RESET

Transamerica Life Insurance Company

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

APPLICATION FOR LIFE INSURANCE

[ ]

PROPOSED INSURED INFORMATION

1. Name *(First, M.I., Last)*		2. Mailing Address (Cannot be a P.O. Box) City, State, Zip		
3. Home Telephone No. ( )	4. Work Telephone No. ( )	5. Birth Date	Age	6. Birth State / Country
7. Height / 8. Weight	9. Marital Status	10. Sex ☐ Male ☐ Female	11. U.S. Citizen ☐ Yes ☐ No	12. *If no, give immigration status/type of visa:*
13. Occupation & Duties	14. Annual Income Current Year _____ Annual Income Previous Year _____ Net Worth _____	15. Social Security No. or Tax I.D. No.	16. Drivers License No./ State	17. E-mail Address

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

BENEFICIARY AND OWNER DESIGNATION *(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed Insured.)*

19. Primary	Relationship	Primary	Relationship
Primary	Relationship	20. Contingent	Relationship

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

21. Name	a. Relationship to Proposed Insured	b. Social Security Number
c. Address (Cannot be a P.O. Box)	d. Birth Date	e. Phone ( )

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

POLICY INFORMATION

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

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

☐ Monthly Bank Draft ☐ Quarterly ☐ Semiannually ☐ Annually ☐ Other _____

26. ADDITIONAL BENEFITS and AMOUNTS

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

☐ Waiver of Premium Benefit Rider (WP)
☐ Waiver of Monthly Deduction
☐ Disability Income Rider (AIR) Monthly Payout $_____
Occupation/Income _____
☐ Critical Illness Rider $_____
☐ Other _____ $_____

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

28. LIFE INSURANCE IN FORCE If none check this box ☐

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

29. DISABILITY INCOME - INSURANCE IN FORCE If none check this box ☐ *Complete only if applying for Disability Rider.*

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

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

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

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

32. Had any health, disability or life insurance pending or contemplated with another company? ☐ Yes ☐ No
33. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? ☐ Yes ☐ No
34. Within the past 5 years,
    a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? (If yes, provide state and drivers license number.) ☐ Yes ☐ No
    b. Been or is now fully or partially disabled? ☐ Yes ☐ No
    c. Been charged with or convicted of any felony or been on probation? ☐ Yes ☐ No
35. Within the past 2 years, (any yes answer to 35a or 35b, complete the Aviation and Avocation Questionnaire)
    a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? ☐ Yes ☐ No
    b. Flown other than as a passenger, or plan to? ☐ Yes ☐ No
    c. Foreign residence or travel contemplated? ☐ Yes ☐ No
36. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ☐ Yes ☐ No
37. Family History: Is there a history of cardiovascular disease (including coronary artery disease, stroke or transient ischemic attack), internal cancer or melanoma in parents/siblings prior to age 60? If yes, please provide details including, type of cancer (if applicable) and if there was a death due to this condition. ☐ Yes ☐ No
38. Have you or any proposed Additional Insured sought protection from creditors within the past 5 years? ☐ Yes ☐ No
39. Do you or any proposed Additional Insured currently or within the past two years consume six or more alcoholic beverages per week? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. ☐ Yes ☐ No
40. Have you or any proposed Additional Insured had any weight change of 10 or more pounds in the past year? ☐ Yes ☐ No

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

42. Have you or any proposed Additional Insured (including any children applying) EVER been diagnosed as having or been told by a medical doctor that you have AIDS, HIV, or AIDS Related Complex (ARC)? ☐ Yes ☐ No

(Questions 43 to 49) Within the past 10 years, have you or any proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having any disease or disorder of the:

43. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? ☐ Yes ☐ No
44. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? ☐ Yes ☐ No
45. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? ☐ Yes ☐ No
46. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? ☐ Yes ☐ No
47. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? ☐ Yes ☐ No
48. Endrocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? ☐ Yes ☐ No
49. Cancer, tumor, polyps, melanoma or other malignancy? ☐ Yes ☐ No
50. Have you or any proposed Additional Insured (including any children applying) had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? ☐ Yes ☐ No
51. Are you or any proposed Additional Insured (including any children applying) currently under the observation of a physician or taking medication? ☐ Yes ☐ No

52. ADDITIONAL INFORMATION *Explain all "yes" answers below. If additional space required, use Supplemental Form SA-ADINFO.*

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

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

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

SECTION 54. ILLUSTRATION CERTIFICATION (Universal Life only) 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.

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

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Transamerica Life Insurance Company, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsurers, MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize. This authorization will expire 30 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

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

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, (3) Notice of Insurance Information Practices, and (4) Disclosure for Accelerated Terminal Illness Benefit, if required. I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

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

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

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

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

Signature of proposed Insured (if age 15 or over)

Signature of proposed Owner (if other than proposed Insured)

Signature of Parent or Legal Guardian (if proposed Insured is under 18 and Parent/Guardian has not signed as Owner)

Signature of Additional Insured

SECTION 55. TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER CERTIFICATION

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

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

Signature of Proposed Owner _____ **Date** _____

SECTION 56. AGENT INFORMATION & SIGNATURE

Signature of Agent | (Print First and Last Name) | Agent #

( ) Telephone Number | Agent Fax # | Agent E-mail Address

Split Agent Signature (If Applicable) | (Print First and Last Name) | Agent #

( ) Telephone Number | Agent Fax # | Agent E-mail Address

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

CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the Conditional Receipt.

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

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

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

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

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

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, the application will be deemed to be rejected by the Company and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment(s) you have made upon return of this Receipt to the Company.

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

Authorization (Signatures Required)
I certify that I have read and reviewed the Conditional Receipt and the acknowledgment of the applicant and proposed Insured in the application. The terms and conditions of the conditional receipt have been explained to me fully by the agent and I understand them.

Dated at _____ on _____ _____

City State Date Signature of Agent or Authorized Company Rep

_____ _____

Signature of proposed Insured Signature of Applicant (if other than proposed Insured)

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 GROUP, INC. (MIB) PRE-NOTIFICATION

To proposed Insured: Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, 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. 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, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual 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, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

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

AGENT'S REPORT

How well do you know proposed Insured? _____

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

Class of Risk Quoted:

Term	UL & IUL
☐ Preferred Plus	☐ Preferred Elite
☐ Preferred Nontobacco	☐ Preferred Plus
☐ Standard Plus	☐ Preferred
☐ Standard Nontobacco	☐ Non-Tobacco
☐ Preferred Tobacco	☐ Preferred Tobacco
☐ Standard Tobacco	☐ Tobacco

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

COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED

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

_____

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

_____

ADDITIONAL REMARKS

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

_____

Signature of Writing Agent

PRE-AUTHORIZED WITHDRAWAL PLAN

I/we, the undersigned, hereby authorize and request _____ to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my/our account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I/we request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I/we agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I/we understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This Authorization may be terminated by either party by giving written notice to the other.

INITIAL PAYMENT (MUST CHECK ONE BOX)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

ACCOUNT INFORMATION

TAPE VOIDED CHECK HERE
(Place tape along TOP of check)

If not attaching void check or if withdrawing from Savings Account, complete the following information

_____
Bank Name, Office or Branch

_____
Bank Address | City | State | Zip Code

Check one: ☐ Checking ☐ Savings

_____
Payor Name(s)

_____ _____
Transit Routing Number | Account Number

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

Premium to Withdraw	
$ _____	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked) ☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

SIGNATURE

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X_____ **Date:** _____

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TRANSAMERICA LIFE INSURANCE COMPANY

Administrative Office: 4333 Edgewood Road NE, 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

Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
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

_____
City, State, Zip Code

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.

Name of Proposed Insured *(Please Print)*

Signature of Proposed Insured or Parent/Guardian

Street

Date Signed

City, State, Zip Code

Date of Birth

RESET

TRANSAMERICA LIFE INSURANCE COMPANY

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: The Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
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 Company, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

TRANSAMERICA
LIFE INSURANCE COMPANY

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Company noted above (the "Company")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: The Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
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 Company, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Illustration Notice

To be completed by the Applicant:

I understand the following concerning the application for the life insurance policy accompanying this form: *(check the appropriate box)*

☐ 1. No illustration has been presented to me prior to the application for this policy.

☐ 2. An illustration was presented to me, but it differs from the coverage I have applied for.

If a policy is issued, an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery. I will review the illustration and sign the acknowledgment to that effect when I receive it and return a copy of the signed illustration to the Company's representative.

Signature of Applicant _____ Date _____

****

To be completed by the Sales Representative

This is to certify that: *(check the appropriate box)*

☐ 1. No illustration was presented at the time of the sale of the life insurance policy applied for on the accompanying application.

Or

☐ 2. An illustration was presented to the Applicant at the time of the sale that was in compliance with state regulations and company requirements. However, the illustration differs from the life insurance policy applied for on the accompanying application.

Signature of Sales Representative _____ Date _____

Reset Form

TRANSAMERICA® LIFE INSURANCE COMPANY

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

GA # _____

Application Part 2
Non-Medical Health History

File # _____

1. **Proposed Insured:** *(Print Full Name)*	2. **Date of Birth:** Month Day Year	3. **Social Security #**

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

Name: _____ Address: _____

Phone: _____ City/St/Zip: _____

Date and reason for last visit: _____

5. **Height:** _____ **Weight:** _____

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

6. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**	**Yes**	**No**
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	☐	☐
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	☐	☐
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐	☐
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	☐	☐
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	☐	☐
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐	☐
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	☐	☐
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	☐	☐
i. Cancer, tumor, polyp or cyst?	☐	☐
j. Any physical deformity or amputation?	☐	☐
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	☐	☐
l. AIDS, HIV or AIDS Related Complex (ARC)?	☐	☐

7.	**Yes**	**No**
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	☐	☐
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	☐	☐

8. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**	**Yes**	**No**
a. Consulted, been examined or been treated by any physician or practitioner?	☐	☐
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	☐	☐
c. Had observation or treatment at a clinic, hospital or other medical facility?	☐	☐
d. Had or been advised to have a surgical procedure?	☐	☐
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	☐	☐
f. Had any injury requiring treatment?	☐	☐

Details:

File # _____

9.	Yes	No
a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	☐	☐
b. Has your weight changed by more than 15 pounds in the past year?	☐	☐
c. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	☐	☐
d. Are you now pregnant?	☐	☐

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

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

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

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

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

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

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

Signed at (City/State) _____ on _____, _____

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

_____
Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

_____
Print name of Proposed Insured

NON-MEDICAL

TRANSAMERICA
LIFE INSURANCE COMPANY

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

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 acquisitions 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, and the contract number if available) and whether each policy 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 agents 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 materials 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 *Printed Name* *Date*

_____ _____

Producer's Signature *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 expense 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?

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499
Fax: 866-622-5007

Telephone Access Privilege Authorization

Our toll-free telephone number - (866) TIIG-VUL or (866) 844-4885 -- lets you reach our Customer Service representatives Monday through Friday, between 8:00 am and 5:00 pm, Central Time. You may also obtain information about your policy after hours by calling this same toll-free number and accessing our automated information system.

In addition, we offer the Telephone Access Privilege. Under this option, you or your registered representative may call our toll-free telephone number to authorize certain transactions on your policy. You may use this option to:

- **TRANSFER** money among investment options on your policy
- **CHANGE** the allocation of future net premium payments
- **REQUEST** a policy loan (not greater than $10,000.00)

We verify the caller's identity by asking the caller to provide us with:

- The **CALLER's** name
- The **POLICY** number
- The **INSURED's**
  - Name
  - Tax Identification Number
  - Date of Birth

To allow us to provide you with this service, simply complete and return the authorization attached below.

PLEASE DETACH AND RETURN

TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499
Fax: 866-622-5007

Telephone Authorization

Insured: _____ (PLEASE PRINT)

Second Insured (if any): _____ (PLEASE PRINT)

Owner: _____ (PLEASE PRINT)

Policy/Certificate ("Policy") Number(s): _____

I/We ("I") hereby authorize Transamerica Life Insurance Company ("Transamerica") to accept telephone instructions I, or my registered representative, pr ovide Transamerica authorizing transfers, net premium allocation instructions, and policy loans (within limits) on the policy or policies identified above. While Transamerica will employ r easonable procedures to confirm that telephone instructions are genuine, we will not be liable for any losses due to unauthorized or fraudulent instructions. I understand that I bear the risk for unauthorized or fraudulent instructions. I agree to hold harmless and indemnify Transamerica and its affiliates and any mutual fund managed by such affiliates and their directors, officers, employees and agents for any losses arising from such instructions.

OWNER SIGNATURE	DATE

❑ **Monumental Life Insurance Company**

❑ **Stonebridge Life Insurance Company**

❑ **Transamerica Life Insurance Company**

❑ **Western Reserve Life Assurance Co. of Ohio**

Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy to not more than 24 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

Receipt of accelerated benefits may be taxable and you should consult your personal tax advisor.

By signing below, you agree that you have read the above and received a copy of this summary and disclosure statement upon delivery of your policy.

_____ _____

Date Owner's (Applicant's) Signature

_____

Agent's Signature

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

RESET

TRANSAMERICA LIFE INSURANCE COMPANY

Administrative Office: 4333 Edgewood Road NE, 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

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

Replacement Transactions Sales Material Certification Statement

Print Producer Name and Code: _____

Print Agency Name and Code: _____

Print Applicant Name: _____

I hereby certify that:

- I used only insurer-approved sales materials;
- Copies of all sales materials used during the solicitation were left with the applicant; and
- Copies of all sales illustrations used during the solicitation were left with the applicant and also sent to the Home Office for the policy file.

_____ _____

Signature of Producer *Date*

I hereby certify that no sales materials or illustrations were used.

_____ _____

Signature of Producer *Date*

Reset Form

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Application Supplement Residency & Travel Questionnaire

1. Proposed Insured: _____ 2.Social Security No.: _____
3. Date of Entry to USA: _____ 4.Place of Birth: _____ 5. Date of Birth: _____
6. Country of Citizenship _____ (if U.S. Citizen, skip to 12.)
7. Do you possess an Alien Registration Receipt, "Green Card"? ☐ Yes ☐ No
8. Type of Visa (see listing of Visa types): _____
9. Visa Expiration Date: _____
10. Do you own assets or property outside the U.S.? (List) _____
    _____
11. Do you own assets or property inside the U.S.? (List) _____
    _____
12. Length of time with present employer: _____
13. Do you plan to travel or reside outside of the U.S.? ☐ Yes ☐ No
    If yes, please provide details.

	Next 12 Months
Destination(s)	
Date(s)	
Duration of Stay	
How Often	

14.Remarks: _____
_____
_____

Visa Types

A:	Government Official	**I:**	Information Media Rep.
B1:	Visitor/Business	**J:**	USIA Education/Cultural Exchange
B2:	Visitor/Medical Treatment	**K1:**	Fiancée/Fiancé
C:	Transit	**L:**	Intra-Company Transfer
D:	Crewman	**M:**	Vocational/Non-Academic Studies
E1:	Treaty Trader	**O1-2:**	Science/Art
E2:	Treaty Investor	**P1-3:**	Athletes, Artists, Entertainers
E3-5:	Misc. Employment Visas	**Q1:**	INS Int'l Cultural Exchange
F1-4:	Family Based/Academic Studies	**R:**	Non-Immigrant Religious
G:	Representative to International Organization	**SB-1:**	Returning Resident Alien
H1-B:	Temporary Worker - Distinguished Merit/Ability	**SD:**	Immigrant - Religious
H-2A/B:	Temporary Worker - General Labor	**TN:**	NAFTA Professionals
H-3:	Temporary Worker - Trainee	Other Category:	_____

It is represented that the statements and answers given in this supplement to the application are true, complete and correctly recorded. It is agreed that this supplement shall be a part of the application to the Company for insurance on the life of the Proposed Insured.

Signed at _____ on _____

_____ _____
Witness Proposed Insured

AGREEMENT OF OWNER IF OTHER THAN PROPOSED INSURED

The Owner agrees to be bound by all statements, answers, and agreements made by the Proposed Insured in this supplement to the application. If the Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as Owner, giving corporate title and full name of corporation.

Signed at _____ on _____

_____ _____
Witness Owner

Corporate Title: _____ Corporation Name: _____

Form **W-8BEN**
(Rev. February 2006)
Department of the Treasury
Internal Revenue Service

Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding

► **Section references are to the Internal Revenue Code.** ► **See separate instructions.**
► **Give this form to the withholding agent or payer. Do not send to the IRS.**

OMB No. 1545-1621

Do not use this form for:	**Instead, use Form:**
• A U.S. citizen or other U.S. person, including a resident alien individual	W-9
• A person claiming that income is effectively connected with the conduct of a trade or business in the United States	W-8ECI
• A foreign partnership, a foreign simple trust, or a foreign grantor trust (see instructions for exceptions)	W-8ECI or W-8IMY
• A foreign government, international organization, foreign central bank of issue, foreign tax-exempt organization, foreign private foundation, or government of a U.S. possession that received effectively connected income or that is claiming the applicability of section(s) 115(2), 501(c), 892, 895, or 1443(b) (see instructions)	W-8ECI or W-8EXP

Note: *These entities should use Form W-8BEN if they are claiming treaty benefits or are providing the form only to claim they are a foreign person exempt from backup withholding.*

• A person acting as an intermediary	W-8IMY

Note: *See instructions for additional exceptions.*

Part I Identification of Beneficial Owner (See instructions.)

1 Name of individual or organization that is the beneficial owner

2 Country of incorporation or organization

3 Type of beneficial owner: ☐ Individual ☐ Corporation ☐ Disregarded entity ☐ Partnership ☐ Simple trust ☐ Grantor trust ☐ Complex trust ☐ Estate ☐ Government ☐ International organization ☐ Central bank of issue ☐ Tax-exempt organization ☐ Private foundation

4 Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

5 Mailing address (if different from above)

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

6 U.S. taxpayer identification number, if required (see instructions) ☐ SSN or ITIN ☐ EIN

7 Foreign tax identifying number, if any (optional)

8 Reference number(s) (see instructions)

Part II Claim of Tax Treaty Benefits (if applicable)

9 **I certify that (check all that apply):**

a ☐ The beneficial owner is a resident of ..... within the meaning of the income tax treaty between the United States and that country.

b ☐ If required, the U.S. taxpayer identification number is stated on line 6 (see instructions).

c ☐ The beneficial owner is not an individual, derives the item (or items) of income for which the treaty benefits are claimed, and, if applicable, meets the requirements of the treaty provision dealing with limitation on benefits (see instructions).

d ☐ The beneficial owner is not an individual, is claiming treaty benefits for dividends received from a foreign corporation or interest from a U.S. trade or business of a foreign corporation, and meets qualified resident status (see instructions).

e ☐ The beneficial owner is related to the person obligated to pay the income within the meaning of section 267(b) or 707(b), and will file Form 8833 if the amount subject to withholding received during a calendar year exceeds, in the aggregate, $500,000.

10 **Special rates and conditions** (if applicable—see instructions): The beneficial owner is claiming the provisions of Article ..... of the treaty identified on line 9a above to claim a ..... % rate of withholding on (specify type of income): .....

Explain the reasons the beneficial owner meets the terms of the treaty article: .....

.....

Part III Notional Principal Contracts

11 ☐ I have provided or will provide a statement that identifies those notional principal contracts from which the income is **not** effectively connected with the conduct of a trade or business in the United States. I agree to update this statement as required.

Part IV Certification

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

1 I am the beneficial owner (or am authorized to sign for the beneficial owner) of all the income to which this form relates,

2 The beneficial owner is not a U.S. person,

3 The income to which this form relates is (a) not effectively connected with the conduct of a trade or business in the United States, (b) effectively connected but is not subject to tax under an income tax treaty, or (c) the partner's share of a partnership's effectively connected income, **and**

4 For broker transactions or barter exchanges, the beneficial owner is an exempt foreign person as defined in the instructions.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the income of which I am the beneficial owner or any withholding agent that can disburse or make payments of the income of which I am the beneficial owner.

Sign Here ► ..... Signature of beneficial owner (or individual authorized to sign for beneficial owner) ..... Date (MM-DD-YYYY) ..... Capacity in which acting

Freedom Index Universal Life II

Offered by Transamerica Life Insurance Company ("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 is calculated in part by reference to an outside index, 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.

This policy is not an investment in the stock market or the index 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 two Account Options: the Basic Interest Account and the Index Account. Interest will be credited differently to the two 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 Account will earn interest at a guaranteed minimum annual interest rate of 1%. Net Premiums received after a Monthly Policy Date that are to be allocated to the Index Account will earn interest at a rate of 1% per annum 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 S&P 500® Index Account is determined using a formula based on changes in the S&P 500® Index, excluding dividend income, and cannot exceed the Cap established by the Company. The Company may determine a different Cap for each Segment and can change 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.

TRANSAMERICA®
LIFE INSURANCE COMPANY

Excess Index Interest (continued)

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.

Monthly Deductions, Index Account Monthly Charges, and certain policyowner transactions, such as 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 to the Basic Interest Account are only allowed at the end of the Segment Period. Transfers from the Basic Interest Account to the Index Account are only allowed on the first day of a policy month.

Loans and Withdrawals

Loans and withdrawals will be taken pro rata from the Basic Interest Account and the Index Account unless I direct otherwise. In each case, they will be taken from the highest numbered Segment first. 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 ten policy years and for ten years from the date of any Face Amount increase. The surrender charge will vary based on the Face Amount 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.

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.

Date: _____ **Applicant Name (print):** _____

Signature of Applicant: _____

Index Universal Life Insurance offered by:
Transamerica Life Insurance Company
4333 Edgewood Rd NE
Cedar Rapids, Iowa 52499

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

Index UL Policy Certification

This form is to be completed, signed and submitted prior to the issuance of any index universal life insurance policy(ies).

Product Name _____

Policy Number _____

Proposed Insured _____

Proposed Owner _____

Please review and sign below to signify your acknowledgment of these statements:

- Before or during the application process for the above-referenced policy, I presented to the proposed owner the risks associated with an index-based product, including among other things:
  - Because a portion of the interest credited to the Index Account is calculated in part by reference to an outside index, there is the potential for greater volatility in the amount of Excess Index Interest credited than of interest credited to the Basic Interest Account;
  - The 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; and
  - The policy is not an investment in the stock market or the index and does not participate in any stock or investments.
- As part of the solicitation and sale of the above-referenced policy, I have not advanced or paid premium for any proposed owner, have not provided any sort of inducement to the proposed insured or proposed owner to purchase insurance, have not provided or promised any sort of rebate, and have not in any other manner violated any provision of applicable "anti-rebating" laws, regulations, or company practices.

By signing this form, I certify that this information is accurate to the best of my knowledge and may be relied upon by Transamerica Life Insurance Company ("TLIC"). I understand that if any of the above acknowledgments is inaccurate, then TLIC may take appropriate disciplinary action, including, without limitation, reversal of commissions and termination of a producer and/or general agent contract.

Please note that each selling agent involved in this transaction must sign and acknowledge that the above is accurate to the best of his/her knowledge.

Producer 1's Name PRINTED	Producer 2's Name PRINTED
Signature	Signature
Date	Date