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 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.
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 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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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 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.
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 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.

RESET

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 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.

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: _____

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

TRANSAMERICA®

Payment Authorization Form

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

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Recurring Draft Day (1st through 28th only)
Initial modal 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 recurring premiums drafted on day policy is issued.

Recurring Premium Payment Mode (choose one)
☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Planned Modal Premium
$ _____

Please select your preferred payment type/s by checking the box for initial and/or recurring payments next to the option you favor. (Ex: I want to make my initial payment by check and recurring payments with ACH.)

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.

Draft upon Underwriter Approval? ☐ **Yes** ☐ **No**

Wait for acceptance to draft after confirmation from agent? ☐ **Yes** ☐ **No**

One-time ACH Debit Authorization

This section should be completed by the Bank Account Holder (Payor). Some policies may require an adjustment payment to cover a gap in premium when certain billing changes occur. This adjustment payment will keep the policy active until your recurring payments begin.

☐ By checking this box and signing this form, you authorize a one-time ACH debit in an amount needed to put your policy in an active status until your recurring payments begin. If this amount has not already been provided, contact us and we will provide you with the exact amount required. If authorized, this ACH debit will be made to your account on or after the date this request is received in good order.

NOTE: If you do not authorize this debit, and payment is still required, you will be contacted.

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 Signature:

X **Date:**

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

Routing Number

Account Number

The account holder is the (choose one):
☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Account Holder Signature:

X **Date:**

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 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.

_____ _____

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 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, 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

Transamerica Life Insurance Company

California Fraud Language Endorsement

It is hereby understood and agreed that the form to which this Endorsement is attached is amended as follows:

For your protection California law requires the following to appear on this form.

Fraud Warning: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

California Fraud Language Endorsement

It is hereby understood and agreed that the form to which this Endorsement is attached is amended as follows:

For your protection California law requires the following to appear on this form.

Fraud Warning: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

TRANSAMERICA®

Notice and Consent for HIV-Related Testing
CALIFORNIA

Transamerica Life Insurance Company

Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

Information about human immunodeficiency virus ("HIV"). HIV is the etiologic virus (cause) of acquired immunodeficiency syndrome ("AIDS") and AIDS-defining illnesses that are serious and can be life-threatening. You can only get HIV by coming into direct contact with certain body fluids from a person with a detectable HIV viral load: blood, semen and pre-seminal fluid, rectal fluids, vaginal fluids, and breast milk. Transmission occurs when these HIV-infected fluids get into the bloodstream of an HIV-negative person through a mucous membrane (found in the rectum, vagina, mouth, or tip of the penis), through open cuts or sores, or by direct injection (from a needle or syringe). If you would like additional information, please begin with these resources:

Office of AIDS, Center for Infectious Diseases
California Department of Public Health
MS 7700 P.O. Box 997426, Sacramento, CA 95899-7426
(916) 558-1784
https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx#

Office of Infectious Diseases National Center for HIV,
Viral Hepatitis, STD, and TB Prevention
Centers for Disease Control and Prevention
800-232-4636
https://www.cdc.gov/hiv/default.html

HIV Test. To evaluate your insurability, the company designated above (the "Insurer") has requested that you agree to an HIV test as part of your application for insurance. There is no cost to you for the HIV test, it will be paid for by the Insurer. There are generally three types of tests to determine if a person is HIV positive: (1) Antigen/Antibody Test that can detect HIV antigens or antibodies 18 to 90 days after exposure; (2) Antibody Test that can detect HIV antibodies 23 to 90 days after an exposure; and (3) Nucleic Acid Test for HIV genetic material that can detect HIV 10 to 33 days after exposure. The testing facility performing the HIV test and analysis will provide you with the type of your HIV test, how it will be performed, its purposes, and its limitations.

HIV Test Result. If your HIV test result is positive, the physician that you designate below will be notified. If you fail to properly designate a physician, then you will be urged to contact a private physician, the county department of health, the State Department of Public Health, local medical societies, or alternative test sites for appropriate counseling.

Name of Your Healthcare Provider _____ Street Address _____

Telephone _____ City, State, Zip Code _____

Confidentiality of Test Results. All test results are required to be treated confidentially. Your test results will be reported to the Insurer and its designated representatives for purposes of underwriting and claims decisions, and, as necessary, for effective legal representation. The test results may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality (use of general codes that include tests unrelated to HIV/AIDS), and for the preparation of statistical reports that do not identify you. Negative test results may be disclosed to reinsurers involved in the underwriting process. Your test results may also be disclosed as required by law, for example, to your local public health official. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date you sign this Consent.

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 fluids for HIV, and disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original. **I understand that after signing this Consent, I may still choose to decline the HIV test and withdraw my application for insurance.**

Proposed Insured (Please Print) _____ Date of Birth _____

Signature of Proposed Insured _____ Date Signed _____

(NF) ACF 2022CA

TRANSAMERICA®

Terminal Illness Accelerated Death Benefit Disclosure

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

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

Terminally Ill or Terminal Illness means the Insured has a medical condition, resulting from bodily injury or disease, or both, which is expected to result in the death of the Insured within 12 months of diagnosis.

Conditions Under which Accelerated Benefits May be Elected: If the Insured becomes Terminally Ill while the policy and rider/endorsement are in effect, you may elect to receive an Accelerated Death Benefit payment subject to the provisions of the policy and rider/endorsement and the following conditions:

1. You must provide us with a Physician's certification of Terminal Illness dated within 30 days of the Accelerated Death Benefit request; and
2. The policy and the rider/endorsement must be in effect at the time of your Accelerated Death Benefit request; and
3. The Face Amount of the policy at the time of the Accelerated Death Benefit request must exceed the minium required by the Accelerated Death Benefit rider/endorsement; and
4. We must receive the written consent of all irrevocable Beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

Charges for Accelerated Death Benefits: There is no premium charge for the Accelerated Death Benefit rider/endorsement, however, an administrative charge and interest discount will be assessed as part of the calculation of an Accelerated Death Benefit payment.

Effect of the Accelerated Death Benefit on the Policy: The policy's benefits and values, as those amounts exist on the date the Accelerated Death Benefit is paid, will be reduced after payment of an Accelerated Death Benefit. The premium and/or charges and monthly deductions, as applicable, for the policy and any affected riders will also be adjusted after an Accelerated Death Benefit is paid.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Payment of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits and entitlements. Accelerated Death Benefits do not and are not intended to qualify as long-term care insurance.

We intend that payments we make under the Accelerated Death Benefit options will receive favorable tax treatment; however, there are circumstances when receipt of an Accelerated Death Benefit payment may be taxable. Please consult your personal tax advisor to determine the tax status of any benefits paid under these options.

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
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®

eDELIVERY | SECURE! EASY! ENVIRONMENTALLY FRIENDLY!

eDelivery Terms and Conditions of Use

The Transamerica company using this form is:

☐ Transamerica Life Insurance Company ☐ Transamerica Financial Life Insurance Company

As used herein, "the Company", "we", "our", or "us" means the Transamerica company checked above.

ELECTRONIC INFORMATION CONSENT – I consent to receive documents and notices applicable to the Eligible Policy/Policies accessed through the Company website or portal, or websites or portals operated on behalf of the Company. These include, but are not limited to: Policy contracts, applications, application supplements and addendums, illustrations, amendments, riders, replacement notices, statements of additional information, conditional receipts, customer correspondence, prospectuses, prospectus supplements, annual and semiannual reports, quarterly statements and immediate confirmations, privacy notices, other notices, and documentation, permitted by law to be sent electronically, in electronic format, when available instead of receiving paper copies of these documents by U.S. mail.

Important Information Concerning Electronic Document Delivery:

- Your consent is voluntary. Documents will only be transmitted to you electronically if you consent.
- There is no charge for electronic delivery, although your internet provider may charge for Internet access.
- You are confirming that you have access to a computer with internet capabilities and an active email account to receive information electronically.
- This Electronic Document Delivery applies only to Eligible Policies accessed through the Company website or portal, or websites or portals operated on behalf of the Company.
- After consenting to Electronic Document Delivery, we will send an email to confirm that the email address you provided is correct. If we are unable to confirm an email address or have reasonable suspicion that an email address is incorrect, we will not activate the consent for electronic delivery, in which case you will continue to receive paper copies of your documents.
- Email filters must be updated to ensure you received email notifications from us.
- Not all contract documentation and notifications may currently be available in electronic format.
- You can request the Company provide paper copies of documents at any time for no charge.
- If an email address changes, you may notify us at any time by contacting us at the phone number listed below or editing your profile on the appropriate website.
- This consent will remain in effect until revoked. You may opt out of receiving records electronically at any time.
- If you choose to revoke your consent, withdrawal of this consent will become effective within two business days after the Company receives your request.

Please call 1-800-851-9777 or visit the Company website at www.transamerica.com if you would like to revoke your consent, wish to receive a paper copy of the information above, or need to update your email address.

☐ By checking this box, I consent to receive electronic transmission of documents and agree to the terms and conditions as described above.

Policy Owner: _____
Email Address Printed Name

Policy Number(s): _____

TRANSAMERICA®

Revised April 30, 2024

CALIFORNIA CONSUMER PRIVACY ACT NOTICE

At Transamerica, it is important to us that you understand how we use and share your personal information. This California Consumer Privacy Act ("CCPA") notice ("Notice") outlines our use and disclosure of personal information pertaining to residents of California that is covered by the CCPA. This Notice applies to users of the websites and mobile applications of the Transamerica companies (collectively "Transamerica", "we", "us" or "our") (for a list of companies, please see our Online Privacy Notice or Contact Us as set forth below) and to our customers.

This Notice supplements the Online Privacy Notice with respect to personal information of California residents that is covered by the CCPA. The CCPA does not apply to: (i) personal information that is subject to the federal Gramm-Leach-Bliley Act ("GLBA"); or (ii) health information subject to the federal Health Insurance Portability and Accountability Act ("HIPAA"). For example, this Notice is not applicable to policyholders or individual customers who have or are using our financial or health products and services primarily for personal, family or household use. If the foregoing applies to you, federal law requires that we provide you with a separate privacy notice. Such notices can be viewed at www.transamerica.com/privacy-policy ("**Online Privacy Notice**," see "**Additional Privacy Notices**").

This Notice identifies the categories of personal information we collect, describes how we use and share personal information, and explains how California residents can make certain requests regarding their personal information.

Categories of Personal Information Collected

The categories of personal information we collect about you depend on what you share with us, the product(s) you have purchased from us, and the service(s) you receive from us. Below, we describe the categories of personal information we have collected in the last 12 months and how we disclose personal information to third parties:

- *Identifiers* such as name, postal address, date of birth, email address, social security number, driver's license number, passport number, or other information that identifies you
- *Demographic and other information* considered to be protected classifications under federal or California law, such as age, race, disability, criminal history, marital status, or medical condition
- *Customer records,* which includes personal information as defined in the California customer records law, such as signature; insurance or other policy number; financial information, including as submitted by you related to your specific financial condition, accounts, or assets, or which relate to a product sold, serviced, or issued by us; and health, prescription, or medical information you have provided to us or authorized us to access
- *Commercial information*, such as transaction information and purchase history, and information relating to your business and property interests
- *Biometric information* such as voiceprints
- *Internet or network activity information*, such as search and browsing history, login credentials, IP address, and device and advertising identifiers
- *Geolocation data*
- *Audio information* such as a voice recording
- *Professional or employment-related information*, such as past and present work history, affiliations, education, and employment
- *Inferences* which we may generate or acquire relating to your preferences, attitudes, characteristics, or behaviors
- *Sensitive Information*, including:
  - social security, driver's license, state identification card, or passport number
  - your account log-in, financial account, debit card, or credit card number in combination with any required security or access code, password, or credentials allowing access to an account
  - racial or ethnic origin, religious or philosophical beliefs, or union membership
  - biometric information, if you elect to use your voiceprint as a security credential
  - personal information collected and analyzed concerning a consumer's health

Sources from Which Personal Information is Collected

We collect these categories of personal information from a variety of sources, including yourself and other sources authorized by you either on this Site or via processing/servicing a product or an application for a product, for example, from your doctor, financial advisor, or credit reporting agency, or other sources needed to underwrite or issue a product or complete a transaction. We also obtain personal information from public records and other widely available sources, and in some cases from companies that assist us with fraud prevention, underwriting and similar services. Internet information may be collected from devices you use to access our websites, mobile applications, and services (including through cookies and similar technologies). Inferences and other categories of personal information may be collected from third parties such as social media providers, advertising networks, marketing and analytics providers, and data brokers. More details may be found in our Online Privacy Statement (see "**Information We Collect**").

Business or Commercial Purposes of Use of Personal Information

We may use personal information for business or commercial purposes including: i) evaluating eligibility for products or services; ii) administering our products, providing services, and delivering content; iii) product pricing, development, and quality assurance; iv) actuarial and research studies, and other technological development and analytics; v) legal and regulatory filings, auditing, and compliance; vi) identity verification, fraud prevention, and information security; vii) supporting, debugging, and maintaining information systems; viii) marketing, advertising, promotions, and sales; and, ix) other operational purposes compatible with the uses related to your initial disclosure. More details may be found in our Online Privacy Statement (see "**How We Use the Information We Collect**").

Notice of Monitoring of Services

See the Online Privacy Statement for a description of how we may monitor visits to our websites and mobile applications, including sessions of users.

To Which Categories of Third Parties is Personal Information Disclosed or "Sold"?

We disclose and have disclosed within the twelve months preceding the Revised Date of this Notice information included under each of the categories listed above to affiliates, to service providers, as authorized by you, and as required or permitted by law. This includes: companies who help us process claims, maintain accounts, and support marketing and sales; credit bureaus; insurance regulators, law enforcement, government authorities and third parties in response to legal processes or to determine eligibility for public benefits; health care professionals (e.g., to verify coverage or provide information relating to a medical condition); other insurance companies (including successor insurers), agents

and insurance support organizations to coordinate benefits or in connection with insurance transactions involving you; group policyholders (e.g., regarding claims experience, benefits administration or service audits); certificate or policyholders (e.g., regarding the status of an insurance transaction); those with a legal or beneficial interest in your assets (e.g., a creditor); employer or plan sponsor (e.g., to support administration of employee accounts as permitted by law); your representatives and lawyers; to prevent or prosecute fraud or crime; to researchers or professional advisers (such as for actuarial or research studies); and to a purchaser, underwriter, or others in connection with the sale or merger of all or part of our business. While we do not currently "sell" or "share" (as such terms are defined under California law) personal information subject to the CCPA, and have not "sold" or "shared" personal information subject to the CCPA in the twelve months preceding the Revised Date of this Notice, we offer you the right to opt-out, as described in the "**Your California Consumer Privacy Rights**" section below.

Sales or Sharing of Minors' Personal Information

We do not sell personal information of individuals we know to be under the age of 16, nor do we share such personal information with third parties for cross-context behavioral advertising.

How Long We Keep Personal Information

The amount of time we retain a particular category of personal information will vary depending on the purpose for which it was collected, our business need for it, and our legal obligations to retain it. We retain your personal information for the time needed to fulfill the purpose for which that information was collected and as required pursuant to our data retention policies, which reflect applicable statute of limitation periods and legal requirements. To determine the appropriate retention period for personal information, we consider the nature and sensitivity of your personal information, the potential risk of harm from unauthorized use or disclosure of your personal information, the purposes for which we collect, use and maintain your personal information and our legal requirements to retain such information.

Your California Consumer Privacy Rights

As a California resident, you have certain rights to make requests regarding your personal information ("Consumer Requests"):

1) Right to Know: You have the right to request that we disclose what personal information we collect, use, disclose, and sell, including: i) specific pieces of information that we have collected about you; ii) categories of personal information we have collected about you; iii) categories of sources from which the personal information is collected; iv) categories of personal information about you that we sold or disclosed for a business purpose; v) categories of third parties to whom the personal information was sold or disclosed for a business purpose; and vi) the business or commercial purpose for collecting, selling or sharing personal information. Please note that Transamerica is not obligated to respond to a California resident's Request to Know more than twice in any 12-month period. Because the information you're requesting is sensitive, prior to sending you your personal information report we will need to verify your identity as noted below.

2) Right to Correct: You have the right to request that we correct inaccurate personal information that we maintain about you.

3) Right to Delete: You have the right to request that we delete personal information we have collected about you, subject to Transamerica's legal rights or obligations to retain such personal information (for example, we have a legal obligation to retain information regarding your account while your account is active and for at least seven years thereafter, we are required to retain a record of your deletion request, we may retain data in archive systems, etc.). Please note that once we delete your information, we cannot restore it.

4) Right to Opt-Out of Sales/Sharing: You have the right to opt out of sales of your personal information or the disclosure of your personal information for cross-context behavioral advertising ("sharing"). Cross-context behavioral advertising refers to the targeting of advertising to an individual based on the individual's personal information obtained from their activity across businesses, websites, or applications other than those provided by Transamerica. While we currently do not sell or share your personal information, if we do so in the future, we will honor your opt-out election. As of the effective date above, we do not respond to Do Not Track signals or other mechanisms that provide consumers the ability to exercise choice regarding the collection of personally identifiable information about an individual consumer's online activities over time and across third-party websites.

- You can make a Consumer Request via our online forms found at www.transamerica.com/ccpa-disclosure or by calling Transamerica, toll-free, at 877-247-2401.
- Transamerica collects certain sensitive information (as discussed above in the "**Categories of Personal Information Collected"** section). We do not use or disclose sensitive information in a manner that requires us to offer a right to limit such use under the CCPA.
- Transamerica does not use automated decision-making tools to process your personal information in a manner that requires us to offer a right to limit such processing under the CCPA.
- Transamerica publishes its response metrics related to Consumer Requests at www.transamerica.com/CCPA-metrics.
- We may limit our response to your rights as permitted by applicable law.

Verification Process & Authorized Agents

Upon receipt of a Consumer Request, we will seek to verify your identity to our reasonable satisfaction before responding. This may require you to submit personal information to us during the verification process. You may authorize another individual to submit a Consumer Request on your behalf through the means indicated above. We may require the authorized agent to provide proof of your signed permission to submit the request and may require you to do one of the following: i) verify your identity directly with us; or ii) directly confirm to us that you have provided the authorized agent permission to submit the request.

Non-Discrimination

You have the right to be free from unlawful discrimination for exercising your privacy rights under the CCPA. In response to your exercise of your rights, we may not: i) deny goods or services; ii) charge different prices or rates for goods or services, including through discounts or other benefits, or imposing penalties; iii) provide a different level of quality of goods or services; or iv) suggest that you will receive a different price or rate for goods or services, or a different level or quality of goods or services. We may, however, charge different prices or rates, or provide a different level or quality of goods or services, if that difference is reasonably related to the value provided to us by your personal information.

Contact Us

If you have questions or any concerns, please call our toll-free number: 877-247-2401 or reach out to us via email: consumerdatarequest@transamerica.com.

TRANSAMERICA®

Notice Regarding Replacement
Replacing Your
Life Insurance Policy or Annuity

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

California Internal Replacement Comparison Form

California Insurance Code section 10509.3 requires that a written statement be provided to the applicant when a replacement of a life insurance policy or annuity is being made if both the replacing insurance company and the existing insurance company are the same.

Please complete the information below in its entirety as appropriate. Do not leave blanks, instead indicate "N/A" for not applicable. A copy is not required to be submitted to the Home Office.

Name of Proposed Insured _____ (First, Middle, Last)

Existing Policy# _____

Policy Information As-of-Date _____

General Information	Existing Life Insurance/Annuity		Proposed Life Insurance	Proposed Annuity
Basic Policy Type/Insured				
Rider 1: Type/Insured				
Rider 2; Type Insured				
Rider 3: Type Insured				
Rider 4: Type Insured				
Issue Age				
Issue Date				
Contestability Period Expires				
Suicide Clause Expires				

Premium Data/ Death Benefits	Existing Life Insurance/Annuity Immediately Before		Proposed Life Insurance	Proposed Annuity
Basic Policy Premium				
Annual Target Premium				
Rider 1 Premium				
Rider 2 Premium				
Rider 3 Premium				
Rider 4 Premium				
Total Premium				
Basic Policy Death Benefit				
Div. Adds Death Benefit				
Rider 1 Death Benefit				
Rider 2 Death Benefit				
Rider 3 Death Benefit				

Cash Value/ Dividends	Existing Life Insurance/Annuity Immediately Before	Immediately	Proposed Life Insurance	Proposed Annuity
Rider 4 Death Benefit				
Guaranteed Cash Value				
Accumulation Fund (UL/UL II Annuities)				
Accumulated Dividends				
Cash Value of Div. Adds.				
Policy Loan				
Loan Inerest Rate %				

Additional Comments:

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 (except HIV status)?	☐	☐	
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 (except HIV 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. Diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	

7.	**Yes**	**No**
a. Within the past ten years, have you 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 (not including HIV tests)?	☐	☐
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. 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 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

Transamerica Life Insurance Company

California Fraud Language Endorsement

It is hereby understood and agreed that the form to which this Endorsement is attached is amended as follows:

For your protection California law requires the following to appear on this form.

Fraud Warning: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of loss is guilty of a crime and may be subject to fines and confinement in state prison.

TRANSAMERICA®

Secondary Addressee

○ **Transamerica Financial Life Insurance Company**
Home Office: Harrison, New York
○ **Transamerica Life Insurance Company**
Home Office: 6400 C Street SW, Cedar Rapids, IA 52499

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 _____

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