

Transamerica Life Insurance Company

Home Office, 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499

APPLICATION FOR LIFE INSURANCE

1. Proposed Insured Name _____ Address _____ City _____ State _____ Zip _____ Telephone (_____) _____		2. Social Security No. _____		3. Birthdate Mo Day Yr		Age _____		Birth Place (State) _____	
		4. Height Ft. In.		Weight Lbs.		5. Sex ☐ Male ☐ Female		6. ☐ Married ☐ Single	
		7. Occupation _____		8. U.S. Citizen ☐ Yes ☐ No If no, give immigration status/type of visa: _____					
9. Life Insurance Amount \$ _____ (a) Plan: _____ (b) Premium \$ _____ (c) Accidental Death Benefit Rider \$ _____ (d) If a policy cannot be issued as applied for, would you accept a rated policy if available? ☐ Yes ☐ No (e) If "yes," adjust face amount to premium? ☐ Yes ☐ No		12. \$ _____ has been paid to Agent under the terms of the receipt given me, bearing the same date as this application.							
10. Is Automatic Premium Loan Option to apply? ☐ Yes ☐ No		13. Owner, if other than the Proposed Insured Name _____ Age _____ Relationship _____ Address _____ City _____ State _____ Zip _____ Social Security or Tax ID No. of Owner _____							
11. Premiums Payable: ☐ Monthly PAC/ACH ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly									
14. Beneficiary Name _____ Age _____ Relationship _____		Contingent Beneficiary Name _____ Age _____ Relationship _____							

Section 1 - If any answer to Question 15, 16, 17, 18, 19, 20 or 21 is "Yes", do not submit an application.

	Yes	No
15. Have you ever been diagnosed with, treated or received medication for congestive heart failure, Alzheimer's disease, dementia, liver cirrhosis, kidney/renal failure or insufficiency, dialysis or lung disorder requiring oxygen?	☐	☐
16. Have you ever been treated with insulin for diabetes and if so, have you ever been diagnosed, treated, or received medication for a circulatory disorder (except high blood pressure under control by medications)?	☐	☐
17. Have you been diagnosed with, treated or advised to be treated within the past 2 years for internal cancer, leukemia, or melanoma?	☐	☐
18. Have you been hospitalized for a mental or nervous disorder within the last year?	☐	☐
19. Have you had a heart attack, stroke, or had or been advised to have a procedure to improve circulation within the past year?	☐	☐
20. Are you now confined to bed or to a hospital, a nursing home or other similar care facility?	☐	☐
21. Have you or any proposed insured ever been diagnosed as having or been treated for AIDS or AIDS Related Complex (ARC), or tested positive for the AIDS virus?	☐	☐

Section 2

22. Have you ever been treated with insulin for diabetes?	☐	☐
23. In the past 5 years, have you been diagnosed with, treated or received medication for internal cancer, leukemia or melanoma?	☐	☐
24. In the past 3 years, have you been diagnosed with, treated or received medication for:		
A) chronic respiratory problems, including asthma?	☐	☐
B) alcoholism or drug abuse?	☐	☐
C) a heart attack, stroke, irregular heart rhythm, or had a procedure to improve circulation?	☐	☐
25. Does the proposed insured intend the replacement or change of any existing life insurance or annuities in connection with this application for insurance?	☐	☐

Special Instructions

Under penalties of perjury, I hereby certify (1) that the Social Security or Taxpayer I. D. number listed above on this application is correct and (2) that I am currently not subject to backup withholding. [Cross out (2) if not correct.] See below***

The statements and answers on this Application are true and complete. It is agreed that (a) this application and any amendments hereto, with the answers made to the medical examiner and recorded on Part Two, if a medical examination is required by the Company, shall be the basis of any insurance granted; (b) no agent or medical examiner has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the Company's rights or requirements or to make or alter any contract; (c) acceptance of any policy issued shall constitute ratification of any endorsements delivered with the policy, except that no change in the amount, classification, plan of insurance or annuity, or benefits shall be effective unless agreed to in writing by the Applicant, and (d) except as may be provided in the conditional receipt bearing the same date as this application, no insurance or annuity shall be considered in force unless and until a policy shall have been issued by the Company and said policy received and accepted by the Applicant and the full first premium paid thereon, all during the lifetime and before any change in the insurability of any person proposed for insurance from that stated herein.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company. At such time, all temporary coverage under the conditional receipt shall end.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Veteran's Administration, Medical Information Bureau 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. A photocopy of this authorization shall be as valid as the original. This authorization is limited to a period of 30 months commencing on the date of this application. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records to any agency employed by the Company to collect and transmit such information.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Dated at _____ city _____ state _____ this _____ day of _____ month _____, _____ year _____.

X _____ X _____
Signature of Applicant, if other than Proposed Insured Signature of Proposed Insured

**AGENT'S REPORT
PLEASE INFORM YOUR CLIENT ABOUT THE TELEPHONE INTERVIEW.**

Best time to call for Personal History Interview. _____ a.m. _____ p.m. Home or work phone number _____

I represent that:

- 1) I have personally seen the Proposed Insured ☐ Yes ☐ No
2) I have truly and accurately recorded on this application the information as supplied by the Owner
and the Proposed Insured ☐ Yes ☐ No

Do you have any knowledge or reason to believe that the insurance applied for will replace or change any
existing insurance or annuity? ☐ Yes ☐ No

(If "Yes", furnish name of Company and Policy Number) _____

Licensed Agent Name (Please Print) Signature of Agent Agent #

***** Purpose of Statement.** This statement is for the payer of interest, dividends, and certain other payments so that you will not be subject to backup withholding that became effective January 1, 1984

This statement is used to report and certify your taxpayer identification number (TIN) to the payer, to certify that you are not subject to backup withholding because of underreporting interest and dividends on your tax return, and to claim exemption from backup withholding if you are an exempt payee.

If you do not certify to your TIN, the payer may be required to withhold taxes on payments made to you.

What is Backup Withholding. The Interest and Dividend Tax Compliance Act of 1983, as amended, requires payers to withhold and pay to IRS taxes on payments of interest, dividends, and certain other payments under certain conditions. This is called "backup withholding." If you give your correct TIN, certify your TIN when required, and report all your taxable interest and dividends on your tax return, your payments will not be subject to backup withholding.

Payments you receive will be subject to backup withholding if:

- (1) You do not furnish your TIN to the payer, or
- (2) IRS notifies the payer that you furnished an incorrect TIN, or
- (3) You are notified by IRS that you are subject to backup withholding because you failed to report all your interest and dividends on your tax return (for interest and dividend accounts only), or
- (4) You fail to certify to the payer that you are not subject to backup withholding under (3) above (for interest and dividend accounts opened after 1983 only), or
- (5) You fail to certify your TIN. This applies only to interest, dividend, broker, or barter exchange accounts opened after 1983, or broker accounts considered inactive in 1983.

For other payments, you are subject to backup withholding only if (1) or (2) above applies.

**AUTHORIZATION TO HONOR CHECKS OR ELECTRONIC DEBITS DRAWN BY
TRANSAMERICA LIFE INSURANCE COMPANY, HOME OFFICE, CEDAR RAPIDS, IA**

To: _____ Branch _____
(Name of Financial Institution)

Financial Institution Address: _____
City _____ State _____ Zip _____

As a convenience to me, I request and authorize you to pay and charge to my account, items (checks or electronic debits) drawn on my account by and payable to the order of the Transamerica Life Insurance Company, provided there are sufficient funds in said account to pay the same upon presentation. I agree that your rights with respect to each such check or electronic debit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check or electronic debit.

I further agree that if any such check or electronic debit be dishonored, whether with or without cause, and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. Account No. _____

Date _____ Signature must be the same as on file at Financial Institution
and if a company account, the name of the account must also be shown.

AGENT: DO NOT DETACH UNLESS PREMIUM IS SUBMITTED WITH APPLICATION.

IMPORTANT: READ BOTH SIDES OF THIS RECEIPT

CONDITIONAL RECEIPT ("RECEIPT")

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO TRANSAMERICA LIFE INSURANCE COMPANY
DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK**

RECEIVED FROM _____, ON _____ (Date)

THE SUM OF \$ _____ IN CONNECTION WITH AN APPLICATION FOR LIFE INSURANCE TO TRANSAMERICA LIFE INSURANCE COMPANY ("COMPANY"), BEARING THE SAME DATE. YOU UNDERSTAND AND AGREE TO THE TERMS, CONDITIONS AND LIMITS OF THIS RECEIPT AND THAT NO COVERAGE UNDER THIS RECEIPT WILL BECOME EFFECTIVE UNLESS ALL CONDITIONS OF THIS RECEIPT (INCLUDING THOSE ON THE REVERSE OF THIS RECEIPT) ARE MET. NO AGENT HAS THE AUTHORITY TO ALTER OR WAIVE ANY OF ITS TERMS OR CONDITIONS.

EFFECTIVE DATE: If all conditions of this Receipt (including those on the reverse of this Receipt) are met, then, this Receipt will provide insurance, subject to the conditions of the policy applied for, effective on the latest of: (a) the date of the application; or (b) the date of completion of the underwriting requirements stated in "2" on the reverse of this Receipt.

END OF INSURANCE: Once begun, any insurance this Receipt provides ends on the earliest of: (a) 60 days after the date of this Receipt; (b) when the Company sends a refund of the premiums which were exchanged for this Receipt; or (c) the date any policy issued goes into effect.

LIABILITY LIMITS: The amount of insurance which may become effective under this Receipt will not exceed the lesser of: (a) the amount of insurance applied for on the application, or (b) \$10,000 (including life insurance and accidental death benefits), less all other sums payable by the Company for the death of a Proposed Insured under any other receipt or pending application. IF ANY OF THE CONDITIONS OF THIS RECEIPT ARE NOT MET, OR IF A PROPOSED INSURED DIES BY SUICIDE, THE LIABILITY OF THE COMPANY WILL BE LIMITED TO THE RETURN OF THE AMOUNT OF MONEY SUBMITTED. THE CONDITIONS AND PROVISIONS ON THE REVERSE OF THIS RECEIPT ARE A PART OF THIS RECEIPT.

Signature of Applicant

Signature of Agent

Detach and leave with applicant

IMPORTANT NOTICE: Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information is 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Transamerica Life Insurance Company or its reinsurers may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

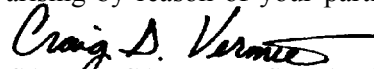
INVESTIGATIVE CONSUMER REPORTS NOTICE: You have the right to be told about, and to see and copy if you wish, items of personal information about you that appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of information you believe to be inaccurate. We will send you a more detailed explanation of our information practices if you send us a written request. You may send your request to the Director of Underwriting, Transamerica Life Insurance Company, 4333 Edgewood Road NE, Cedar Rapids, IA, 52499.

INDEMNIFICATION AGREEMENT

To the Financial Institution named on the reverse side.

So that you may comply with your depositor's request this Company agrees:

1. To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft, or order, whether or not genuine, purporting to be executed or issued by or on behalf of the Transamerica Life Insurance Company, or any electronic fund transfer, purporting to be drawn by the Transamerica Life Insurance Company and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
2. In the event that any such check, draft, order, or electronic fund transfer shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
3. To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.



Secretary, TRANSAMERICA LIFE INSURANCE COMPANY

Authorized in a resolution adopted by the Board of Directors of the Transamerica Life Insurance Company.

Detach and leave with applicant

CONDITIONS WHICH MUST BE MET BEFORE INSURANCE MAY BECOME EFFECTIVE UNDER THIS CONDITIONAL RECEIPT:

1. The full first premium on the premium mode selected for the policy and benefits applied for (including any extra premiums for occupation, aviation or sport) is paid when the application is signed; provided, however, the first premium will not be considered paid unless any check, draft, or other instrument of payment (given as payment) is paid in accordance with its terms;
2. Each Proposed Insured has completed any required medical examinations, diagnostic tests, or personal history interviews; or provided any other required evidence;
3. Each Proposed Insured is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium rates or amount of coverage;
4. On the Effective Date, the state of health and all factors affecting the insurability of each Proposed Insured must be as stated in applications required by the Company;
5. All required portions of the application must be completed, and each question must be truthfully and completely answered;
6. This Receipt has not been transferred and no alterations have been made to the printed form; and
7. The amount of insurance requested on the application does not exceed \$10,000.

IMPORTANT: If a policy differing in plan, amount of insurance, or premium from that applied for is offered by the Company, no insurance will be considered in effect under the application unless and until the full first premium is paid and such policy is received and accepted by the applicant, all during the lifetime and before any change in the insurability of any person proposed for insurance from that stated in the application.

If you do not hear from us within 60 days from the date of this Receipt, please notify Transamerica Life Insurance Company, Home Office, 4333 Edgewood Road NE, Cedar Rapids, IA, 52499, or call 1-800-238-4302, furnishing your name, date and amount of payment, and the name of the agent.

Detach and leave with applicant

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Veteran's Administration, Medical Information Bureau 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. A photocopy of this authorization shall be as valid as the original. This authorization is limited to a period of 30 months commencing on the date of this application. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records to any agency employed by the Company to collect and transmit such information.