



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

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

**Proposed Insured:** \_\_\_\_\_  
 First Middle Last Suffix Mr./Mrs./Ms./Dr.

Birthdate: \_\_\_\_\_ Age \_\_\_\_\_ Birth Place: \_\_\_\_\_ Male  Female   
 Mo. Day Yr.

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

Employer: \_\_\_\_\_ Area Code & Work Phone \_\_\_\_\_

Occupation: \_\_\_\_\_

Annual Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_

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

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

If Trust, provide name and date of Trust: \_\_\_\_\_

Relationship to Proposed Insured: \_\_\_\_\_

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

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

Beneficiary's Name and Relationship to Proposed Insured: \_\_\_\_\_

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

1. Plan Applied For: \_\_\_\_\_ Kind Code: \_\_\_\_\_

2. Risk Classification: Preferred Plus/Select  Preferred  Standard Plus  Standard   
 Extra Rating of  \_\_\_\_\_ Other  \_\_\_\_\_

3. Nicotine Classification: Nicotine  Non-Nicotine

4. Amount Applied For \$ \_\_\_\_\_

5. Additional Benefits by Rider:  Waiver of Premium/Waiver Provision  Accident Indemnity \$ \_\_\_\_\_  Other \_\_\_\_\_ \$ \_\_\_\_\_

6. Premium Payment Mode:  Annual  Semi-Annual  Quarterly  Monthly  Other \_\_\_\_\_  
 PAC  Direct Bill

7. Complete for Flexible Premium Plans:  
 Required Premium Per Year (RAP) \$ \_\_\_\_\_  
 Planned Periodic Premium \$ \_\_\_\_\_  
 + Initial Lump Sum \$ \_\_\_\_\_  
 = Total Initial Premium \$ \_\_\_\_\_

8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect?  Yes  No (APL will be in effect unless no is checked.)

9. Do you have any existing life insurance or annuities? If none, check this box . If yes, please list the policies below.

a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.

Type of Coverage (Personal / Business / Employer Provided / Group)	Company/Policy Number	Face Amount	Replacement?
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		\$	<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Total Accidental Death insurance in force with all companies: \$ \_\_\_\_\_

**APPLICATION (NB)**

continued on next page

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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

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**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, subject to any incontestability provision of such insurance.**



**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)

**FRAUD WARNING:** 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.

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



**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

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> <b>MONTHLY</b> (This will be elected if no box is checked) | <input type="checkbox"/> <b>PREMIUM</b>    | <input type="checkbox"/> <b>NEW AUTHORIZATION</b>      |
| <input type="checkbox"/> <b>QUARTERLY</b>   | <input type="checkbox"/> <b>LOAN REPAY</b> | <input type="checkbox"/> <b>BANK CHANGE</b>            |
| <input type="checkbox"/> <b>SEMI-ANNUAL</b>   | <input type="checkbox"/> <b>SAVINGS</b>    | <input type="checkbox"/> <b>ADD TO EXISTING POLICY</b> |
| <input type="checkbox"/> <b>ANNUAL</b>  | <input type="checkbox"/> <b>CHECKING</b>   | <input type="checkbox"/> <b>OTHER</b> _____            |

**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**



## 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 50 Braintree Hill, Suite 400, Braintree, MA 02184-8734, 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 \_\_\_\_\_, 20\_\_\_\_\_  
Signature of Proposed Owner Date

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

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

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

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

Original



**CONDITIONAL RECEIPT  
PLEASE READ THIS CAREFULLY**

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

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

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

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

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

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; 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**

To evaluate your insurability, the insurer named above ("the Insurer") has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of 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 tests will be performed by a certified 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.

The Department of Health and Human Services Office on HIV/AIDS has prepared the attached listing of medical facilities which provide HIV pre-test counseling. Behaviors that place you at risk for HIV infection include sexual contact or sharing needles or syringes with an infected person.

### **Meaning of Positive Test Results**

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.

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

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

### **Confidentiality of Test Results**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. The test 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. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

### **Notification of Test Results**

If your test results are negative, no routine notification will be sent to you. If your test results are positive or indeterminate, Washington state law [WAC 248-100-209 (4)] requires that post-test counseling occur at the time the test result is given to you. Please designate your private physician in the space provided below so that the insurer can have him or her tell you the test result and provide the required post-test counseling. If you do not designate a physician, the insurer will disclose the test result to the local health department so they may give the test result to you and provide the required post-test counseling. According to Washington state law positive or indeterminate test results cannot be sent directly to you.

Name of physician for reporting a positive or indeterminate test result:

\_\_\_\_\_

Name

\_\_\_\_\_

Street

\_\_\_\_\_

City, State, Zip Code

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

**Consent**

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

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

\_\_\_\_\_  
Street

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

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

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



## HIV Antibody Testing/Counseling Services

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Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, your own physician or health care provider is your best source of information. Other counseling services may also be available to you.

As required by Washington law, the following list of counseling resources is being provided to you. It was provided by the Department of Health and Human Services Office on HIV/AIDS, which is subject to change without notice to Transamerica Occidental Life Insurance Company ("the Company"). Therefore, the Company makes no representations or warranties that this information is accurate as of the date you receive this list. Also, the Company makes no representations or warranties about the quality or nature of any services these resources may provide.

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

### **Adams County Health Department**

103 West Main  
Ritzville, Washington 99169-1407  
(509) 659-3319

### **Asotin County Health District**

431 Elm Street  
Clarkston, Washington 99403  
(509) 758-3344

### **Benton-Franklin Health District**

506 McKenzie  
Richland, Washington 99352-3520  
(509) 943-2614 (Richland)  
(509) 546-9737 (Pasco)  
(509) 586-0207 (Kennewick)

### **Bremerton-Kitsap County Health Department**

109 Austin Drive  
Bremerton, Washington 98312  
(360) 478-5235 / (800) 874-2437

### **Chelan-Douglas County Health District**

P.O. Box 429  
Wenatchee, Washington 98807-0429  
(509) 664-5306 / (800) 336-5306

### **Clallam County Health Department**

223 East Fourth Street  
Port Angeles, Washington 98362-3098  
(360) 417-2352

### **Columbia County Health District**

221 E. Washington Street, Suite 101 PH  
Dayton, Washington 99328  
(509) 382-2181

### **Cowlitz-Wahkiakum Health District**

600 Broadway  
Longview, Washington 98632-7269  
(360) 414-5599

### **Garfield County Health District**

10th & Columbia (P.O. Box 130)  
Pomeroy, Washington 99347  
(509) 843-3412

### **Grant County Health District**

1021 Broadway  
Moses Lake, Washington 98837  
(509) 776-7960

### **Grays Harbor County Health Department**

2109 Sumner Avenue  
Aberdeen, Washington 98520  
(360) 532-8631

### **Island County Health Department**

P.O. Box 5000  
Coupeville, Washington 98239  
(206) 679-7351

### **Jefferson County Health Department**

Castle Hill Center  
615 Sheridan  
Port Townsend, Washington 98369-2439  
(360) 385-9400

### **Kittitas County Health Department**

507 Nanum  
Ellensburg, Washington 98926  
(509) 962-7515  
(509) 773-4565 Goldendale  
(509) 493-1558 White Salmon

### **Lewis County Health District**

360 N.W. North Street  
Chehalis, Washington 98532-1900  
(360) 740-1223 / (800) 562-6130

### **Lincoln County Health Department**

P.O. Box 1207  
Davenport, Washington 99122  
(509) 725-1001

### **Mason County Health Department**

303 North 4th  
Shelton, Washington 98584  
(360) 427-9670, Ext. 400

### **Northeast Tri-County Health District**

P.O. Box 270  
Colville, Washington 99114  
(509) 684-5048

**Okanogan County Health District**

P.O. Box 231  
Okanogan, Washington 98840  
(509) 422-3867

**Pacific County Health Department**

P.O. Box 26  
South Bend, Washington 98586  
(360) 875-9343

**Pierce County Health Department**

3629 S D Street  
Tacoma, Washington 98408-6897  
(253) 798-6060

**San Juan County Health Department**

P.O. Box 607  
Friday Harbor, Washington 98250-0607  
(360) 378-4474

**King County - Seattle****AIDS Prevention Unit**

(206) 205-7837 / (800) 678-1595

**Harborview Hospital STD Clinic**

No anonymous testing  
(206) 731-3590

**Harborview Women's Clinic**

(206) 223-3367

**Seattle Gay Clinic**

(206) 461-4540

**Skagit County Health Department**

700 South Second Street, Room 301  
Mount Vernon, Washington 98273-3684  
(360) 336-9380

**Skamania County Health Department**

683 SW Rock Creek Drive  
Stevenson, Washington 98648  
(509) 427-5138

**Snohomish Health District**

3020 Rucker Avenue, Suite #206  
Everett, Washington 98201-3971  
(206) 339-5251 or 1-800-344-2437

**Southwest Washington Health District**

2000 Fort Vancouver Way  
Vancouver, Washington 98663  
(360) 696-8425

**Spokane County Health District**

West 1101 College Avenue  
Spokane, Washington 99201-2095  
(509) 324-1600 / (800) 456-3236

**Thurston County Health Department**

529 Southwest Fourth Avenue  
Olympia, Washington 98501-1097  
(206) 786-5581 Ext. 6944

**Wahkiakum County Health Department**

P. O. Box 397  
Cathlamet, Washington 98612  
(360) 795-6207

**Walla Walla County-City Health Department**

310 West Poplar (P.O. Box 1753)  
Walla Walla, Washington 99362  
(509) 527-3290

**Whatcom County Health Department**

1500 N. State Street  
Bellingham, Washington 98225  
(206) 676-4593

**Whitman County Health Department**

North 310 Main Street  
Colfax, Washington 99111  
(509) 397-6280

**Yakima County Health District**

104 North First Street  
Yakima, Washington 98901  
(509) 249-6518 / (800) 535-2271

Insured: \_\_\_\_\_

Policy/Application No.: \_\_\_\_\_

**THIS DISCLOSURE STATEMENT CONTAINS A BRIEF DESCRIPTION OF SOME OF THE IMPORTANT FEATURES OF THE ACCELERATED DEATH BENEFIT OPTION. READ YOUR ENTIRE ENDORSEMENT CAREFULLY FOR DETAILS.**

### DESCRIPTION

Accelerated Death Benefit Option - An option for the Owner to choose to receive a portion of the death benefit while the Insured is still alive, subject to satisfactory evidence that the Insured has 12 months or less to live because of a Terminal Illness. Terminal Illness is a medical condition, resulting from bodily injury (excluding self-inflicted injury) or disease, or both, and:

- which has been diagnosed by a Physician after the policy issue date shown on page 2 of the policy data; and,
- for which the diagnosis is supported by clinical, radiological, laboratory, or other evidence of the medical condition which is satisfactory to us; and,
- which is not curable by any means available to the medical profession; and,
- which a Physician certifies is expected to result in death within 12 months of diagnosis and the certification is within 30 days of the Accelerated Death Benefit request.

The amount available is up to 75% of the current death benefit, up to a maximum of \$250,000 per life, with a minimum payment of \$10,000. An administrative fee of \$250.00 will be assessed. If the maximum Accelerated Death Benefit is not taken in the initial request, a subsequent request may be submitted, subject to the provisions of the option, and another fee will be assessed when any additional Accelerated Death Benefit is paid.

The policy values and policy death benefit will be adjusted to reflect the payment of an Accelerated Death Benefit. They will be reduced by the same proportionate ratio as the amount of the Accelerated Death Benefit paid to the amount of insurance before the Accelerated Death Benefit was paid.

If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

Accelerated Death Benefit funds are paid to the Owner. There is no restriction on how the funds are used.



\* D T O 6 0 \*

**GENERAL REQUIREMENTS**

1. The policy must be in force on the date the Accelerated Death Benefit is approved; and,
2. We must receive a written request to exercise this option at the Home Office or our designated Administrative Office within 30 days after the certification of diagnosis of the Terminal Illness, or as soon as reasonably possible. The request should include the name of the Insured, the policy number and, must be signed and dated by the Owner. If the policy has an irrevocable beneficiary, that person(s) must also sign the request. If the policy is assigned, we must receive a completed and signed release of assignment. If the policy was issued in a community property state, we may require your spouse to sign the request; and,
3. We must receive written proof of the Insured's Terminal Illness before we make an Accelerated Death Benefit payment. This proof will consist of a Physician's certification acceptable to us. We may request additional medical information from the Physician submitting the certification or any Physician we consider qualified.

**AGREEMENT**

**I, the Owner:**

1. UNDERSTAND AND AGREE THAT THIS OPTION IS LIMITED TO TERMINAL ILLNESS AS DESCRIBED BY THIS DISCLOSURE STATEMENT.
2. UNDERSTAND AND AGREE THAT NO AGENT, BROKER AND/OR OTHER SALES REPRESENTATIVE HAS THE AUTHORITY TO MAKE ANY CHANGE WHATSOEVER TO ANY PART OF THIS OPTION OR DISCLOSURE STATEMENT.
3. UNDERSTAND AND AGREE THAT THIS OPTION WILL NOT PROVIDE ANY BENEFIT FOR ANY TERMINAL ILLNESS WHICH EXISTED BEFORE THE ISSUE DATE.

Signed at \_\_\_\_\_ on \_\_\_\_\_, 20 \_\_\_\_\_

\_\_\_\_\_  
Soliciting Agent's Signature(s)

\_\_\_\_\_  
Insured's Signature

\_\_\_\_\_  
Owner's Signature

\_\_\_\_\_  
GA Code

If Owner is a corporation, the signature and title of an authorized officer other than the Insured is required and the full name of the corporation must be shown.



**NOTICE OF RIGHTS TO UNDERWRITING INFORMATION**

**If your policy is issued other than as applied for:**

- **Upon written request Transamerica Life will provide you with the specific reason or reasons for our decision within 90 business days.**
- **Give the specific items of personal or privileged information that support those reasons.**
- **Provide you with the names and addresses of the source of the information.**
- **Provide an oral explanation of reason or reasons for decision if you desire.**
- **If you ask us to amend, correct or delete any information about you in our files and we refuse to do so, you have the right to give us a concise statement of what you believe is the correct information and why you disagree with the information contained in our file. We will make your statement a part of your file.**

**You may send your inquiry to:**

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

**Thank you for the opportunity to serve your insurance needs**



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.

Form with three rows for Name of Primary/Secondary Proposed Insured/Patient, Date of birth, and Last four digits of SSN.

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
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.

Form with three rows for Name of Primary/Secondary Proposed Insured/Patient, Date of birth, and Last four digits of SSN. Includes a row for Name(s) of Unemancipated Minors.

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.

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## Important Notice Regarding Replacement of Insurance

*(Save this notice! It may be important to you in the future.)*

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one - or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

**Statement to Applicant By Agent or Broker:** *(Use additional sheets, as necessary.)*

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  No  Yes, explain:
  
2. Are there penalties, set up or surrender charges for the new policy?  No  Yes, explain emphasizing any extra cost for early withdrawal:
  
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  
 No  Yes, explain:
  
4. Are there adverse tax consequences from the replacement under current tax law?  No  Yes, explain:
  
5. a) Are interest earnings a consideration in this replacement?  No  Yes.  
b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings, and the reduction of earnings that may result from set up charges, policy fees, and other factors.
  
6. Are minimum amounts required to be on deposit before excess interest will be paid?  No  Yes, explain:



\* D T 0 1 6 \*

7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity:
- a) Are the interest rates quotes before \_\_\_\_\_ or after \_\_\_\_\_ fees and mortality charges have been deducted?
  - b) Interest rates are guaranteed for how long? \_\_\_\_\_
  - c) The minimum interest rate to be paid is how much? \_\_\_\_\_
  - d) If applicable, the rate you pay to borrow is and the limit on the amount that can be borrowed is \_\_\_\_\_.
  - e) The surrender charges are \_\_\_\_\_.
  - f) The death benefit is \_\_\_\_\_.
8. Are there other short or long term effects from the replacement that might be materially adverse?  
 No  Yes, explain:

\_\_\_\_\_  
*Signature of Agent or Broker*

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

\_\_\_\_\_  
*Name of Agent or Broker (Print or Type)*

\_\_\_\_\_  
*Address*

<b>Information on Life Insurance Policy(ies) or Annuity Contract(s) to be Replaced:</b>		
<i>Name of Insurer</i>	<i>Name of Insured</i>	<i>Policy/Contract No.</i>

**Caution:** The insurance commissioner suggests you consider these points:

- Usually, contestable and suicide periods start again under a new policy. Benefits might be excluded under a new policy that would be paid under existing insurance.
- Terminating or altering existing coverage, before new insurance has been issued, might leave you unable to purchase other life insurance or let you buy it only at substantially higher rates.
- You are entitled to advice from the existing agent or company. Such advice might be helpful.
- Study the comments made above by the agent or broker. They apply to you and this proposal. They are important to you and your future.

Completed Copy Received: \_\_\_\_\_

(Applicant's Signature)

(Date)

**This Completed Form Should Be Filed Permanently With Your New Insurance Policy.**



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                      2.  Business
- Income                                       Keyperson
  - Estate Planning                               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 or 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 \$ \_\_\_\_\_



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

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: \_\_\_\_\_