



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

Rev 12/08



* D T O O 8 *

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 representations and not warranties. **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 during the contestability period for 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 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

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"/> MONTHLY (This will be elected if no box is checked) | <input type="checkbox"/> PREMIUM | <input type="checkbox"/> NEW AUTHORIZATION |
| <input type="checkbox"/> QUARTERLY | <input type="checkbox"/> LOAN REPAY | <input type="checkbox"/> BANK CHANGE |
| <input type="checkbox"/> SEMI-ANNUAL | | <input type="checkbox"/> ADD TO EXISTING POLICY |
| <input type="checkbox"/> ANNUAL | PICK A DATE TO DRAFT (1-28) _____ | <input type="checkbox"/> OTHER _____ |

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

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

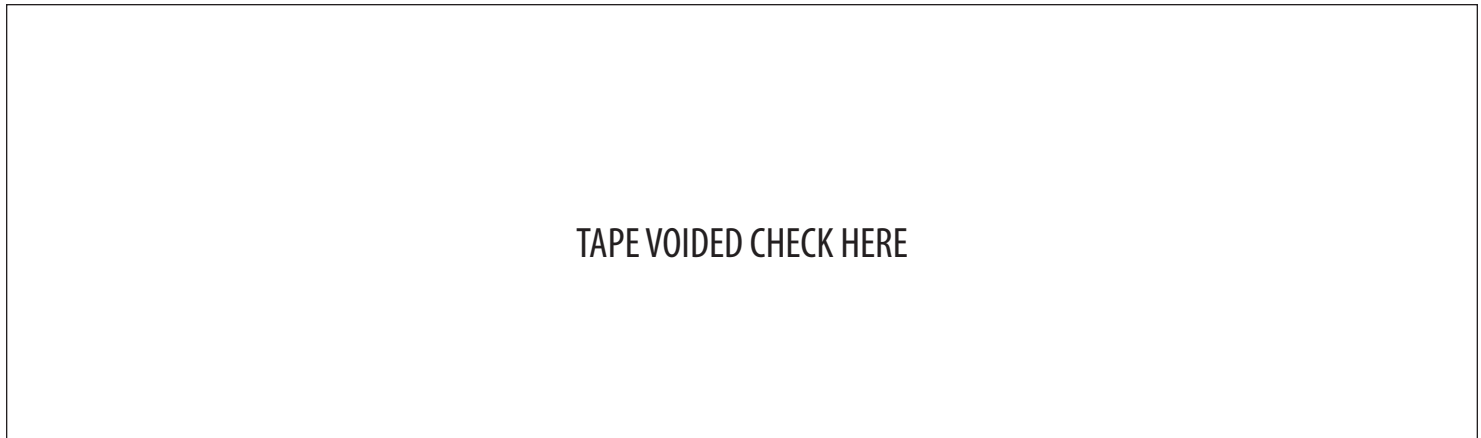
I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements 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

AIDS

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during intravenous drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another male, intravenous drug users, hemophiliacs, and persons who have engaged in high risk behaviors with any of these persons. AIDS does not typically develop until a person has been infected with HIV for several years. A person may remain free of symptoms for years after becoming infected. An infected person has a significant chance of developing AIDS over the next 10 years.

THE HIV ANTIBODY TEST

Before you consent to testing, please read the following important information:

Purpose. This test is being run to determine whether you may have been infected with HIV. If you are infected, you are probably not insurable. This test is not a test for AIDS; AIDS can only be diagnosed by medical evaluation.

Positive test results. If you test positive, you should seek medical follow-up with your personal physician because you may be infected with HIV.

Accuracy. An HIV test will be considered positive only after confirmation by a laboratory procedure that the state health officer has determined to be highly accurate. Nonetheless, the HIV antibody test is not 100% accurate. Possible errors include:

False positives: The test gives a positive result, even though you are not infected. This happens only rarely and is more common in persons who have not engaged in high-risk behavior. Retesting should be done to help confirm the validity of a positive test.

False negatives: The test gives a negative result, even though you are infected with HIV. This happens most commonly in recently infected persons; it takes at least 4 to 12 weeks for a positive test result to develop after a person is infected.

Possible Adverse Effects of Test. A positive test result may cause you significant anxiety. A positive test may result in uninsurability for life, health, or disability insurance policies for which you may apply. Although prohibited by law, discrimination in housing, employment, or public accommodations may result if your test results were to become known to others. A negative result may create a false sense of security.

Disclosure of results. A positive test result will be disclosed to you or the physician, or county health department that you designate.

Confidentiality. Like all medical information, HIV test results are confidential. An insurer, insurance agent, or insurance-support organization is required to maintain the confidentiality of HIV test results. However, certain disclosures of your test results may occur, including those authorized by consent forms that you may have signed as part of your overall application. When necessary for business reasons in connection with insurance you have or have applied for, an insurer may disclose test results to others such as its affiliates, reinsurers, employees, or contractors to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purpose for which that disclosure is authorized. In addition, a report of a non-specific test abnormality may be made to the Medical Information Bureau, a national insurance data bank.

Prevention. Persons who have a history of high-risk behavior should change these behaviors to prevent getting or giving AIDS, regardless of whether they are tested. Specific important changes in behavior include safe sex practices (including condom use for sexual contact with someone other than a long-term monogamous partner) and not sharing needles.

Information. Further information about HIV testing and AIDS can be obtained by calling the Oregon AIDS hotlines at (800) 777-2436 or (503) 223-2437.

Notice and Consent for
HIV-Related Testing
Oregon

AUTHORIZATION AND CONSENT FOR TESTING

To evaluate your insurability, Transamerica Life Insurance Company (the "Company") is requesting a blood, oral or urine specimen for testing and analysis to determine the presence of Human Immunodeficiency Virus (HIV) antibodies. The HIV test protocol consists of two ELISA tests confirmed by a Western Blot or another test or series of tests that the state epidemiologist finds to be no less accurate. An HIV test will be considered other than normal only after confirmation by a laboratory procedure that the state health officer has determined to be extremely reliable. If your HIV test result is other than normal, your application will be adversely affected. If your HIV test results are normal, no routine notification will be sent to you.

If the HIV test results are other than normal, you may designate one or more of the following to receive the test results:

A Physician

The County Health Department

Name

Name

Street

Street

City, State, Zip Code

City, State, Zip Code

Directly to me (If you request the results be sent directly to you, you will be contacted by the Company to reconsider naming a personal physician to receive the results.)

I have read and understand this *Notice and Consent for HIV-Related Testing* form, and I consent to the testing of my blood, urine or oral specimen for HIV antibodies and disclosure of the test results as described. This consent is valid for 6 months following the date this form is signed.

Name of Proposed Insured (*Please Print*)

Date of Birth

Signature of Proposed Insured

Date Signed



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.

Some portion of the payment under the Accelerated Death Benefit may be taxable. The Owner should consult a qualified tax advisor to assess the impact of this benefit on the Owner and the policy.

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



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.



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.



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
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



**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:

<i>INSURER NAME</i>	<i>CONTRACT OR POLICY #</i>	<i>INSURED</i>	<i>REPLACED (R) OR FINANCING (F)</i>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____



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

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature

Printed Name

Date

Producer's Signature

Printed Name

Date

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

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

PREMIUMS:

Are they affordable?

Could they change?

You're older -- are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

(Claims on most new policies for up to the first two years can be denied based on inaccurate statements.

Suicide limitations may begin anew on the new coverage.)

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

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

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

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality and financial stability of the new company compare with your existing company?



Transamerica Life Insurance Company
 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 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
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 representations and not warranties. 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: _____