will see the questions this Shopper's Guide answers. Then read the Shopper's Guide carefully. If you see a term you don't understand, look in the glossary starting on page 36. (Terms in **bold** in the text are in the glossary.) Take your time. Decide if buying a policy might be right for you.

If you decide to shop for a long-term care insurance policy, start by getting information about the long-term care services and facilities you might use and how much they charge. Use the worksheets at the back of this Shopper's Guide to write down information. Use Worksheet 1—*Availability and Cost of Long-Term Care in My Area* on page 46 to collect information about the facilities and services in your area. Then, as you shop for a policy, use Worksheet 2—*Compare Long-Term Care Insurance Policies* on page 48 to compare long-term care insurance policies.

If you have questions, call your state insurance department or another consumer assistance agency in your state. See the list of state insurance departments, agencies on aging, and **state health insurance assistance programs** starting on page 57.

Transamerica Life Insurance Company

Administrative Office located at: 6400 C Street SW, Cedar Rapids, IA 52499. Telephone: (319) 355-8511

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___NO**

If you answered “yes” to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy number or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.
I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant’s Signature and Printed Name Date

_____ _____
Producer’s Signature and Printed Name Date

_____ I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

- Are they affordable?
- Could they change?
- You're older – are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
- What surrender charges do the policies have?
- What expenses and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:

- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- [Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

- What are the tax consequences of buying the new policy?
- Is this a tax-free exchange? (See your tax advisor)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

30 DAY RIGHT TO CANCEL

In the event of a replacement transaction, you may cancel this policy by delivering or mailing a written request to the Company. You must return the policy to the Company before midnight of the thirtieth day after the day you receive it. You will receive an unconditional full refund of all premiums or considerations paid on it, less any withdrawals and indebtedness, including any policy fees or charges or, in the case of a variable or market value adjustment policy, payment of the cash surrender value provided under the policy plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy. Your written request given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid.

RESET

Transamerica Financial Foundation IUL®

Offered by Transamerica Life Insurance Company, Cedar Rapids, IA ("the Company")

Statement of Understanding and Acknowledgment

Applicant's Name: _____

I am applying for an Index Universal Life Insurance Policy to be issued by the Company. In connection with my application I understand that:

THE POLICY

This policy is intended for people whose primary purpose in buying life insurance is for the death benefit.

Since a portion of the interest credited to the Index Account(s) is calculated in part by reference to outside indexes, there is the potential for greater volatility in the amount of Excess Index Interest credited than of interest credited to the Basic Interest Account. This policy works best for those individuals who can tolerate fluctuations in interest crediting and is not recommended for policyowners who do not intend to allocate a significant portion of their net premiums to the Index Account(s).

This policy is not an investment in the stock markets or the indexes and does not participate in any stock or investments.

PREMIUMS

I must pay premiums on a regular basis to keep the policy in effect. The policy may lapse if I do not have sufficient Cash Surrender Value (Policy Value less the Surrender Charge and less any Loan Balance) in the policy to pay the next Monthly Deduction and Index Account Monthly Charge and have not paid enough premiums to meet the Minimum No Lapse Premium requirement. In that event, I would be required to pay additional premiums to keep the policy in force.

ACCOUNT OPTIONS

The policy I am applying for allows me to allocate my net premium payments to more than one Account Option: the Basic Interest Account and the Index Accounts. Interest will be credited differently to the different Account Options.

INTEREST

Net premiums allocated to the Basic Interest Account will earn interest at the Current Interest Rate declared by the Company. This rate is guaranteed never to be less than 2% per year. Net Premiums received after a Monthly Policy Date that are to be allocated to the Basic Interest Account will earn interest at the Current Interest Rate until the next Monthly Policy Date, when they will be placed into the next Basic Interest Account Segment.

Net Premiums allocated to the Index Accounts will earn interest at a guaranteed minimum annual interest rate of 0.75%. Net Premiums received after a Monthly Policy Date that are to be allocated to an Index Account will earn interest at the guaranteed rate until the next Monthly Policy Date, when they will be placed into the next Index Account Segment. Additional interest ("Excess Index Interest") may be credited at of the end of each one-year Segment Period.

EXCESS INDEX INTEREST

Excess Index Interest on the Index Accounts is determined using a formula based on changes in the index(es), excluding dividend income, and cannot exceed the Cap established by the Company. The Company may determine a different Cap for each Segment and can increase or decrease the Cap at its discretion at the Segment Anniversary. Current Caps will be shown in Policy Statements and may be obtained from the Company's Administrative Office.

Excess Index Interest, if any, is credited to a segment at the end of each one year Segment Period. Any Policy Values, Death Benefit or Cash Surrender Value determined during a Segment Period will be based only on guaranteed minimum interest that has already been credited during the Segment Period. A Policy Statement reflecting Policy Values and the interest credited for a policy year will be provided annually.

EXCESS INDEX INTEREST (CONTINUED)

Monthly Deductions, Index Account Monthly Charges, and certain policyowner transactions, such as transfers, loans and withdrawals, occurring during a Segment Period will reduce the value used in determining Excess Index Interest. This will result in the reduction of any Excess Index Interest that might otherwise have been credited at the end of the Segment Period. Upon surrender of the policy, no Excess Index Interest will be credited for partial years on any Index Account Segment.

TRANSFERS

Transfers from an Index Account Segment will only be processed at the end of the Segment Period. For purposes of dollar cost averaging, transfers to an Index Account are processed on the monthly policy date following receipt of the request. Transfers from the Basic Interest Account will only be processed on the monthly date following receipt of the request.

LOANS AND WITHDRAWALS

Loans and withdrawals may be taken from the Basic Interest Account and the Index Accounts(s). Loans and withdrawals are Subject to certain fees and charges and to the conditions and limitations specified in the policy.

SURRENDERS

If the policy is surrendered, the Cash Surrender Value of the policy will be equal to the Policy Value less any applicable surrender charges and any Loan Balance. Surrender charges apply for the first fifteen policy years and for fifteen years from the date of any Face Amount increase. The surrender charge will vary based on the Face Amount and duration of the Policy and the issue age, gender and class of risk of the insured on the policy date and at the time of any increase in the Face Amount.

CONSUMER BROCHURE

I have received a copy of the Consumer Brochure containing information regarding the policy. I understand that I have a certain period of time after receipt of the policy issued to me to review and return it for a refund of premium as described in the policy.

I have read and understand the above disclosures of certain limitations and restrictions regarding the policy and the Index Account(s).

The guaranteed minimum interest rates for the Basic Interest Account and Index Accounts are shown on the previous page. Non-guaranteed rates and other elements appearing on illustrations or other related materials are hypothetical and actual results may be less favorable than those shown on such documents. I understand I may select the assumed rates and elements used in illustrations or other related materials.

Date: _____ Applicant Name (print): _____

Signature of Applicant: _____

INDEX UNIVERSAL LIFE INSURANCE IS NOT A SECURITY and index universal life insurance policies are not an investment in the stock market or in the indexes. Index Account Interest is based, in part, on index performance.

Past performance of an index is not an indication of future index performance. There is no guarantee that any Excess Index Interest will be credited above the guaranteed minimum interest rate for the Index Account(s). Additionally, there is no guarantee that the company will declare an interest rate greater than the guaranteed minimum interest rate for the Basic Interest Account.

TRANSAMERICA®

Index Universal Life Insurance offered by:
Transamerica Life Insurance Company, Cedar Rapids, IA • Home Office: Cedar Rapids, IA

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

TRANSAMERICA LIFE INSURANCE COMPANY

CONSENT TO SHARE INFORMATION WITH THIRD PARTY SERVICE PROVIDER UNDER ADDITIONAL SERVICES RIDER

In consideration of having the Additional Services Rider ("Rider") attached to the life insurance policy insuring my life, I, the insured person, consent to the insurance company sharing my personal information, including, but not limited to, my name, street and electronic mail address, telephone number, gender, date of birth, policy number, and policy face amount and status (collectively "Information"), with the third party provider of the services described in the Rider during the term of, and in accordance with, the Rider. I agree that the insurance company can collect, use and share such Information with the third party service provider to facilitate the services described in the Rider.

I further agree that the insurance company is not responsible for any further use, sharing or disclosure of my Information by the third party service provider, or such third party service provider's privacy practices.

I understand that I may revoke this consent, in writing, at any time. However, any use, disclosure or sharing of my Information that occurred prior to the date I revoke this consent is not affected.

_____

Signature of Insured (Parent/Legal Guardian, if signing for a minor)

_____ _____

Print Insured Name (and Parent/Legal Guardian name, if a minor) Date

If the Policy Owner is other than the Insured, also complete the following:

Acknowledged and agreed to by:

_____

Signature of Policy Owner

_____ _____

Print Policy Owner Name Date

TRANSAMERICA®

Payment Authorization Form

Policy Number (for existing policies only)

Introduction

Instructions:

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

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

Insured FIrst Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Recurring Draft Day (1st through 27th only)

Initial modal premium is withdrawn upon receipt of the application and a completed Conditional Receipt and not on the day chosen for recurring payment. If a Conditional Receipt is not received with the application, then the initial premium is drafted at policy placement.

_____

Leave the above blank to have recurring premiums drafted on day policy is issued.

Recurring Premium Payment Mode (choose one)

☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Planned Modal Premium

$ _____

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

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Check	☐ **Initial**	Mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	This method only available quarterly, semiannually, or annually.
Lump Sum	☐ **One Time Draft Amount** $ _____	At Issue I approve to have the One Time Draft amount drafted from the account below.

Draft upon Underwriter Approval? ☐ **Yes** ☐ **No**

Wait for acceptance to draft after confirmation from agent? ☐ **Yes** ☐ **No**

One-time ACH Debit Authorization

This section should be completed by the Bank Account Holder (Payor). Some policies may require an adjustment payment to cover a gap in premium when certain billing changes occur. This adjustment payment will keep the policy active until your recurring payments begin.

☐ By checking this box and signing this form, you authorize a one-time ACH debit in an amount needed to put your policy in an active status until your recurring payments begin. If this amount has not already been provided, contact us and we will provide you with the exact amount required. If authorized, this ACH debit will be made to your account on or after the date this request is received in good order.

NOTE: If you do not authorize this debit, and payment is still required, you will be contacted.

Bank Draft (ACH/EFT) Payment Information

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

Account Holder First Name _____ Account Holder Last Name _____

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

_____

Financial Institution Name

_____

Routing Number _____ Account Number _____

The account holder is the (choose one):

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

Account Holder Signature:

X _____ **Date:** _____

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

Consents

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

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

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

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

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

INTERNATIONAL BROKERAGE AGENCIES, INC.

HIPAA AUTHORIZATION RELEASE
TO OBTAIN AND DISCLOSE INFORMATION

Name of Proposed Insured

Please Print

_____ _____/_____/_____

First MI Last DOB Month/Day/Year

I authorize any person licensed to provide health care services, hospital, clinic or other medical or medically related facility, insurer, reinsurer, insurance support organization, the Medical Information Bureau, Inc., consumer report agency, state motor vehicle agency, employer, or any other person or institution to release to each of the insurance companies listed below, as well as to their reinsures, any insurance support organizations, those person authorized to represent them; and International Brokerage Agencies, Inc.; any information related to my mental and physical health, lab results, other insurance coverage, hazardous activities, character, general reputations, finances, occupations, other personal traits, drug and/or alcohol use and driving record for me and my minor children who are to be insured. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases.

THIS AUTHORIZATION APPLIES TO THE FOLLOWING:

- Aetna Companies
- Allstate Health Solutions
- American National
- APPS
- Brighthouse Life
- Corebridge
- ExamOne
- Express Imaging Services
- Fidelity Life
- Gerber
- Global Atlantic
- Illinois Mutual
- IMG
- J&H
- John Hancock
- Kemper
- Legal & General
- Lincoln Financial Group
- MassMutual
- Mutual of Omaha
- Nationwide
- North American
- OneAmerica
- Pacific Life
- Principal Life
- Protective
- Prudential
- SBLI
- Securian Financial
- Symetra
- Transamerica
- World Trips

By my signature below, I acknowledge that any agreements I have made with my Providers that restrict disclosure of my medical records and any associated HIPPA protected health information do not apply for purposes of this authorization and I instruct my physician, health care professional, hospital, clinic, medical facility or any other health care provider to release and disclose my entire medical record without restriction to International Brokerage Agencies, Inc. I understand that any information that it is disclosed pursuant to this authorization may be re-disclosed and no longer covered by certain federal rules governing privacy and confidentiality of health information.

The information contained in these medical and financial records will be held in confidence and may be used only for the purpose of the procurement, or the evaluation or underwriting for the possible procurement, of life, health, disability income, long term care, or other insurance products. The contents therein may be reviewed and assessed by a qualified staff consisting of medical directors, underwriters, underwriting assistants, or other related employees involved in the submission, receipt, or evaluation of insurance applications or prospective applications of the insurance companies listed above and their re-insurers as well as International Brokerage Agencies, Inc. and its staff, employees and affiliated companies.

I understand and agree that this form is not an application for life insurance and that no life insurance coverage is provided in connection with this form.

This authorization shall be valid for twenty-four (24) months from the date below. A copy of this authorization shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand I may revoke this authorization in writing at any time by providing that written notification to International Brokerage Agencies, Inc. at the service address below. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

I agree that a photographic copy or facsimile of this Authorization shall be valid as the original. I agree that this Authorization shall remain valid for the lifetime of the undersigned, absent any provision of any applicable state statute regulation to the contrary, in which event it shall remain valid for the maximum period permitted there under. I understand that if I refuse to sign this authorization, International Brokerage Agencies, Inc. may not be able to provide full and complete information about the insurance coverage and its cost that may be available to me. I also understand and acknowledge that each of the insurers listed on this form or to which I may formally apply, may require me to sign a similar authorization used exclusively by such insurer before they will process my application or offer insurance coverage. I understand that my Providers may not refuse to provide treatment or payment for health services if I refuse to sign this authorization.

_____ _____

Signature of Proposed Insured Name of Proposed Insured

_____ _____ _____

City State Month/Day/Year

International Brokerage Agencies, Inc.
P.O. Box 1345, Joshua, TX 76058
Phone: (817) 752-4980; Fax: (817) 752-4982