BBVA

VIP

Transamerica Universal Life Instructions

1. Copy of Laser Visa

2. If the client does not have one, then you will need a copy of the U.S. Immigration Form I-94 (used to enter the United States).

3. Copy of Passport

4. Inspection Limits:
   Ages 18-60 $5 Million and over of death benefit
   Ages 61-80 $2 Million and over of death benefit
   Ages 81-up on any face amount

5. Personal History Interview is possible on all foreign national Cases.

INITIAL UNDERWRITING REQUIREMENTS CHART

Amount Underwritten	Issue Age							
	0–17	18–40	41-50	51–60	61–70	71–75	76–80	81+
$0 – 100,000	Nonmed	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS SUP MVR	Paramed ABC HOS SUP MVR	Medical ABC HOS SUP ECG MVR
$100,001 – 250,000	Nonmed	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS ECG SUP MVR	Paramed ABC HOS ECG SUP MVR	Medical ABC HOS ECG SUP MVR IR
$250,001 – 500,000	Nonmed	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS ECG MVR	Paramed ABC HOS ECG SUP MVR	Medical ABC HOS ECG SUP MVR	Medical ABC HOS ECG SUP MVR IR
$500,001 – 1,000,000	1	Paramed ABC HOS MVR	Paramed ABC HOS MVR	Paramed ABC HOS ECG MVR	Paramed ABC HOS ECG MVR	Paramed ABC HOS ECG MVR SUP PFS	Medical ABC HOS ECG MVR SUP PFS	Medical ABC HOS ECG MVR SUP IR PFS
$1,000,001 – 2,000,000	2	Paramed ABC HOS MVR PFS	Paramed ABC HOS ECG MVR PFS	Paramed ABC HOS ECG MVR PFS	Paramed ABC HOS ECG MVR PFS	Paramed ABC HOS ECG MVR PFS SUP	Medical ABC HOS ECG MVR PFS SUP	Medical ABC HOS ECG MVR SUP IR PFS
$2,000,001 – 3,500,000	3	Paramed ABC HOS MVR PFS	Paramed ABC HOS ECG MVR PFS	Medical ABC HOS ECG MVR PFS	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS
$3,500,001 – 5,000,000	4	Medical ABC HOS ECG MVR PFS	Medical ABC HOS ECG MVR PFS	Medical ABC HOS ECG MVR PFS	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS
$5,000,001 – 10,000,000	5	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS
$10,000,001 and higher*	6	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS ECG MVR IR PFS	Medical ABC HOS TRD MVR IR PFS	Medical ABC HOS TRD MVR IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS	Medical ABC HOS ECG MVR SUP IR PFS

1–6 Call Transamerica New Business & Underwriting Support Unit at (800) 295-3990 as applicable.

* Third party financial verification required.

1-800-VIP-LIFE

NEW BUSINESS TRANSMITTAL FORM

Agent/Broker Name:_____

Agent/Broker Email:_____

Agent/Broker Phone:_____

Agent/Broker Fax:_____

Client (s) Name:_____

_____

Date:_____

Carrier:_____

Product:_____ **(Term/UL/SUL/VUL/MoneyGuard/Annuity)**

Attached, I have enclosed the following (please check):

Application:_____

Exam:_____

APS:_____

Check:_____ **in the amount of:**_____

**** IF NO EXAM IS ATTACHED I WOULD LIKE (please check):**

_____ **VIP TO ORDER THE EXAM**

_____**I WILL ORDER THE EXAM**

TRANSAMERICA
LIFE INSURANCE COMPANY

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

GA #_____

Individual Life Insurance Application For One Life Part 1

Proposed Insured: _____ _____ _____ _____ _____
First Middle Last Suffix Mr./Mrs./Ms./Dr.

Birthdate: _____ Age _____ Birth Place: _____ Male ☐ Female ☐
Mo. Day Yr.

Soc. Sec. No.: _____ U.S. Citizen ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: _____ _____
Area Code & Work Phone

Occupation: _____

Annual Income $_____ Net Worth $_____

Residence: _____ _____ _____ _____ _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Area Code & Home Phone

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

Address: _____ _____ _____ _____ _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: _____

_____

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

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

Type of Coverage (Personal / Business / Employer Provided / Group)	Company/Policy Number	Face Amount	Replacement?
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

   b. Total Accidental Death insurance inforce with all companies: $ _____

10. Is any application for life insurance pending with any other company? ☐ Yes ☐ No
If yes, give company name, amount applied for and total amount to be placed. _____

11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? ☐Yes ☐ No If yes, give insurance company name, owner's name, and amount of insurance of each policy.

_____

12. Mail Additional Premium Notices To: _____

Address: _____
No. & Street City State Zip Country

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

☐ ☐ 13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.

☐ ☐ 14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.

15. Have you used nicotine at any time? Date Last Used

☐ ☐ Cigarettes _____
☐ ☐ Cigar/Pipe/Chewing Tobacco _____
☐ ☐ Other _____

16. Driver's License #: _____ State: _____

In the past five years, have you been convicted of or pleaded guilty to:

☐ ☐ a. Moving violations? If yes, give dates and type. _____
☐ ☐ b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐ ☐ c. Reckless driving? If yes, give dates. _____

☐ ☐ 17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.

☐ ☐ 18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.

☐ ☐ 19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.

☐ ☐ 20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Remarks: Give details for any questions answered yes

_____

_____

_____

_____

_____

_____

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

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

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: 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.

NOTICE TO CONSUMER

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

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

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the 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.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

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

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

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

Signed at _____ on _____, _____
City-State Date

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

Signed at _____ on _____, _____
City-State Date

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

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

_____ X _____
Signature of Licensed Producer

_____

_____

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL: _____

PRODUCER 1: _____ | _____ SHARE %: _____
LAST FIRST

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

PRODUCER 2: _____ | _____ SHARE %: _____
LAST FIRST

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

PRODUCER 3: _____ | _____ SHARE %: _____
LAST FIRST

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

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

What is the purpose for insurance? _____

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

How long have you known the Proposed Insured? _____

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

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

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

X _____
Signature of Producer

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

Unless a Conditional Receipt was issued along with this authorization, I/we agree this authorization shall not become effective for payment of the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

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

☐ **PREMIUM**
☐ **LOAN REPAY**
☐ **PREMIUM DEPOSIT ACCT.**

☐ **NEW AUTHORIZATION**
☐ **BANK CHANGE**
☐ **ADD TO EXISTING POLICY**
☐ **OTHER** _____

PICK A DATE TO DRAFT (1-28) _____

NAME OF FINANCIAL INSTITUTION: _____
PHONE #: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
ACCOUNT NUMBER: _____
NAME(S) ON BANK ACCOUNT: _____
ROUTING#: _____

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

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

AUTHORIZATION TO HONOR PAC WITHDRAWALS

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

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

BANK SIGNATURE(S) OF DEPOSITOR(S) _____ DATE _____ SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR _____

TAPE VOIDED CHECK HERE

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Life Insurance Company (the Company) may make a brief report to the MIB Group, Inc. (MIB) and its members or affiliates, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

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 seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

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

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

INSTRUCTIONS FOR CONDITIONAL RECEIPT

DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

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

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

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

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

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

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

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

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

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

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

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

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

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

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

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

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

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

_____ _____

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

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

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from_____, the sum of $_____ for the life insurance application dated _____, with _____ as the Proposed Insured.

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

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

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

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

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

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

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

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

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

Dated at_____ on _____, 20 ____ X_____
City, State Date Insurance Producer or other Company Authorized Rep

---

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

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

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

Proposed Owner

TRANSAMERICA
LIFE INSURANCE COMPANY

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

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 of the life insurance policy 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 _____

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 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 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

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*

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.			

* D T 0 1 6 *

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

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the HIPAA Privacy Rule

Name of Insured/Patient	Date of Birth

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as MIB, Inc.) or other health care provider that has provided payment, treatment or services to the insured/patient named above ("the Providers") to disclose the entire medical record and any other protected health information concerning the insured/patient to the company(ies) referenced on this authorization ("the Company(ies") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements the insured/patient has made to restrict his or her protected health information do not apply to this authorization and I instruct the Providers to release and disclose the entire medical record without restriction.

This protected health information is to be disclosed under this Authorization at my request, as permitted by § 164.508(c)(1)(iv) of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to the Company(ies) at 4333 Edgewood Rd NE, Cedar Rapids, IA 52499, Attention: HIPAA Privacy Official. Alternatively, I may revoke this authorization by sending a written revocation directly to the Providers. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that the Company(ies) has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information (such as the HIPAA Privacy Rule). However, the Company(ies) will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and its own privacy policy.

I understand that the Providers may not refuse to provide treatment or payment for health care services because I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release the complete medical record of the insured/patient, the Company(ies) may not be able to make any benefit payments. I acknowledge that I have received a copy of this authorization.

_____ _____

Signature of Personal Representative of the Insured/Patient

Date

_____

Description of Personal Representative's Authority or Relationship to Insured/Patient

SSN of Insured/Patient: _____

Address: _____

Policy or contract number (if known):

_____

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Personal Supplement to Application for Life Insurance

File # _____

Name of Proposed Insured: _____ Date of Birth: _____

Name of Additional Proposed Insured: _____ Date of Birth: _____

Section A. PURPOSE OF INSURANCE

1. ☐ Personal
   - ☐ Income
   - ☐ Estate Planning

2. ☐ Business
   - ☐ Keyperson
   - ☐ Stock Repurchase
   - ☐ Buy-Sell
   - ☐ Creditor Amount of Loan $ _____
   - ☐ Yes ☐ No Is Insurance required by the Creditor?

3. How was the amount of insurance arrived at? _____

(If applying for personal insurance, proceed to questions 7, 8, 9 & 10.)

Section B. BUSINESS INFORMATION

4. ☐ Yes ☐ No Are other Corporate Officers or partners insured or being insured?
   Give details and explanation _____

5. Percent of corporation of partnership owned by Proposed Insured? ____% Additional Proposed Insured? ____ %

6. Corporation or Partnerships:

	Estimated Current Year	Past Year
Net Worth $		
Gross Sales $		
Net Income $		

Current estimated market value of the business $ _____

DISCLOSURE
Continued on Reverse Side

FINANCIAL INFORMATION

If a joint policy is being applied for, complete questions 7 through 10 jointly for both the Proposed Insured and the Additional Proposed Insured.

7.

	Estimated Current Year	Past Year		Estimated Current Year	Past Year
ANNUAL INCOME					
Earned Income			**ASSETS**		
Annual Salary or Wages	$	$	Cash	$	$
Bonuses	$	$	Real Estate	$	$
Other Earned Income	$	$	Stocks & Bonds	$	$
Total Earned Income	$	$	Autos	$	$
			Personal	$	$
Unearned Income			Business Equity	$	$
Dividends & Interest	$	$	Other	$	$
Net Real Estate Income	$	$	**Total Assets**	$	$
Net Business Investment Income	$	$			
Other:	$	$	**LIABILITIES**		
Other:	$	$	Mortgages	$	$
Total Unearned Income	$	$	Business	$	$
			All Other Personal	$	$
TOTAL ANNUAL INCOME	$	$	**Total Liabilities**	$	$

8. Estimated Net Worth $_____

9. ☐ Yes ☐ No At this time are you currently in bankruptcy or have you been the subject of any voluntary or involuntary bankruptcy proceeding pending within the past 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

_____

_____

10. ☐ Yes ☐ No Do you have a prepared financial statement? If yes, please attach a copy.

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 and any Additional Proposed Insured, and shall be the basis for any policy issued on this application.

Signed at _____ on _____ , _____

_____ _____

Signature of Proposed Insured Signature of Witness

_____ _____

Signature of Additional Proposed Insured Signature of Witness

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 and any Additional Proposed Insured in this supplement to the application.

Signed at _____ on _____ , _____

_____ _____

Signature of Owner Signature of Witness

If Owner is a corporation, an authorized officer, other than the Proposed Insured, must sign as owner, give Corporate title and full name of Corporation. Corporation Name: _____

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**	Details:
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?	☐	☐

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

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Application Supplement

Proposed Insured: _____ Application No: _____

The following question is required by state law:

EXISTING INSURANCE
Does the applicant have any existing life insurance policies or annuity contracts?
☐ Yes ☐ No

If the question is answered "Yes", the required replacement notice must also be completed.

Signed at _____ on _____ 20 _____

_____ Producer

_____ Applicant

_____ Agency Code

_____ Joint Applicant (if applicable)

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Application Supplement for Children's Insurance Rider

File # _____

1. Child(ren) proposed for coverage under the Children's Insurance Rider

Name: First, Middle Initial, Last	Age	Date of Birth	Sex	Height	Weight

2. ☐ Yes ☐ No Are all the children being covered U.S. Citizens? If no, give details in Remarks.

3. ☐ Yes ☐ No Is coverage under the Children's Insurance Rider being requested for all minor children of the Proposed Insured?
If no, give details in Remarks.

4. ☐ Yes ☐ No Are any children proposed for coverage not living with the Proposed Insured?
If yes, give details in Remarks.

5. Give details to all yes answers in Remarks, including all dates and diagnoses.

Yes	No	Has any child proposed for coverage been diagnosed with:
☐	☐	Congenital Heart Abnormalities, Heart Disorder, Epilepsy, Cancer, Malignancy, Blood Disorder, Leukemia, Diabetes, Cystic Fibrosis, Kidney Disease, Brain or Neurological Disorder?
☐	☐	Asthma or other lung disease or injury or illness requiring hospitalization?

Remarks

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

Signed at _____ (city-state)

Date: _____

_____
Signature of Proposed Insured

_____
Witness of Proposed Insured Signature

Signed at _____ (city-state)

_____ (date)

_____
Signature of Owner (if other than Proposed Insured)

_____
Witness of Owner Signature

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Verification of Irrevocable Trust Agreement

This form must be submitted whenever an irrevocable trust is named the owner and/or beneficiary of a life insurance policy. It is required at the time of new business application, or when any transfer of ownership and/or change in beneficiary designation occurs. When making a service request (such as a policy loan, withdrawal/partial surrender, plan change, conversion, etc.) on an existing trust-owned policy for which no verification form has been previously provided, please submit it with the request.

VERIFICATION OF IRREVOCABLE TRUST AGREEMENT
for Administration of Life Insurance Policies

Application/Policy No.: _____ Insured(s): _____

_____

Applied to/issued by:
Transamerica Life Insurance Company
(herein called "Transamerica")

Name of Trust: _____

Date of Trust: _____ Trust Tax ID No: _____

Name(s) of Grantor(s): _____

Name(s) of Trustee(s): _____

Name of Current Owner *(For Ownership Change Only)*: _____

The undersigned hereby certify that the Grantor(s) has/have entered into a trust agreement, dated _____, with the above-named Trustee(s). The Grantor(s) has/have executed the trust, and it is in full force and effect as of the date of this Verification.

The undersigned further certify, attest and represent that they have examined the trust agreement and in their opinion and/or in the opinion of their counsel, the following statements and responses are in accordance with the terms and provisions of the trust agreement:

1. **Life Insurance Purchase by Trustee(s):** Does the trust agreement allow the Trustee(s) to acquire life insurance providing coverage on the life (lives) of the Grantor(s) and/or anyone in whom the trust beneficiary(ies) has/have an insurable interest? ☐ Yes ☐ No

2. **Acceptance of Life Insurance as Trust Property:** Do the trust provisions permit the Trustee(s) to accept life insurance policies by transfer or assignment of ownership rights, or as beneficiary(ies)? ☐ Yes ☐ No

3. **Powers of Trustee(s):** (a) Does the trust empower the Trustee(s), in his/her/their absolute discretion and as policy owner(s), to exercise and enjoy all options, elections, benefits, rights and privileges pertaining to such insurance policy(ies)? ☐ Yes ☐ No

   (b) If more than one (1) Trustee is designated, can each Trustee act independently of the other Trustee(s) with respect to the insurance policy(ies) held by the trust? ☐ Yes ☐ No

[*NOTE:* *If any of the questions is answered "No," the Trustee(s) must submit a written explanation with this Verification.*]

The undersigned agree that Transamerica shall have no further duty to inquire into the terms and provisions of the trust or the authority of the Trustee(s). Transamerica shall be fully protected in taking or permitting any action in reliance on any instrument or document executed by the Trustee(s) in his/her/their capacity as owner(s), and it shall not incur any liability for so doing. Transamerica is hereby fully discharged from any and all liability for any amounts paid to the Trustee(s), or paid in accordance with his/her/their direction, and shall not have any obligation whatsoever to see to the use and/or the application of any funds so paid by it to the Trustee(s).

Signed at: _____, on _____, 20 _____

_____
Name of Trust

_____ By: _____
Witness Individual Trustee(s)

_____
Name of Corporate Trustee

_____ By: _____
Witness Officer's Signature and Title

_____ _____
Witness Current Owner's Signature
(For Ownership Change Only)

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

BBVA Investments

Compañias

21st Century
American General Life
Allianz
Allstate
American National
AXA Equitable
Banner
Coventry
EMSI
Genworth Financial
Hartford
Indianapolis Life
ING
Integrity Life Solutions
Jefferson Pilot
John Hancock
Lincoln Benefit
Lincoln Financial
Mass Mutual
Met Life
Midland National
Mutual of Omaha
New York Life
North American
Northwestern Mutual
Pacific Life
Phoenix Mutual
Principal Financial
Protective
Prudential
Strategic Medical Consulting, Inc.
Sun Life
Transamerica Occidental Life Ins. Co.
United of Omaha
United States Life
US Financial
West Coast Life

Autorización para que la información de salud se pueda comunicar a la aseguradora VIP Insurance y sus compañias asociadas

La presente autorización se ajusta a la privacidad establecida por la ley de responsabilidad y portabilidad de los seguros médicos de Estados Unidos (HIPAA, por sus siglas en ingles)

_____ ___/___/_____ _____-____-_____

Nombre del asegurado / paciente (En letras de imprenta) | Fecha de nacimiento | Numero de Seguro Social

Yo autorizo que todo proveedor de un plan de salud, médico, profesional de la salud, hospital, clínica, laboratorio, farmacia, administrador de prestaciones farmacéuticas, centro médico, compañía de seguro, organización de apoyo para compañías de seguro u otro proveedor de servicios de salud (los "Proveedores") que, en forma directa o indirecta, haya hecho un pago en mi nombre, o me haya proporcionado un tratamiento o prestado servicios, comunique a Volente Insurance Partners, LLC (la "Compañía"), así como a sus empleados, agentes, representantes y filiales, la historia clínica completa, incluidos los informes de los exámenes personales y cualquier otra información de salud protegida. Esta autorización abarca la información sobre el diagnóstico o el tratamiento del virus de inmunodeficiencia humana (VIH) y de enfermedades de transmisión sexual. Asimismo, comprende la información sobre el diagnóstico o el tratamiento de las enfermedades mentales y del consumo de alcohol, estupefacientes y tabaco, con exclusión de las notas de las sesiones de psicoterapia.

Con su firma al pie de esta autorización, el que suscribe concluye todos los acuerdos que haya celebrado con los Proveedores para restringir la divulgación de la información de salud protegida, autorizándolos para comunicar su historia clínica completa sin limitación.

La información de salud protegida de quien suscribe se comunicará conforme a la presente Autorización, con la que la Compañía podrá: 1) transmitirla a otras compañías para que puedan proporcionarle al interesado un contrato de seguro mediante la evaluación de los requisitos, los riesgos, la emisión de la póliza y la solicitud de la cobertura; 2) procurar el reaseguro de otras compañías; 3) administrar los reclamos de seguro, así como evaluar o satisfacer la cobertura y la provisión de las prestaciones; 4) administrar la cobertura; y 5) llevar a cabo otras actividades permitidas por la legislación aplicable que se relacionen con la cobertura que el interesado tenga o haya solicitado en la Compañía.

Esta autorización será válida por veinticuatro meses desde su firma al pie. Por su parte, las copias de esta autorización tendrán la misma validez que el documento original. El interesado entiende que tiene el derecho de revocar la autorización en cualquier momento, por medio de una solicitud a tal fin dirigida al Ejecutivo de Privacidad HIPPA, o HIPPA Privacy Official en idioma inglés, de la Compañía, al domicilio 355 County Road 185, Suite 800, Cedar Park, TX 78613. La autorización también se podrá revocar enviando la solicitud mencionada a los Proveedores. La revocación no surtirá efecto cuando alguno de los Proveedores haya actuado en virtud de esta autorización ni cuando la Compañía tenga el derecho de impugnar un reclamo o la cobertura conforme a las pólizas de seguro. Por su parte, la información que se comunique conforme a esta autorización podrá quedar sujeta a retransmisión por parte de sus destinatarios, caso en el que ya no contará con la protección de la normativa federal que contempla la privacidad y la confidencialidad de la información de salud (p. ej., la privacidad establecida por la ley mencionada en el encabezado).

El que suscribe entiende que si decide no firmar esta autorización, la Compañía podrá no procesar su solicitud y, en caso de que ya se haya emitido una póliza de seguro, podrá no cubrir sus prestaciones; y declara que ha recibido una copia de esta autorización.

X _____ _____

Firma del asegurado / paciente o de su representante personal | Fecha

_____

Descripción de la relación o el poder del representante personal del asegurado / paciente

REPORTE MEDICO

Nombre del asegurado / paciente

Nombre del Doctor

Ciudad, Estado

Fecha de Nacimiento

Estimado Doctor:

En orden para poder establecer elegibilidad para un seguro de vida de este paciente, favor de completar la forma adjunta. Estamos interesados en información relacionada a visitas de consultas de este paciente con Usted en los últimos 5 años. Si es posible, favor de incluir copias de los resultados de posibles estudios y procedimientos diagnósticos. Autorización para que Usted pueda remitir esta información acompaña esta forma.

Si requiere más espacio para completar esta información, favor de copiar la hoja adherida las veces que sea necesario. Si Usted prefiere no usar esta forma, regrésela con el reporte que usted desee mandar. Favor de enviar esta información vía fax al (512)-794-0126.

Gracias por su cooperación.

Atentamente,

REPORTE MEDICO

Nombre del asegurado / paciente _____ Ciudad, Estado _____

FECHA	QUEJAS Y DESCUBRIMIENTOS FISICOS Y ABNORMALES	DURACION DE ENFERMEDAD	DIAGNOSIS	TRATAMIENTO

- Resultados de exámenes o laboratorios (Radiografías, Electrocardiogramas, Reportes Patológicos, Etc., incluyendo fechas.) _____

_____

- Condición presente._____

_____

- Se a consultado algún otro o cirujano? Fecha y diagnosis. _____

_____

- Favor de anotar cualquier otra información pertinente a la salud de este paciente._____

_____

- En su conocimiento, sabe Usted si este paciente a fumado en los últimos 12 meses?_____

_____

Nombre: _____

Firma: _____ Fecha: _____