RESET

TRANSAMERICA LIFE INSURANCE COMPANY

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

HIPAA Authorization for Release of Health-Related Information

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

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

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

Policy or contract number (if known): _____

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

TRANSAMERICA® LIFE INSURANCE COMPANY

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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- 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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TRANSAMERICA®
LIFE INSURANCE COMPANY

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

GA # _____

Individual Life Insurance Application For One Life Part 1

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

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

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

Employer: _____ _____
Area Code & Work Phone

Occupation: _____

Annual Income $ _____ Net Worth $ _____

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

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

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

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

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

Beneficiary's Name and Relationship to Proposed Insured: _____

_____

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

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

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

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

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

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

_____

12. Mail Additional Premium Notices To: _____

Address: _____
No. & Street City State Zip Country

Yes	No	**"You" means any person proposed to be insured.**
☐	☐	13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
☐	☐	14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
		15. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		16. Driver's License #: _____ State: _____
		In the past five years, have you been convicted of or pleaded guilty to:
☐	☐	a. Moving violations? If yes, give dates and type. _____
☐	☐	b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐	☐	c. Reckless driving? If yes, give dates. _____
☐	☐	17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
☐	☐	18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☐	19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Remarks: Give details for any questions answered yes

_____

_____

_____

_____

_____

_____

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

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

FRAUD WARNING

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

NOTICE TO CONSUMER

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

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

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

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 this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

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

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

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

Signed at _____ on _____ , _____
City-State Date

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

Signed at _____ on _____ , _____
City-State Date

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

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

_____ X _____
Signature of Licensed Producer

_____

_____

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL: _____

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

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

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

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

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

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

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

What is the purpose for insurance? _____

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

How long have you known the Proposed Insured? _____

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

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

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

X _____
Signature of Producer

Reset Form

Payment Authorization Form

TRANSAMERICA®

Policy Number (for existing policies only)

Introduction

Instructions:

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

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

Questions?

Contact your Financial Professional

Visit us at: transamerica.com

Call us at: 1-800-797-2643

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Recurring Draft Day (1st through 28th only)
Initial premium is withdrawn upon receipt of the application and a completed Conditional Receipt and not on the day chosen for recurring payment. If a Conditional Receipt is not received with the application, then the initial premium is drafted at policy placement.

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

Recurring Payment Frequency (choose one)

- ☐ Monthly
- ☐ Quarterly
- ☐ Semiannually
- ☐ Annually

Total Premium

$

Please select your preferred payment type/s by checking the box for initial and/or recurring payments next to the option you favor.

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Credit Card	☐ **Initial**	Tokenize your card number, and complete the Credit Card Payment section below
Check	☐ **Initial**	Mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	This method only available quarterly, semiannually, or annually. Monthly premium available for minimum of $83.33.

Credit Card Payment Information

Credit Card Type: ☐ **VISA** ☐ **MasterCard**

PCI Token #

Create your PCI token at: creditcardtoken.transamerica.com
(Reminder: When you enter your credit card information on the Token website, your unique number will start with a "T". Be sure to write the full number, including the T, on the line to the left.)

Cardholder First Name

Cardholder Last Name

Card Exp.Date ____/____

Payment Amount $____,____.____

The cardholder is the (choose one):

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

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

X _____

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

Bank Draft (ACH/EFT) Payment Information

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

Account Holder First Name

Account Holder Last Name

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

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

The account holder is the (choose one):

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

Account Holder Signature:

X _____

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

Consents

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

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

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

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

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

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Notice 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, 6400 C Street SW, Cedar Rapids, IA 52499.

INSTRUCTIONS FOR CONDITIONAL RECEIPT

DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

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

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

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

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

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

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

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

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

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

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

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

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

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

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

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

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

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

_____ _____

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 6400 C Street SW, 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

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

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, 6400 C Street SW, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

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

Proposed Owner

RESET

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

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

OWNER - if other than Primary Insured

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

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

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

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

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

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

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

AGENT

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

Date

Producer or Agent Signature

Owner Signature

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

Notice and Consent for HIV-Related Testing UTAH

Notice and Consent for HIV-Related Testing
(Which May Include AIDS Virus (HIV) Antibody/Antigen Testing)

To determine your insurability, the insurer designated above (the "Insurer") is requesting that you provide a sample of your blood and/or other bodily fluids for testing and analysis. In order to adequately perform all testing procedures, it may be necessary for you to provide a sample of more than one of these bodily fluids. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), screening for liver or kidney disorders, diabetes, immune disorders, and other physical conditions.

All test results will 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, employees, or contractors. If the Insurer is a member of MIB, Inc. (MIB), and should the Insurer request an additional sample of bodily fluid for further testing, and you choose to decline that request, your declination to be tested will be reported to MIB. Regardless of the number of tests requested, if the final test results for HIV antibodies/antigens are other than normal, the Insurer will report to MIB, a generic code which signifies only a non-specific abnormality. If your HIV test is normal, no report will be made about it to MIB. Other test results may be reported to MIB in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. The laboratory, physician or other health care provider will report positive test results to the health department. If you have not designated a physician or other health care provider to receive disclosure of positive test results, the Insurer will report positive test results to the Utah Department of Health.

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.

Positive HIV antibody or antigen test results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

I authorize positive test results to be sent to the following designated physician or health care provider.

_____
Name of Physician or Heath Care Provider

_____
Address

_____
City, State, Zip

_____
Telephone

Notice and Consent for HIV-Related Testing UTAH

Consent

I have read and I understand this Notice and Consent for HIV-Related Testing (Which May Include AIDS Virus (HIV) Antibody/Antigen Testing). I voluntarily consent to the withdrawal of a sample of blood and/or other bodily fluid(s), the testing of those samples, and the disclosure of 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.

Proposed Insured (*Please Print*)	Date of Birth
Signature of Proposed Insured	Date Signed

Reset Form

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Notice and Consent for Testing which may include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the insurer named above (the "Insurer") is requesting that you provide a sample of your blood and/or other bodily fluid for testing and analysis. In order to adequately perform all testing procedures, it may be necessary for you to provide a sample of more than one of these bodily fluids. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test performed is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats), screening for liver or kidney disorders, diabetes, immune disorders, and other physical conditions.

All test results will 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, employees, or contractors. If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and should the Insurer request an additional sample of bodily fluid for further testing, and you choose to decline that request, your declination to be tested will be reported to the MIB, Inc. Regardless of the number of tests requested, if the final test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. 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.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results. The laboratory, physician or other health care provider will report positive test results to the health department. If you have not designated a physician or other health care provider to receive disclosure of positive test results, the Insurer will report positive test results to the Utah Department of Health.

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.

Positive HIV antibody or antigen test results or other significant abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

Notice and Consent for HIV-Related Testing Utah

I have read and I understand this *Notice and Consent for Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing* form. I voluntarily consent to the withdrawal from me of blood and/or other bodily fluid(s), the testing of that blood and/or other bodily fluid(s), and the disclosure of the test results as described.

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.

I authorize positive test results to be sent to the following:

Designated Physician or Health Care Provider:

Name

Street

City, State, Zip Code

Name of Proposed Insured *(Please Print)*

Date of Birth

Signature of Proposed Insured

Date Signed

DT028

Transamerica Life Insurance Company
Transamerica Financial Life Insurance Company

Consent to do Business Electronically and Electronic Delivery of and/or Access to Policy Documents

What is the purpose of this Consent and Disclosure?
You are applying for an insurance policy ("Policy") from either Transamerica Life Insurance Company or Transamerica Financial Life Insurance Company (either individually or collectively, "Transamerica") and have expressed your desire to conduct business electronically and for electronic delivery and access, with regard to the Policy, as well as documents related to the Policy. To conduct business electronically, receive documents applicable to the Policy in electronic format, and access documents electronically via a hyperlink contained in an electronic mail ("email") or attached to an email, you must provide Transamerica, and its authorized designees and agents, with your consent. If you indicated your consent by electronically signing this document where indicated below, you will be providing Transamerica and its authorized designees and agents, with your consent:

1. To have the information described in this document (Consent to do Business Electronically and Electronic Delivery of and/or Access to Policy Documents, hereinafter referred to as "Consent") made available and delivered to you electronically;

2. To execute via electronic means the documents that are described in this Consent;

3. To submit, via electronic means, your application for an insurance product; and

4. To all of the terms and conditions set forth in this Consent.

What does this Consent cover once I consent?
This Consent covers your agreement to all of the terms and conditions of this Consent, including your agreement to:

1. **Permit the Owner of the Policy to receive via electronic means the documents that Transamerica is required by law or regulation to provide or make available to you in writing ("Required Documents"), as well as other information and documents (collectively, "Other Documents");**

2. **Permit the Owner of the Policy to receive via electronic means privacy notices from Transamerica, including those companies on whose behalf Transamerica sends privacy notices, including World Group Securities, Inc. and Transamerica Financial Advisors, Inc., as well as from any affiliate or subsidiary companies administering or supporting any Policy issued as part of your application (collectively "Privacy Notices");**

3. **Permit the Owner and Insured (and Third Party, if applicable) to submit via electronic means your application for an insurance product;**

4. **Permit the Owner and Insured (and Third Party, if applicable) to execute via electronic means certain Required Documents and Other Documents; and**

5. **Be bound with the same force and effect as if you had signed your name on paper by hand when you electronically sign this Consent where indicated below and click "OK" or otherwise apply your electronic signature to Required Documents or Other Documents.**

NOTE: IF THE OWNER IS NOT THE INSURED, THEN BOTH WILL NEED TO SIGN THE CONSENT BELOW

What is the Scope of this Consent?
This Consent applies to all documents related to your Policy, including, but not limited to, the following: Privacy Notices, prospectuses, prospectus supplements, annual and semiannual reports, annual and quarterly statements, confirmation statements, statements of additional information, proxy solicitation materials, conditional receipts, application, application supplements and addendums, Policy contract, illustrations, amendments, riders, replacement notices, customer correspondence, and any other Required Documents and Other Documents when available (collectively, "Policy Documents"). These Policy Documents will generally be accessible through a hyperlink delivered via email to the Owner's email address(es) written below when electronic access to the various Policy Documents is available from Transamerica.

Even though you have provided Transamerica with this Consent, Transamerica may, at its option, or as required by law: (a) deliver Policy Documents to you on paper, and (b) require that certain communications from you be delivered to Transamerica on paper.

Can I get paper copies of the Policy Documents?
Yes. You may obtain paper copies of any of the Policy Documents at any time and without charge by contacting Transamerica at the address provided below. If you do not wish to access all Policy Documents electronically, please call Transamerica's Customer Service Department at the telephone number provided below.

Should I maintain copies of the Policy Documents?

Yes. You agree to print or save this Consent and all Policy Documents, and to keep printed or electronic copies of them for your records. If you have any trouble with printing or saving, you should contact Transamerica.

How long will this Consent remain in effect?
This Consent shall become effective once you sign below and remains in effect for so long as your Policy remains in effect, or until you withdraw your consent (as described in the next section), whichever occurs first.

What if I change my mind?
If at any time you would like to cease doing business electronically with Transamerica with respect to your Policy, you will need to provide Transamerica with written notice of your withdrawal of your consent to do so, which will then terminate this Consent. You may withdraw consent at any time and without charge by contacting Transamerica. Your withdrawal of consent and the termination of this Consent will become effective two (2) business days after Transamerica's receipt of your withdrawal. Thereafter, all Policy Documents will be provided to you on paper and you will no longer be able to conduct business with us electronically, unless you provide your consent again.

What if my contact information changes?
You must keep Transamerica informed of any changes to your email address(es) and all other contact information by contacting Transamerica at the contact information provided below. You agree to hold Transamerica harmless with respect to any emails sent to the incorrect email address due to your failure to provide Transamerica with a current or valid email address.

You can contact Transamerica as follows:

For all products except Financial Foundation IUL:

Mail: 6400 C Street SW
Cedar Rapids, IA 52499
Telephone: 1-800-852-4678
Internet: www.transamerica.com

For Financial Foundation IUL:

Mail: 6400 C Street SW
Cedar Rapids, IA 52499
Telephone: 1-800-851-9777
Internet: https://tlic.transamerica.com

Are there any hardware or software requirements?
Yes. To access, receive, and retain the Policy Documents sent or made available to you electronically by Transamerica, you must have access to a computer with an Internet connection. You must have a valid email address, be able to send and receive emails, and be able to save the Policy Documents to a storage device for later reference or have the computer connected to a printer so you can print out such documents. Unless notified otherwise, Transamerica will be providing or making available these documents to your agents and insurance representatives. The minimum hardware and software requirements are:

Computer Compatibility

Item		Minimum	
Memory (RAM)		2 GB	
Hard Drive Space		1 GB available for storage of electronic documents	
Operating System		Windows Vista with Service Pack 2 or a later version MAC OS 10.x or higher	
Screen Resolution		1060 x 800 pixels at 16-bit color resolution	
Screen Display Size		12 inches measured diagonally	
Browser Application		Internet Explorer 9.0 or higher with all critical updates Mozilla Firefox: Google Chrome Safari 5 or higher *** We will not support beta versions of any browsers.	
PDF Reader		Adobe Acrobat Reader 6.0 or higher	
Speed		DSL or broadband service	

Mobile Device Compatibility

Operating Systems	Apple Devices: iOS7 or higher Android Devices: Android 4 or higher

You should check the Technical Requirements periodically for updates on supported software and browsers. From time to time we may offer services or features that require a certain type of browser of configuration. If we detect that your browser is not properly configured, we may provide you with a notice on how to properly update your browser. Also, the browsers we support may change over time. We reserve the right to discontinue supporting a certain browser or operating system if we believe that it suffers from a security flaw or other flaw that makes it unsuitable for use with the insurance products.

What else should I know about this Consent?
Your consent is voluntary. If you consent, you are consenting to conduct business electronically and to receive and access Policy Documents electronically. You cannot consent to receive or access Policy Documents electronically without consenting to conduct business electronically. However, if you wish to consent to conduct business electronically but do not wish to receive or access Policy Documents electronically, you need to sign this Consent and call Transamerica's Customer Service Department at the telephone number provided above to opt-out of electronic delivery and/or access and to receive Policy Documents by mail.

There is no charge for electronic delivery of Policy Documents, although your internet provider may charge for internet access. Unless required by law, you will NOT receive electronic copies in addition to paper copies.

For California Only: An additional consent for electronic delivery may be required before Required Documents are delivered to you electronically. Absent an additional consent, Policy Documents other than Required Documents may be delivered electronically under this Consent or Transamerica may elect to deliver all Policy Documents by mail.

By signing below, I attest that I: (i) have carefully read this Consent using computer hardware and software that meet the minimum hardware and software requirements described above; (ii) agree to conduct business electronically; (iii) agree to receive all mailings and communications, which may even include cancellation or nonrenewal notices, electronically; (iv) agree to receive Policy Documents in electronic format; (v) agree to access Policy Documents electronically; and (vi) accept and sign this Consent voluntarily and with full knowledge and understanding of its terms and conditions. I will save a copy of this Consent.

Name of Insured | **Insured Email Address**

Signature of Insured | **Date**

Phone Number of Insured

Please check the box below or complete Owner information. Complete Additional Owner information, if applicable.

☐ **Owner is same as Insured**

Name of Owner, if other than Insured | **Owner Email Address**

Signature of Owner, if other than insured | **Date**

Phone Number of Owner, if other than insured

Name of Additional Owner, if applicable | **Additional Owner Email Address**

Signature of Additional Owner, if applicable | **Date**

Note: If there are more than two (2) Additional Insureds, please complete additional forms.

Name of Additional Insured (if any)	**E-mail Address of Additional Insured (if any)**
Signature of Additional Insured (if any)	**Date**
Name of Additional Insured (if any)	**Email address of Additional Insured (if any)**
Signature of Additional Insured (if any)	**Date**

IF THERE ARE THIRD PARTIES SIGNING REQUIRED DOCUMENTS OR OTHER DOCUMENTS, PLEASE HAVE THEM COMPLETE THE INFORMATION BELOW. FOR ADDITIONAL THIRD PARTIES, PLEASE COMPLETE ADDITIONAL FORMS.

Name of Third Party	**Status of Third Party (*e.g.*, Guardian, Payor, *etc.*)**
Signature of Third Party	**Date**
Name of Additional Third Party	**Status of Third Party (*e.g.*, Guardian, Payor, *etc.*)**
Signature of Additional Third Party	**Date**

Name of Trustee	**Signature of Trustee**	**Date**
Name of Authorized Person	**Signature of Authorized Person**	**Date**

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Replacement Transactions Sales Material Certification Statement

Print Producer Name and Code: _____

Print Agency Name and Code: _____

Print Applicant Name: _____

I hereby certify that:

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

_____ _____
Signature of Producer *Date*

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

_____ _____
Signature of Producer *Date*

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Important Notice: Replacement of Life Insurance or Annuities

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

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

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

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

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

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

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

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ☐ YES ☐ NO

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

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

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

The existing policy or contract is being replaced because _____

_____

_____

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

_____ _____

Applicant's Signature *Printed Name* *Date*

_____ _____

Producer's Signature *Printed Name* *Date*

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

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

PREMIUMS:

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

POLICY VALUES:

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

INSURABILITY:

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

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

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

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

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

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

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

Reset Form

TRANSAMERICA® LIFE INSURANCE COMPANY

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

GA # _____

Application Part 2
Non-Medical Health History

File # _____

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

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

Name: _____ Address: _____

Phone: _____ City/St/Zip: _____

Date and reason for last visit: _____

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

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

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

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

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

* D T 0 3 8 *

 File # _____

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

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

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

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

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

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

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

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

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

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

_____
Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

_____
Print name of Proposed Insured

NON-MEDICAL