

# Authorization Form

This Authorization is HIPAA compliant



Date: \_\_\_\_\_ Advisor Name: \_\_\_\_\_ Advisor Phone: (\_\_\_\_) \_\_\_\_\_  
Insured Name: \_\_\_\_\_ Maiden Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
SSN: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State: \_\_\_\_\_

The purpose of this Authorization is to permit Ash Brokerage to obtain and release nonpublic personal information about me, the Proposed Insured named above, for the purposes of determining my eligibility for, and obtaining insurance products and services from, one or more of the insurers or other institutions listed below.

I specifically authorize any physician or other medical practitioner, hospital, clinic, or other health-related facility, medical testing laboratory, insurer, state motor vehicle department, my past or current employer(s), the Social Security Administration and any other organization, institution or person who has information or documentation about me to release such information and documentation to Ash Brokerage, its authorized representatives and one or more of the insurers or other institutions listed below. The information and documentation to be released to Ash Brokerage shall specifically include any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition including, but not be limited to, documents relating to my mental and physical health, mental health records, drug/alcohol abuse treatment records, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, any other communicable disease records, genetic testing, general reputation, mode of living, finances, occupation, driving records and other personal traits ("Information").

Additionally, I specifically authorize Ash Brokerage to release any and all Information it receives about me to the companies listed below. I also specifically authorize Ash Brokerage and the companies listed below to release any and all Information about me to their respective reinsurers, underwriters or other persons or organizations performing business, professional or insurance functions for them. I also authorize the Medical Information Bureau, Inc. (MIB\*) to release any and all Information about me directly to any company listed below, upon such company's request, provided the company is a member of MIB.

This Authorization shall be effective for two (2) years after the date signed below. I understand I have the right to revoke this Authorization at any time by sending a written notice of revocation to Ash Brokerage, 7609 W. Jefferson Blvd., Fort Wayne, IN 46804. I understand any action taken in reliance on this Authorization prior to Ash Brokerage's receipt of the written notice of the revocation shall be valid. I also understand any information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected under federal or state privacy rules.

I understand execution of this Authorization is voluntary and that I can refuse to sign this Authorization. I understand my refusal to sign this Authorization will not affect my ability to obtain treatment or payment or my eligibility for health care benefits. However, I understand my refusal to sign this Authorization may prevent me from obtaining insurance products or services from one or more of the companies below.

I acknowledge that I have read and understand the above and agree this Authorization was completed prior to my signature. I further agree that a copy of this Authorization, whether a

photocopy, carbon copy, or otherwise, shall have equal standing as if it were an original and can be relied upon by Ash Brokerage and/or any third party designated herein.

Proposed Insured's Signature / Guardian, Custodian or Authorized Representative - Include Capacity

Date

Broker / Advisor / Agency / Firm Signature

Date

Accordia Life  
AIG / American General  
Allianz  
Allianz Life of NY  
American Equity  
American Memorial  
American National  
American National of NY  
Americo Financial Life and Annuity Insurance  
Ameritas  
Assurity  
Athene Annuity  
Athene Life of NY  
AXA Equitable  
Banner Life  
Columbian Life Insurance  
Columbian Mutual Life  
Companion Life of NY  
Equitrust  
Fidelity & Guaranty  
Fidelity & Guaranty of NY  
Fidelity Life  
Fidelity Security  
Forethought Life Insurance Co.  
Genworth Life  
Genworth Life and Annuity Ins. Co.  
Genworth Life Ins. Co of New York  
Genworth LTC  
Gerber  
Gleaner

Guarantee Trust Life  
Guggenheim  
Great American  
Great Western Insurance Company  
Illinois Mutual  
Impaired Disability Underwriters  
Integrity Life  
John Hancock LTC  
John Hancock of NY  
John Hancock USA (MAN)  
Kemper  
Lafayette Life  
Liberty Life  
Life Insurance Co. of the Southwest  
Lincoln National Life  
Lincoln National Life of NY  
MassMutual LTC  
MetLife Insurance Company USA  
MetLife DI  
Midland National  
Minnesota Life  
Mutual of Omaha  
National Guardian  
National Integrity Life  
National Life Group  
National Western  
Nationwide – Provident Mutual  
New York Life  
North American  
Petersen International

Phoenix Life Insurance Co.  
Presidential  
Presidential Life Disability NY  
Principal Life Insurance Company  
Principal National Insurance Company  
Protective Life  
Protective Life of NY  
Prudential Insurance Company of America  
Reliance Standard  
Reliastar - QuintaFlex  
Reliastar - Life Insurance Company  
Reliastar - Life Insurance Company of NY  
Savings Bank Life Insurance Co. of MA  
Securian Life  
Security Life of Denver Insurance Company  
Security Mutual of NY  
The Standard  
The Standard Life Insurance Company of NY  
State Life  
Symetra  
Transamerica Insurance Company  
Transamerica of NY  
United Home Life  
United of Omaha  
Universal Life  
US Life of New York  
Voya Insurance & Annuity Company  
William Penn of NY  
Zurich

Other Company: \_\_\_\_\_

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

Ash Brokerage will employ its best efforts to disclose information only to those insurance companies deemed necessary to provide the best result for the proposed insured.

\*MIB is a not-for-profit organization of life insurance companies and operates an information exchange for its members. Upon request of a member company, in connection with determining your eligibility for insurance, MIB may supply that member company with information in its file.

MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734 or email [info@mib.com](mailto:info@mib.com)

Protecting your privacy is very important to Ash Brokerage. We are committed to safeguarding the information you provide us and using it responsibly. Because of our commitment to you, we have adopted and adhere to the following policy regarding the privacy of your personal information.

## Collection of Information

We may collect nonpublic personal financial information about you from some or all of the following sources:

- Information we receive from you on applications, new account forms and fact-finding questionnaires;
- Your transactions with us, our affiliates and those product sponsors with whom we have vendor agreements or other arrangements for the provision of services to you;
- Information we receive from non-affiliated third parties including, but not limited to, consumer reporting agencies;
- Affiliated and unaffiliated product sponsors with whom we have selling relationships and whose products you own.

## Disclosure of Information

We will not share nonpublic personal information concerning our potential, current or former customers with affiliated or unaffiliated third parties, except as permitted by law. Nor will we share this information for marketing purposes, except as permitted by law. We will not sell, trade or rent your personal information to any third parties.

Generally, we may disclose customer nonpublic personal information to affiliates and non-affiliated third parties that provide services to us or have contracts with us to supply the products or services that you have requested through us. Examples of third parties with whom we may share your information include:

- Insurance companies, mutual fund companies, insurance support organizations and other product sponsors to affect purchases and sales and allow for the servicing of your account;
- Your advisor or broker/dealer;
- Clearing agencies through whom we clear and settle securities transactions;
- Third-party investment advisory firms with whom we have relationships for the management of customer advisory accounts;
- Businesses, such as banks and other financial institutions, with whom we have an agreement for the marketing and sale of products and services;
- Regulatory or law-enforcement authorities; and
- Recordkeeping companies

Where we share your nonpublic personal information with third parties for the purposes noted above, we ensure there are contractual restrictions on their use and disclosure of that information.

## Protection of Information

We have security practices and procedures in place to prevent unauthorized use or access to your nonpublic personal information. Within Ash Brokerage, your information is only available to those individuals requiring access to process or service your transactions with us, and those fulfilling compliance, legal or audit functions on our behalf. We maintain physical, electronic and procedural safeguards to ensure the protection of your nonpublic personal information in accordance with state and federal privacy regulations.



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 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

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**I, the Proposed Insured, and I, the Owner if different, hereby represent** that the statements and answers given in this application are true, complete and correctly recorded to the best of my knowledge and belief. **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.



\* D T O O 9 \*

## 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.

This authorization will be valid for 26 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

**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)

**Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.**

Signed at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
City-State Date

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

Signed at \_\_\_\_\_ on \_\_\_\_\_, \_\_\_\_\_  
City-State Date

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

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

\_\_\_\_\_  
X \_\_\_\_\_  
Signature of Licensed Producer

(NOT PART OF APPLICATION)

**REPORT BY AGENCY OFFICE**

DATE: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_ OFFICE ID#: \_\_\_\_\_

CASE MANAGER: \_\_\_\_\_ E-MAIL: \_\_\_\_\_

PRODUCER 1: \_\_\_\_\_ SHARE %: \_\_\_\_\_  
LAST FIRST

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

PRODUCER 2: \_\_\_\_\_ SHARE %: \_\_\_\_\_  
LAST FIRST

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

PRODUCER 3: \_\_\_\_\_ SHARE %: \_\_\_\_\_  
LAST FIRST

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

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

What is the purpose for insurance? \_\_\_\_\_

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

How long have you known the Proposed Insured? \_\_\_\_\_

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

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

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

X

Signature of Producer

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

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

POLICY NO.	INSURED	AMOUNT

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

- ☐ **PREMIUM**  
☐ **LOAN REPAY**  
☐ **SAVINGS**  
☐ **CHECKING**

- ☐ **NEW AUTHORIZATION**  
☐ **BANK CHANGE**  
☐ **ADD TO EXISTING POLICY**  
☐ **OTHER** \_\_\_\_\_

**PICK A DATE TO DRAFT (1-28)** \_\_\_\_\_

**NAME OF FINANCIAL INSTITUTION:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**ACCOUNT NUMBER:** \_\_\_\_\_

**NAME(S) ON BANK ACCOUNT:** \_\_\_\_\_

**ROUTING#:** \_\_\_\_\_

**AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM**

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

**AUTHORIZATION TO HONOR PAC WITHDRAWALS**

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

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

\_\_\_\_\_  
BANK SIGNATURE(S) OF DEPOSITOR(S)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR

TAPE VOIDED CHECK HERE



\* D T O 8 4 \*  
TG-NF



## 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](http://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, 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 to the best of my knowledge and belief; 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.
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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 to the best of my knowledge and belief; 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, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

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

Proposed Owner



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

## Beneficiary/Additional Insured Information Form

<b>PRIMARY INSURED</b>				
1. Last Name		First Name		2. SS# Last 4 Digits
<b>OWNER - if other than Primary Insured</b>				
1. Last Name		First Name		2. TIN/SS# Last 4 Digits
<b>ADDITIONAL/OTHER PROPOSED INSURED - if applicable</b>				
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
<b>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.</b>				
Name / Address		DOB	Percent	Relationship
				Phone # SSN / Tax ID#
<b>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.</b>				
Name / Address		DOB	Percent	Relationship
				Phone # SSN / Tax ID#
<b>AGENT</b>				
<input type="checkbox"/> 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	

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**YOU HAVE THE RIGHT TO NAME A SECONDARY ADDRESSEE  
ON YOUR LIFE INSURANCE POLICY TO RECEIVE NOTICE  
OF LAPSE OR TERMINATION OF THIS POLICY  
WHEN DUE TO NONPAYMENT OF PREMIUM.**

Please complete the following information to add a secondary addressee on your policy.

**SECONDARY ADDRESSEE:**

Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

Telephone Number \_\_\_\_\_

Signature of \_\_\_\_\_

Secondary Addressee \_\_\_\_\_

Date \_\_\_\_\_

**POLICY INFORMATION:**

Insured \_\_\_\_\_

Owner \_\_\_\_\_

Owner's Address \_\_\_\_\_

\_\_\_\_\_

Policy Number(s) \_\_\_\_\_

Signature of Owner \_\_\_\_\_

Date \_\_\_\_\_

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. It may take a few weeks to many years for symptoms to appear but they usually include fever, diarrhea, tiredness and enlarged lymph glands.

To evaluate your insurability, the insurer named above (the "Insurer") has requested that you provide a sample of your bodily fluid(s) for testing and analysis to determine the presence of HIV antibodies. Antibodies to HIV are produced by the body of a person who has been infected with HIV. Antibodies are the body's way of fighting the infection. By signing and dating this Consent, you agree that this test may be done.

## **The HIV Antibody Test**

A series of tests will be performed by a licensed laboratory through a medically accepted procedure. The most commonly used tests are the ELISA or "EIA" and the Western blot. If the ELISA shows the sample is positive for HIV, then the Western blot is done to confirm that initial result.

The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally the test may be negative in persons who are infected with HIV.

## **Meaning of Test Results**

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

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

## **Counseling**

Many public health organizations have recommended that before taking an HIV-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your physician or health care provider. A list of counseling resources is provided for your information. Other counseling services may also be available to you.

# Notice and Consent for HIV-Related Testing California

## Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting or claims decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer. Negative test results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not specifically disclose that you were subject to testing related to the human immunodeficiency virus. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date you sign this Consent.

## Notification of Test Results

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your physician or health care provider so that the Insurer can have him or her tell you the test result and explain its meaning. If you do not have a private physician, the test results can be sent directly to you, marked "Personal & Confidential", at your residence address.

Name of physician or health care provider:

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Street

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City, State, Zip Code

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## Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing*. I voluntarily consent to provide a sample of my bodily fluid(s), the testing of my bodily fluid(s) for HIV antibodies, and 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.

Name of Proposed Insured (*Please Print*)

Date of Birth

Signature of Proposed Insured

Date Signed





## Counseling Resources List

As required by California law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Transamerica Life Insurance Company (TLIC). Therefore, TLIC makes no representations or warranties that this information is accurate as of the date you receive this list. Also, TLIC makes no representations or warranties about the quality or nature of any services these resources may provide.

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

### **HIV/AIDS HOTLINE — National**

(800) 342-2437 English  
(800) 222-9432 Spanish  
(800) 243-7889 TTY/TDD users

### **HIV/AIDS HOTLINE - California**

(800) 367-2437 English, Spanish & Filipino  
(888) 225-2437 TTY users

### **California Dept. of Health Services**

(916) 449-5905

### **Alameda County HIV/AIDS Services**

(510) 873-6500

### **Contra Costa County AIDS Program**

(925) 313-6771

### **Fresno County Human Health Services**

(559) 445-3434

### **Kern County Dept. of Health**

(661) 868-0503

### **Los Angeles County**

(213) 351-8000  
Long Beach (562) 570-4320  
Pasadena (626) 794-6025

### **Marin County HIV Services**

(415) 499-7804

### **Monterey County Dept. of Health**

(831) 647-7932

### **Orange County Health Care**

(714) 834-7700

### **Riverside County HIV/AIDS Hotline**

(800) 243-7275 or (909) 358-5307

### **Sacramento County Department**

(916) 874-7720

### **San Bernardino County Health Department**

(800) 255-6560 or (909) 383-3060

### **San Diego County Office of AIDS Coordination**

(619) 296-3400

### **San Francisco**

(415) 863-2437

### **San Joaquin County AIDS Project**

(209) 468-3821

### **San Luis Obispo County - HIV Prevention Project**

(800) 544-6016 or (805) 781-5540

### **San Mateo County AIDS Program**

(650) 573-2588

### **Santa Barbara County Public Health Department**

(805) 681-5120

### **Santa Clara - HIV/AIDS Prevention Program**

(408) 494-7870

### **Santa Cruz County - AIDS Project Program**

(831) 427-3900

### **Solano County Public Health**

Fairfield (707) 428-1131  
Vallejo (707) 553-5331

### **Sonoma County**

(707) 545-4551

### **Stanislaus County HIV/STD Program**

(209) 558-8866

### **Ventura County Public Health Services**

(805) 652-6583

## Terminal Illness Accelerated Death Benefit Disclosure

You may request an accelerated death benefit when the Insured has been diagnosed with a Terminal Illness. A Terminal Illness is a medical condition, resulting from injury or disease which, as diagnosed by a Physician, has reduced life expectancy to not more than 12 months from the date of the Physician's certification. We must receive written proof of the Insured's Terminal Illness before we make an accelerated death benefit payment. We reserve the right to seek a second medical opinion or have the Insured examined at our expense by a Physician we choose.

We will pay an accelerated death benefit upon due proof that the Insured has a Terminal Illness, subject to the following conditions:

1. The Terminal Illness is first diagnosed on or after the later of the Date of Issue or Policy Date; and
2. The policy and endorsement are in force at the time of the accelerated death benefit request; and
3. The Face Amount of the policy at the time the accelerated death benefit request is received is at least \$25,000; and
4. At the time you request to exercise the accelerated death benefit, there must be at least two (2) years remaining before the Expiry Date of the policy;
5. We receive written proof of the Insured's Terminal Illness satisfactory to us, including a Physician's certification; and
6. We receive a consent form signed by all irrevocable beneficiaries and all assignees in a form acceptable to us.

An administrative fee will be deducted from the present value of each accelerated death benefit amount requested. As of the Endorsement Date, the administrative charge is \$350. The administrative charge will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index (CPI) since 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used.

The maximum death benefit you may accelerate is equal to the lesser of:

1. 100% of the Face Amount of the policy; or
2. \$500,000, including all other accelerated death benefit amounts previously elected or currently under review under all policies, endorsements or riders issued by us on the life of the Insured.

The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the accelerated death benefit is paid will also be reduced. The reduced premium will equal the appropriate premium rate applied to the reduced Face Amount plus any applicable policy fee. We will provide you with information showing the reduced Face Amount resulting from the accelerated death benefit payment.

### RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE AND YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.

By signing below, you agree that you have read the above and received a copy of this disclosure form.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner's (Applicant's) Signature

\_\_\_\_\_  
Agent's Signature

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

<b>1. Proposed Insured: (Print Full Name)</b> _____	<b>2. Date of Birth:</b> Month _____ Day _____ Year _____	<b>3. Social Security #</b> _____
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**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. <b>HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:</b>	Yes	No
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood (except HIV status)? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Sugar, protein or blood in urine, sexually transmitted disease (except HIV disease), stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands? .....	<input type="checkbox"/>	<input type="checkbox"/>
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones? .....	<input type="checkbox"/>	<input type="checkbox"/>
h. Any disease or abnormality of the eyes, ears, nose, throat or skin? .....	<input type="checkbox"/>	<input type="checkbox"/>
i. Cancer, tumor, polyp or cyst? .....	<input type="checkbox"/>	<input type="checkbox"/>
j. Any physical deformity or amputation? .....	<input type="checkbox"/>	<input type="checkbox"/>
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>
l. Diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .....	<input type="checkbox"/>	<input type="checkbox"/>

Details:

7.	Yes	No
a. Within the past ten years, have you used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician? .....	<input type="checkbox"/>	<input type="checkbox"/>
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? .....	<input type="checkbox"/>	<input type="checkbox"/>

8. <b>OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:</b>	Yes	No
a. Consulted, been examined or been treated by any physician or practitioner? .....	<input type="checkbox"/>	<input type="checkbox"/>
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study (not including HIV tests)? .....	<input type="checkbox"/>	<input type="checkbox"/>
c. Had observation or treatment at a clinic, hospital or other medical facility? .....	<input type="checkbox"/>	<input type="checkbox"/>
d. Had or been advised to have a surgical procedure? .....	<input type="checkbox"/>	<input type="checkbox"/>
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever? .....	<input type="checkbox"/>	<input type="checkbox"/>
f. Had any injury requiring treatment? .....	<input type="checkbox"/>	<input type="checkbox"/>



\* D T O 3 8 \*

- |    |   |                          |                          |
|----|---|--------------------------|--------------------------|
| 9. |   | <b>Yes</b>               | <b>No</b>                |
| a. | Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. | Has your weight changed by more than 15 pounds in the past year? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. | Are you now pregnant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

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?.....                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 15. Do you participate in athletics ( <i>Team or Individual</i> )?.....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 16. Have you ever used any tobacco products? .....                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 17. Do you get regular examinations by your health care provider? .....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 18. Do you get regular annual dental checkups? .....                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 19. Do you clean your house or do yard work?.....                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 20. Do you have a pet? .....   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 21. Are you a member of a social group or volunteer for charity work?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

It is represented that the statements and answers given above are true, complete, and correctly recorded to the best of my knowledge and belief. 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**

**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:

- 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.
- 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.
- 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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- 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 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.**

**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:

- 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.
- 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.
- 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 AIDS (except HIV exposure/testing), and use of alcohol, drugs and tobacco including alcohol or drug abuse treatment. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- 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.
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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:  
Cedar Rapids, IA 52499  
Administrative Office:  
4333 Edgewood Rd NE  
Cedar Rapids, IA 52499

## Chronic Illness and Critical Illness Accelerated Death Benefit Disclosure

This disclosure form provides a brief description of the accelerated death benefit options available under your policy. For details regarding your rights and obligations under the policy, please read your policy carefully. Accelerated benefits are payments made to you during the lifetime of the Insured in lieu of payment of the full death benefit of the policy.

*Chronically Ill* means the Insured:

- (a) Is unable to perform without Substantial Assistance from another person for a period of at least 90 days, at least two out of six Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or
- (b) Requires Substantial Supervision by another person, for a period of at least 90 consecutive days, to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

*Critically Ill* means the Insured has been diagnosed with a medical condition that would, in the absence of treatment, result in the Insured's death within 12 months.

**Conditions Under which Accelerated Benefits May be Elected:** If the Insured becomes Critically Ill or Chronically Ill while this policy is In Force, you may elect to receive an Accelerated Death Benefit payment subject to the provisions of the policy and the following conditions:

1. You must provide us with the required certification applicable to the requested form of Accelerated Death Benefit.
2. This policy must be In Force at the time of your Accelerated Death Benefit request; and
3. The Face Amount of this policy at the time the Accelerated Death Benefit request is received must be at least \$25,000; and
4. The waiting period must have expired; and
5. We must receive the consent of all irrevocable beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

**Amount of Benefit:** The Accelerated Death Benefit payment we make to you will be less than the amount of the death benefit which you request to accelerate. The Accelerated Death Benefit payment for the amount of the death benefit which you request to accelerate will be calculated as  $A - B - C - D$  where A, B, C, and D are determined as follows:

- A. The present value of the amount of the death benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your rider(s) form.
- B. Any due or unpaid premium if we make payment during the grace period.
- C. The actuarial present value of future premiums, excluding rider premiums that would otherwise be payable to keep this policy In Force during the period of the Insured's remaining lifetime at time of the acceleration, using the applicable rated age, mortality table, and interest rate.
- D. An administrative charge for each Accelerated Death Benefit request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2014 is \$350, but will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index for All Urban Consumers (CPI) since January 1, 2014. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used.



If we approve your request for a Chronic Illness Accelerated Death Benefit or Critical Illness Accelerated Death Benefit, the amount that may be payable will be based in part on the Insured's remaining life expectancy at the time of the acceleration. The longer the Insured's remaining life expectancy, the lower the payment amount will be. The shorter the Insured's remaining life expectancy, the higher the payment amount will be.

**Maximum Benefit:** The maximum death benefit you may accelerate over the lifetime of the Insured is equal to the lesser of:

- 1. 90% of the Face Amount of this policy; or
- 2. \$500,000, including all other Accelerated Death Benefits previously elected or currently under review under all policies, endorsements or riders issued by us or our affiliates on the life of the Insured.

The maximum death benefit you may accelerate in any 12 month period because the Insured is Chronically Ill is 24% of the Face Amount of the policy at the time of the initial acceleration.

**Effect of Benefit on Policy:** The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the Accelerated Death Benefit is paid will be adjusted. The adjusted premium will equal the appropriate premium rate applied to the reduced Face Amount plus any applicable policy fee. We will provide you with information showing the reduced Face Amount resulting from the Accelerated Death Benefit payment.

As an example of the impact that election of an Accelerated Death Benefit has on policy values, consider the following situation:

Prior to Election		Upon Partial Election of 50% of Face Amount		Upon Full Election	
Face Amount	= \$200,000	Remaining Face Amount	= \$100,000	Face Amount	= \$0
Annual Premium	= 4,000	Remaining Annual Premium	= 2,000	Annual Premium	= 0

**Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under this rider.**

By signing below, you agree that you have read the above and received a copy of this disclosure form.

\_\_\_\_\_

Date

\_\_\_\_\_

Owner's (Applicant's) Signature

\_\_\_\_\_

Agent's Signature

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





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

## **IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS**

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Website ([www.insurance.ca.gov](http://www.insurance.ca.gov)) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit, doing so will reduce the amount that your beneficiary will receive upon your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, you should seek assistance from a qualified tax advisor.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Agent Signature



Transamerica Life Insurance Company  
Home Office: 4333 Edgewood Road N.E.  
Cedar Rapids, IA 52499

## Notice To Applicant Regarding Replacement Of Long-Term Care Insurance Or Life Insurance Including Accelerated Death Benefits

According to information you have furnished, you intend to lapse or otherwise terminate existing life insurance or long-term care insurance and replace it with a life insurance policy with an accelerated death benefit to be issued by Transamerica Life Insurance Company. Your new accelerated death benefit coverage provides 30 days within which you may decide, without cost, whether you desire to keep the coverage. Please note that your underlying life insurance policy may only provide for a 10-day period during which you may decide, without cost, whether you will keep the coverage. For your own information and protection, you should be aware of, and seriously consider, certain factors that may affect the insurance protection available to you under the new coverage.

This accelerated death benefit is NOT Nursing Home, Home Care, or Long-Term Care Insurance, and it is not intended or designed to eliminate your need for that coverage. There are no restrictions or limitations on the use of the accelerated death benefit proceeds.

If you want long-term care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site ([www.insurance.ca.gov](http://www.insurance.ca.gov)) that provides information regarding long-term care insurance.

If you want to replace existing coverage with life insurance that includes an accelerated death benefit, you should note the following:

- (1) Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, policyholders or certificate holders should seek assistance from a qualified tax adviser.
- (2) Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, the applicant/buyer should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your coverage had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

Note: One copy of notice shall be retained by the applicant and one signed copy shall be retained by the Company.

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

- ☐ Additional or different benefits (please specify) \_\_\_\_\_ .
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ Other (please specify) \_\_\_\_\_ .

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agent/Insurance Producer, Broker or Other Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Type or print Name & Address of Agent/Insurance Producer, Broker



Transamerica Life Insurance Company  
Home Office: 4333 Edgewood Road N.E.  
Cedar Rapids, IA 52499

## Accelerated Death Benefit Rider Replacement Question

### Section I - Proposed Owner

First	Middle	Last	Soc. Sec. No.

### Section II - Proposed Insured

First	Middle	Last	Soc. Sec. No.

### Section III - Replacement Question

You are applying for a life insurance policy with accelerated death benefit riders. By applying for this policy, do you intend to replace any stand-alone long term care (LTC) insurance policy or any life insurance policy with a LTC Insurance rider currently in force?

☐ Yes ☐ No

**I, the Proposed Insured, and I, the Proposed Owner if different, hereby represent** that the statements and answers given in this supplement form are true and complete to the best of my/our knowledge and belief.

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(City and State) (Month) (Date) (Year)

\_\_\_\_\_  
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor)

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(City and State) (Month) (Date) (Year)

\_\_\_\_\_  
Signature of Owner (if other than proposed Insured)

Signed at \_\_\_\_\_ on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(City and State) (Month) (Date) (Year)

\_\_\_\_\_  
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

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

- ☐ **PREMIUM**  
☐ **LOAN REPAY**  
☐ **SAVINGS**  
☐ **CHECKING**

- ☐ **NEW AUTHORIZATION**  
☐ **BANK CHANGE**  
☐ **ADD TO EXISTING POLICY**  
☐ **OTHER** \_\_\_\_\_

**PICK A DATE TO DRAFT (1-28)** \_\_\_\_\_

**NAME OF FINANCIAL INSTITUTION:** \_\_\_\_\_

**PHONE #:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY, STATE, ZIP:** \_\_\_\_\_

**ACCOUNT NUMBER:** \_\_\_\_\_

**NAME(S) ON BANK ACCOUNT:** \_\_\_\_\_

**ROUTING#:** \_\_\_\_\_

**AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM**

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

**AUTHORIZATION TO HONOR PAC WITHDRAWALS**

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

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

\_\_\_\_\_  
BANK SIGNATURE(S) OF DEPOSITOR(S)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR

TAPE VOIDED CHECK HERE



\* D T O 8 4 \*