TRANSAMERICA®

HIPAA Authorization for Release of Health-Related Information

Transamerica Life Insurance Company

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

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 Companies noted above (the "Companies")], 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 Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. Description of the information that may be used or disclosed: This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.
4. The information will be used or disclosed only for the following purpose(s): For the purpose of underwriting my insurance application with the Companies, 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 Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their 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 Companies 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 Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

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

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

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

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

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

Policy or contract number (if known): _____

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

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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 Companies noted above (the "Companies")], 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 Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. Description of the information that may be used or disclosed: This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.
4. The information will be used or disclosed only for the following purpose(s): For the purpose of underwriting my insurance application with the Companies, 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.

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- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies 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 Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

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

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

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

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

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

Policy or contract number (if known): _____

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

Reset Form

TRANSAMERICA LIFE INSURANCE COMPANY

Individual Whole Life Insurance Application

TRANSAMERICA®

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

"Company," "We,""Our," and "Us" all refer to Transamerica. Unless otherwise stated, "You" refers to the Proposed Primary Insured.

1. PROPOSED PRIMARY INSURED PERSONAL INFORMATION

Legal First Name	Middle Name	Legal Last Name	Suffix	Gender ☐ Male ☐ Female

Social Security Number/ITIN	Date of Birth (mm/dd/yyyy)	Place of Birth (State / Territory, Country)

Physical Address (No P.O. Boxes)	Apartment / Unit

City	U.S. State / Territory	Zip Code	Country

Phone Number ☐ Mobile | Email Address

2. COVERAGE ELIGIBILITY

☐ **I confirm that I have not been diagnosed with, treated for, tested positive for, or been given medical advice by a licensed member of the medical profession for any of the following:**

Alzheimer's Disease or any type of Dementia/organic brain syndrome, cognitive impairment, memory loss, or mental incapacity; Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease) or other motor neuron disease; amputation (other than due to accident/ trauma); metastatic, recurrent cancer, or multiple cancers, or cancer (any type other than basal cell of skin) within the last 2 years; Cerebral Palsy; Down Syndrome; Pulmonary Fibrosis; Sickle Cell Anemia; currently bedridden, residing in a nursing home, assisted or long term care facility, or receiving hospice, palliative, or home health care; or employed by any cannabis related businesses.

Eligibility for coverage is not available if any of the above listed conditions apply. Please proceed to the following section only if the box is checked.

3. PERSONAL HISTORY

A. Have you been treated, counseled, or advised to seek treatment or counseling for the use of alcohol or drugs or joined an organization for dependence or abuse in the past ☐ 0–2 years?, ☐ 2–4 years?, ☐ 4–10 years?, ☐ none of these?

Have you used sedatives, amphetamines, barbiturates, opiates, or any hallucinogenic or narcotic drug except as prescribed by a physician in the past ☐ 0–2 years?, ☐ 2–4 years?, ☐ 4–10 years?, ☐ none of these?

Have you been convicted of or pleaded no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) in the past ☐ 0–2 years?, ☐ 2–4 years?, ☐ none of these? Number of these offenses in the past 4 years: _____

Have you been convicted of or pleaded no contest to a felony in the past ☐ 0–3 years?, ☐ 3–5 years?, ☐ 5–10 years?, ☐ none of these? Total number of felonies, convicted or pleaded no contest to in the past 10 years: _____

B. Height (feet and inches)	**C.** Current Weight (pounds)

D. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a licensed member of the medical profession for any of the following: (Select all that apply)

- ☐ Heart Disease
- ☐ Congestive Heart Failure (CHF)
- ☐ Transient Ischemic Attack (TIA) or Stroke/ Cerebrovascular Accident (CVA)
- ☐ Disease or disorder of the kidneys including Polycystic Kidney Disease (PKD) or Neurogenic Bladder (not Kidney Stones unless diagnosed a "Stone Former")
- ☐ Disease or disorder of the liver or Hepatitis
- ☐ Diabetes (other than during pregnancy)
- ☐ Chronic Obstructive Pulmonary Disease (COPD) or any respiratory disorder or disease (excluding allergies or mild Asthma) "Mild" asthma is categorized as: no daily symptoms, no limitations to daily activities, no reduced lung function, no regular use of oral steroids, and no ER visits or hospitalizations due to asthma in the last five years.
- ☐ Cancer or malignancy of any kind (exclude benign or non-melanoma skin cancers or fatty tumors)
- ☐ None of the above

3. PERSONAL HISTORY (Continued)

	Yes	No
E. During the last 3 months, have you been placed on treatment for anemia by a licensed member of the medical profession (lower than normal number of red blood cells)? Include diet, iron pills, iron shots, infusions as treatment.	☐	☐
In the last 12 months, were you a patient in a hospital overnight? (Do not include hospitalization due to child birth without complications or an overnight stay in an emergency room.)	☐	☐
Have you ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐
Have you ever used nicotine in any form? This includes cigarettes, e-cigarettes/vapes, chewing tobacco/smokeless tobacco, pipe, cigar, nicotine gum/patch, or other nicotine delivery system. If "Yes," date of last use: _____	☐	☐
In a typical week, do you perform any intentional physical activity such as yard work, walking, exercising, or playing sports for at least 10 consecutive minutes? Days: _____	☐	☐

4. U.S. CITIZENSHIP

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?
☐ **Yes** ☐ **No** ⟶ ☐ Green Card

Green Card Number and Expiration Date	Country of Citizenship

5. OTHER INSURANCE

	Yes	No
1. Do you have any pending applications or existing life insurance or annuities with the company or any other company?	☐	☐
2. Will the insurance applied for discontinue, replace, or change any existing life or annuity coverage?	☐	☐

If "Yes" to questions 1 or 2, please provide details below and complete state required forms, if applicable.
For Internal Replacements, complete the Withdrawal/Surrender Form.

Types of coverage include: Personal, Business, Employer-Provided, Group

Type of Coverage	Company	Policy Number	Face Amount	Replacement	Pending Application
			$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Yes ☐ No	☐ Yes ☐ No

6. OWNER

Complete this section only if the owner is not the Proposed Primary Insured.
If there is a Contingent Owner, complete the Contingent Owner Form.

Legal First Name	Middle Name	Legal Last Name	Suffix	Gender ☐ Male ☐ Female

Social Security Number/ITIN	Date of Birth (mm/dd/yyyy)	Place of Birth (State / Territory, Country)

Physical Address (No P.O. Boxes)	Apartment / Unit

City	U.S. State / Territory	Zip Code	Country

Phone Number ☐ Mobile	Email Address

6. OWNER (Continued)

Owner's relationship to Proposed Primary Insured

☐ Spouse ☐ Child ☐ Parent ☐ Grandparent ☐ Domestic Partner ☐ Other _____

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

☐ Green Card

Green Card Number and Expiration Date

Country of Citizenship

7. BENEFICIARIES

Total between all primary beneficiaries must equal 100%. Total between all contingent beneficiaries must equal 100%. If you need space for more beneficiaries, complete the Beneficiary Supplement.

Beneficiary Information					
Primary First & Last Name		Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
Mailing Address				Social Security Number/ITIN	
☐ Primary ☐ Contingent	First & Last Name	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
Mailing Address				Social Security Number/ITIN	
☐ Primary ☐ Contingent	First & Last Name	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
Mailing Address				Social Security Number/ITIN	

8. PRODUCT DETAILS

Product Name

Coverage Amount
$

(This is the amount of life insurance coverage you are applying for.)

Planned Premium Amount
$

Rate Class Applied for:

☐ Preferred Non-tobacco ☐ Preferred Tobacco
☐ Standard Non-tobacco ☐ Standard Tobacco ☐ Graded

☐ Request to backdate the policy to 'Save Age'

If a policy cannot be issued as applied for, would you accept a modified rate class and/or plan?

☐ **Yes** ☐ **No**
if "Yes" →

Adjust face amount to premium?

☐ **Yes** ☐ **No**

Automatic Premium Loan (subject to policy loan provisions): ☐ Elect ☐ Do Not Elect

8. PRODUCT DETAILS (Continued)

Benefit	Amount
☐ Accidental Death Benefit Rider	Coverage amount equal to policy face amount
☐ Child/Grandchild Rider (If elected, complete supplement form) By checking this box, I attest that no child listed on the supplemental application has been diagnosed with a terminal illness expected to result in death within 24 months, and I am the parent/guardian of each child listed or the legal guardian has approved the application for insurance.	$

I agree that if (1) the proposed insured does not qualify for the rate class above, I am applying for the best rate class available; (2) the proposed insured qualifies for the rate class but the premium amount paid or authorized with this application is not sufficient, the Company shall issue the policy for a reduced coverage amount modified according to the applicable rates for that coverage amount. If the planned premium amount shown in this application is other than the amount required for the policy issued, the Company will increase or decrease the coverage amount for that policy. If the proposed insured qualifies for the Graded rate class, no riders will be issued.

9. PAYMENT OPTIONS

Choose the premium payor, payment type and mode, and complete the Payment Authorization form.

Premium Payor: ☐ Proposed Primary Insured ☐ Owner ☐ Other (if chosen, complete Premium Payor Supplement)

Payment Type: ☐ Bank Draft ☐ Credit/Debit Card ☐ Social Security Benefits Billing ☐ Direct Bill

Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

10. SECONDARY ADDRESSEE

Legal First Name | Middle Name | Legal Last Name

Mailing Address | Apartment / Unit

City | U.S. State / Territory | Zip Code | Country

Phone Number ☐ Mobile | Email Address

11. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and complete to the best of my knowledge and belief. I agree (A) this application shall consist of the Individual Life Insurance Application, the Individual Life Insurance Application - Personal History, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (B) that the Producer does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the Owner must have personally received and accepted the policy during the lifetime of each Insured and there must have been no change in the insurability of any Insured; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, to the best of my knowledge and belief. Unless otherwise stated, the undersigned Insured is the premium payor and Owner of the policy applied for.

I hereby authorize any licensed physician, medical practitioner, pharmacy and pharmacy benefit managers, hospital, clinic or other medical or medically related facility, wellness/fitness, financial services or insurance company, MIB, LLC ("MIB"), consumer reporting agency, data aggregator, or any other organization, institution or person, that has any records or knowledge of me or my health/fitness, finances, credit history, credit standing, credit capacity, life activities or purchase history, to give to the Company, or its reinsurers, any such information. This may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I understand a credit report may be requested in connection with this authorization. I also understand that any credit reporting agency contacted in connection with this authorization may retain and use any information provided about me to the credit reporting agency to the extent that the information is in addition to or more current than the information currently held by such credit reporting agency, and do consent to such use of my information.

I hereby expressly consent to receive calls about my application from the Company or its representatives that involve the use of an automatic telephone dialing system and/or an artificial or prerecorded voice. This authorization will be valid for 24 months. Information released shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. 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 understand the Company may use the information collected via this authorization: (1) to underwrite my insurance application, (2) to support the operations of the Company's business, (including performing actuarial or internal business studies, research and analytics and other analysis), or (3) if a policy is issued, to evaluate contestability and eligibility for benefits, the policy's continuation or replacement, the policy's reinstatement, or to contest a claim under the policy.

The Company shall have 60 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 Owner or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the Notice of Disclosure for (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application , subject to any Incontestability provision of such insurance.

The **USA PATRIOT ACT** requires all financial institutions to obtain, verify, and maintain information that identifies each person who opens a new account with the Company, or assumes ownership of an existing policy or contract. To meet this federal obligation, we will ask for your name, address, date of birth, or articles of incorporation or similar documents and other information, including a driver's license or other government-issued identification that will allow us to verify your identity. This process may include the use of third-party sources to verify the information provided.

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

Signature of Proposed Insured	Date	City	U.S. State / Territory
Signature of Applicant/Owner (If other than Proposed Insured)	Date	City	U.S. State / Territory
Print Agent Name	Agent Florida License ID Number	Agent Signature	

NOTICE OF DISCLOSURE

Please provide a copy of these notices to the applicant and to any proposed Insureds not living in the household.

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics, and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any: Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, 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 (ftc.gov). The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The 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 mib.com.

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our producer may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to: Transamerica Life Insurance Company, Attn: Director of Underwriting, 6400 C Street SW, Cedar Rapids, Iowa 52499.

Reset Form

AGENT'S REPORT

TRANSAMERICA®

	Agent Name	Agent Number	Profile Number	% of Agent's Split
Producer 1				
Producer 2				
Producer 3				
Producer 4				

2. AGENT DISCLOSURE

How long have you known the Proposed Primary Insured? | Relationship to Proposed Primary Insured:

	Yes	No
Does the Proposed Insured have existing life insurance policies or annuity contracts with the company or any other company?	☐	☐
Will the policy applied for discontinue, replace, or change any existing life insurance policy or annuity?	☐	☐
If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements?		
If "No," explain.	☐	☐
Has any application for life, health, disability, or long term care insurance been declined,withdrawn, postponed, rated, modified, issued with an exclusion rider, canceled, or renewed?	☐	☐
Are you financially responsible for the Proposed Primary Insured?	☐	☐
Are you or any of your family members named as a beneficiary on this policy application?	☐	☐
If "Yes," what insurable interest do you/your family member have in the life of the insured(s)?		
Do you intend to submit multiple applications on any of the proposed insureds?	☐	☐
Is the Agent or Split Agent also the Insured, Owner, Applicant or Payor?	☐	☐
Is the Proposed Primary Insured or Owner related to any affiliated Broker/Dealer office or employee?	☐	☐
If "Yes," name and address of Broker/Dealer		

City | U.S. State / Territory | Zip Code

Did you provide the "Notice of Disclosure" to the Proposed Primary Insured? ☐ **Yes** ☐ **No** ☐ **N/A**

How was this sale taken?

☐ **In Person** ☐ **Phone or Video Call** ☐ **Other** _____

Was the identification of the Proposed Primary Insured verified during the sale? ☐ **Yes** ☐ **No**

Type of government-issued photo ID

Issuer of Identification Document | Number | Expiration Date

3. CORRESPONDENCE INFORMATION

Case Manager Name (if applicable)	
Agent/Case Manager Email	Office ID
Agent/Case Manager Phone Number	Agent/Case Manager Fax Number

4. SIGNATURE

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of each person seeking to open this policy and verified that each person seeking to open this policy is the same person in the documents reviewed. I certify that I used only company approved sales materials and copies of all sales materials used during the solicitation were provided to the Applicant. I attest that neither I nor the beneficiary translated, the translator is fluent in both languages involved, the Applicant and/or Proposed Insured fully understood everything translated, and that a similarly disinterested translator will participate through to policy delivery. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action, or prosecution for violation of state or federal criminal laws.

As part of the application review, I discussed with the Applicant the possibility to designate a secondary addressee and the Applicant declined to designate a secondary addressee.

Payment with application not accepted if: (1) the Proposed Insured does not reside in the U.S., or (2) the 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.

Signature of Writing Agent/Registered Representative

Date (mm/dd/yyyy)

Reset Form

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 and attach a separate sheet if there is more than one policy number. Note that not all payment options are available on all products.

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

Or fax it to us at:
1-800-235-4782

Questions?

Contact your Financial Professional

Visit us at: transamerica.com

Call us at: 1-800-797-2643

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Draft Date (MM/DD, 1st through 28th only)

__/__

If you select an initial premium draft date in the future, it cannot be greater than 30 days after the application date, and you will not have potential coverage until that date under the Conditional Receipt.

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

Recurring Payment Frequency (choose one)

☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Total Premium

$ ___,___.___

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

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/ EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Social Security Benefits Billing (SSB)	☐ **Initial** ☐ **Recurring**	Complete the SSB Option info on the next page. To pay by SSB Card, tokenize the card # and fill out the Credit Card Payment section; or for direct SSB account draft, fill out the Bank Draft Payment section.
Credit Card	☐ **Initial** ☐ **Recurring**	Tokenize your card number, and complete the Credit Card Payment section below
Check	☐ **Initial**	No additional form required; mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	No additional form required; this method only available quarterly, semiannually, or annually.

If using Social Security Benefits for either form of payment, please enter payer date of birth and then select one:

Payer date of birth

__/__/__

☐ Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)

☐ Benefit Paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)

☐ Benefit Paid on Second Wednesday (Option C)

☐ Benefit Paid on Third Wednesday (Option D)

☐ Benefit Paid on Fourth Wednesday (Option E)

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 at left.)*

Cardholder First Name

Cardholder Last Name

Card Exp.Date __/__

Payment Amount $

The cardholder is the (choose one):

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

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

X _____

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

Bank Draft (ACH/EFT) Payment Information

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

Account Holder First Name

Account Holder Last Name

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

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

The account holder is the (choose one):

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

Account Holder Signature:

X _____

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

Consents

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

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

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

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

Bank Account Will be Subject to Identity Verification
To help ensure the security of your funds, if bank account information is provided, the Company may obtain a consumer report from a Consumer Reporting Agency (“CRA”) to help verify the validity and accuracy of the account information provided. If I have provided the company with bank account information, I authorize the Company to obtain a consumer report from the CRA as described above, and acknowledge that I: (1) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA; and (2) consent to such sharing, retention, and use.

Reset Form

TRANSAMERICA LIFE INSURANCE COMPANY

Individual Whole Life Insurance Application for Juveniles

TRANSAMERICA®

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

"Company," "We," "Our," and "Us" all refer to Transamerica. Unless otherwise stated, "You" refers to the Proposed Primary Insured.

1. PROPOSED PRIMARY INSURED PERSONAL INFORMATION

Legal First Name	Middle Name	Legal Last Name	Suffix	Gender
				☐ Male ☐ Female

Social Security Number/ITIN	Date of Birth (mm/dd/yyyy)	Place of Birth (State/Territory, Country)

Physical Address (No P.O. Boxes)	Apartment/Unit

City	U.S. State/Territory	Zip Code	Country

2. COVERAGE ELIGIBILITY

☐ **I confirm that I have not been diagnosed with, treated for, tested positive for, or been given medical advice by a licensed member of the medical profession for any of the following:**

Cognitive impairment, memory loss, or mental incapacity; other motor neuron disease, Cerebral Palsy, Cystic Fibrosis, Huntington's Disease; amputation (other than due to accident/trauma); bone marrow, stem cell, or organ transplant (other than corneal); Cancer (any type other than basal cell of skin) within the last 2 years or metastatic(including lymph nodes) or recurrent cancer or multiple cancers; Pulmonary Fibrosis; Sickle Cell Anemia; Down Syndrome; Autism; Depression; Bipolar; Schizophrenia; eating disorder; suicide attempt; cardiac surgery; Diabetes Type I or II; chronic pain; Muscular Dystrophy; paralysis; Heart Failure; I am not currently pending surgery requiring general anesthesia; receiving hospice, palliative, or home health care, or incarcerated.

Eligibility for coverage is not available if any of the above listed conditions apply. Please proceed to the following section only if the box is checked.

3. PERSONAL HISTORY

A. Current Height (feet and inches)	**B.** Current Weight (pounds)

	Yes	No
C. Have you ever used sedatives, amphetamines, barbiturates, opiates, or any hallucinogenic or narcotic drug except as prescribed by a physician?	☐	☐
Have you ever been treated, counseled, or advised to seek treatment or counseling by a licensed professional for the use of alcohol or drugs or joined an organization for dependence or abuse?	☐	☐
Have you ever been convicted of or pleaded no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI)?	☐	☐
Have you ever been convicted of or pleaded no contest to a felony?	☐	☐
Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐	☐

3. PERSONAL HISTORY (Continued)

D. Have you ever been diagnosed with, treated for, tested positive for, or been given medical advice by a licensed member of the medical profession for any of the following? (Select all that apply)

Childhood Cancers ☐ Yes ☐ No

Heart or Blood Vessels ☐ Yes ☐ No
- ☐ Congenital heart disease
- ☐ Irregular heart beat/arrhythmia
- ☐ Murmur
- ☐ Any other disease or disorder of the heart or blood vessels

Brain or Nervous System ☐ Yes ☐ No
- ☐ Epilepsy/Seizures
- ☐ Any other disease or disorder of the brain or nervous system

Blood ☐ Yes ☐ No
- ☐ Platelet disorders
- ☐ Any other abnormality of the spleen, bone marrow, or blood

Digestive ☐ Yes ☐ No
- ☐ Any disease or disorder of the esophagus, stomach, liver, pancreas, intestine, or colon

Lungs ☐ Yes ☐ No
- ☐ Asthma
- ☐ Any other disease or disorder of the lungs or respiratory system

Renal & Reproductive ☐ Yes ☐ No
- ☐ Disease or disorder of the bladder
- ☐ Disease or disorder of the kidney

Renal & Reproductive (cont'd) ☐ Yes ☐ No
- ☐ Any other disease or disorder of the urinary or reproductive organs

Mental Health ☐ Yes ☐ No
- ☐ Anxiety
- ☐ Attention deficit disorder (ADD/ADHD)
- ☐ Any other psychiatric mental or emotional condition or disorder

Muscles, Skin, Joints, Bones, Connective Tissue, Eyes, & Ears ☐ Yes ☐ No
- ☐ Rheumatoid arthritis (JRA)
- ☐ Autoimmune disorder
- ☐ Any other disease or disorder of the musculoskeletal system, skin, or spine

4. U.S. CITIZENSHIP

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** → ☐ Green Card

Green Card Number and Expiration Date	Country of Citizenship

5. OTHER INSURANCE

	Yes	No
1. Do you have any pending applications or existing life insurance or annuities with the company or any other company?	☐	☐
2. Will the insurance applied for discontinue, replace, or change any existing life or annuity coverage?	☐	☐

If "Yes" to questions 1 or 2, please provide details below and complete state required forms, if applicable.
For Internal Replacements, complete the Withdrawal/Surrender Form.

Types of coverage include: Personal, Business, Employer-Provided, Group

Type of Coverage	Company	Policy Number	Face Amount	Replacement	Pending Application
			$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Yes ☐ No	☐ Yes ☐ No
			$	☐ Yes ☐ No	☐ Yes ☐ No

6. OWNER

Complete this section only if the owner is not the Proposed Primary Insured.
If there is a Contingent Owner, complete the Contingent Owner Form.

Legal First Name | Middle Name | Legal Last Name | Suffix | Gender ☐ Male ☐ Female

Social Security Number/ITIN | Date of Birth (mm/dd/yyyy) | Place of Birth (State/Territory, Country)

Physical Address (No P.O. Boxes) | Apartment/Unit

City | U.S. State/Territory | Zip Code | Country

Phone Number ☐ Mobile | Email Address

Owner's relationship to Proposed Primary Insured

☐ Parent ☐ Grandparent ☐ Legal Guardian ☐ Other _____

Does the Proposed Insured live with the parent or the legal guardian listed above?

☐ **Yes** ☐ **No** → Please Explain

Are you a U.S. citizen? ☐ Green Card

☐ **Yes** ☐ **No** →

Green Card Number and Expiration Date | Country of Citizenship

7. BENEFICIARIES

Total between all primary beneficiaries must equal 100%. Total between all contingent beneficiaries must equal 100%. If you need space for more beneficiaries, complete the Beneficiary Supplement.

Beneficiary Information					
Primary First & Last Name		Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
Mailing Address				Social Security Number/ITIN	
☐ Primary ☐ Contingent	First & Last Name	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
Mailing Address				Social Security Number/ITIN	
☐ Primary ☐ Contingent	First & Last Name	Date of Birth (mm/dd/yyyy)	Phone Number	Relationship	Benefit %
Mailing Address				Social Security Number/ITIN	

8. PRODUCT DETAILS

Product Name

Coverage Amount
$
(This is the amount of life insurance coverage you are applying for.)

Planned Premium Amount
$

Rate Class Applied for:

☐ Preferred Juvenile ☐ Standard Juvenile

☐ Request to backdate the policy to 'Save Age'

If a policy cannot be issued as applied for, would you accept a modified rate class? ☐ **Yes** ☐ **No**

if "Yes" →

Adjust face amount to premium? ☐ **Yes** ☐ **No**

Automatic Premium Loan (subject to policy loan provisions): ☐ Elect ☐ Do Not Elect

I agree that if (1) the proposed insured does not qualify for the rate class above, I am applying for the best rate class available; (2) the proposed insured qualifies for the rate class but the premium amount paid or authorized with this application is not sufficient, the Company shall issue the policy for a reduced coverage amount modified according to the applicable rates for that coverage amount. If the planned premium amount shown in this application is other than the amount required for the policy issued, the Company will increase or decrease the coverage amount for that policy.

9. PAYMENT OPTIONS

Choose the premium payor, payment type and mode, and complete the Payment Authorization form.

Premium Payor: ☐ Proposed Primary Insured ☐ Owner ☐ Other (if chosen, complete Premium Payor Supplement)

Payment Type: ☐ Bank Draft ☐ Credit/Debit Card ☐ Social Security Benefits Billing ☐ Direct Bill

Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

10. SECONDARY ADDRESSEE

Legal First Name | Middle Name | Legal Last Name

Mailing Address | Apartment / Unit

City | U.S. State / Territory | Zip Code | Country

Phone Number ☐ Mobile | Email Address

11. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Each of the undersigned hereby certifies and represents as follows:

The statements and answers given on this application are true and complete to the best of my knowledge and belief. I agree (A) this application shall consist of the Individual Life Insurance Application, the Individual Life Insurance Application - Personal History, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (B) that the Producer does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the Owner must have personally received and accepted the policy during the lifetime of each Insured and there must have been no change in the insurability of any Insured; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete. Unless otherwise stated, the undersigned Insured is the premium payor and Owner of the policy applied for.

I hereby authorize any licensed physician, medical practitioner, pharmacy and pharmacy benefit managers, hospital, clinic or other medical or medically related facility, wellness/fitness, financial services or insurance company, MIB, LLC ("MIB"), consumer reporting agency, data aggregator, or any other organization, institution or person, that has any records or knowledge of me or my health/fitness, finances, credit history, credit standing, credit capacity, life activities or purchase history, to give to the Company, or its reinsurers, any such information. This may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also may include information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I understand a credit report may be requested in connection with this authorization. I also understand that any credit reporting agency contacted in connection with this authorization may retain and use any information provided about me to the credit reporting agency to the extent that the information is in addition to or more current than the information currently held by such credit reporting agency, and do consent to such use of my information.

I hereby expressly consent to receive calls about my application from the Company or its representatives that involve the use of an automatic telephone dialing system and/or an artificial or prerecorded voice. This authorization will be valid for 24 months. Information released shall comply with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. 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 understand the Company may use the information collected via this authorization: (1) to underwrite my insurance application, (2) to support the operations of the Company's business, (including performing actuarial or internal business studies, research and analytics and other analysis), or (3) if a policy is issued, to evaluate contestability and eligibility for benefits, the policy's continuation or replacement, the policy's reinstatement, or to contest a claim under the policy.

The Company shall have 60 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 Owner or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

I acknowledge receipt of the Notice of Disclosure for (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Pre-Notification, and (3) Notice of Insurance Information Practices.

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application , subject to any Incontestability provision of such insurance.

The **USA PATRIOT ACT** requires all financial institutions to obtain, verify, and maintain information that identifies each person who opens a new account with the Company, or assumes ownership of an existing policy or contract. To meet this federal obligation, we will ask for your name, address, date of birth, or articles of incorporation or similar documents and other information, including a driver's license or other government-issued identification that will allow us to verify your identity. This process may include the use of third-party sources to verify the information provided.

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

Signature of Proposed Insured (Child age 16 and over must sign)	Date	City	U.S. State/Territory
Signature of Parent or Legal Guardian (For Insured(s) 15 and under)	Date	City	U.S. State/Territory
Signature of Applicant/Owner (If other than Proposed Insured)	Date	City	U.S. State/Territory

Print Agent Name	Agent Florida License ID Number	Agent Signature

NOTICE OF DISCLOSURE

Please provide a copy of these notices to the applicant and to any proposed Insureds not living in the household.

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics, and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any: Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, 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 (ftc.gov). The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The 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 mib.com.

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our producer may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to: Transamerica Life Insurance Company, Attn: Director of Underwriting, 6400 C Street SW, Cedar Rapids, Iowa 52499.

Reset Form

AGENT'S REPORT

TRANSAMERICA®

	Agent Name	Agent Number	Profile Number	% of Agent's Split
Producer 1				
Producer 2				
Producer 3				
Producer 4				

2. AGENT DISCLOSURE

How long have you known the Proposed Primary Insured? | Relationship to Proposed Primary Insured:

	Yes	No
Does the Proposed Insured have existing life insurance policies or annuity contracts with the company or any other company?	☐	☐
Will the policy applied for discontinue, replace, or change any existing life insurance policy or annuity?	☐	☐
If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements?		
If "No," explain.	☐	☐
Has any application for life, health, disability, or long term care insurance been declined,withdrawn, postponed, rated, modified, issued with an exclusion rider, canceled, or renewed?	☐	☐
Are you financially responsible for the Proposed Primary Insured?	☐	☐
Are you or any of your family members named as a beneficiary on this policy application?	☐	☐
If "Yes," what insurable interest do you/your family member have in the life of the insured(s)?		
Do you intend to submit multiple applications on any of the proposed insureds?	☐	☐
Is the Agent or Split Agent also the Insured, Owner, Applicant or Payor?	☐	☐
Is the Proposed Primary Insured or Owner related to any affiliated Broker/Dealer office or employee?	☐	☐
If "Yes," name and address of Broker/Dealer		

City | U.S. State / Territory | Zip Code

Did you provide the "Notice of Disclosure" to the Proposed Primary Insured? ☐ **Yes** ☐ **No** ☐ **N/A**

How was this sale taken?

☐ **In Person** ☐ **Phone or Video Call** ☐ **Other** _____

Was the identification of the Proposed Primary Insured verified during the sale? ☐ **Yes** ☐ **No**

Type of government-issued photo ID

Issuer of Identification Document | Number | Expiration Date

3. CORRESPONDENCE INFORMATION

Case Manager Name (if applicable)	
Agent/Case Manager Email	Office ID
Agent/Case Manager Phone Number	Agent/Case Manager Fax Number

4. SIGNATURE

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of each person seeking to open this policy and verified that each person seeking to open this policy is the same person in the documents reviewed. I certify that I used only company approved sales materials and copies of all sales materials used during the solicitation were provided to the Applicant. I attest that neither I nor the beneficiary translated, the translator is fluent in both languages involved, the Applicant and/or Proposed Insured fully understood everything translated, and that a similarly disinterested translator will participate through to policy delivery. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action, or prosecution for violation of state or federal criminal laws.

As part of the application review, I discussed with the Applicant the possibility to designate a secondary addressee and the Applicant declined to designate a secondary addressee.

Payment with application not accepted if: (1) the Proposed Insured does not reside in the U.S., or (2) the 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.

Signature of Writing Agent/Registered Representative

Date (mm/dd/yyyy)

Reset Form

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 and attach a separate sheet if there is more than one policy number. Note that not all payment options are available on all products.

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

Or fax it to us at:
1-800-235-4782

Questions?

Contact your Financial Professional

Visit us at: transamerica.com

Call us at: 1-800-797-2643

Insured First Name

Insured Last Name

Policy Owner First Name

Policy Owner Last Name

Draft Date (MM/DD, 1st through 28th only)

__/__

If you select an initial premium draft date in the future, it cannot be greater than 30 days after the application date, and you will not have potential coverage until that date under the Conditional Receipt.

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

Recurring Payment Frequency (choose one)

☐ Monthly ☐ Semiannually
☐ Quarterly ☐ Annually

Total Premium

$ ___,___.___

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

Payment Type Options	Initial and/or Recurring Payment	Form Information
Bank Draft (ACH/ EFT)	☐ **Initial** ☐ **Recurring**	Complete the ACH payment section below
Social Security Benefits Billing (SSB)	☐ **Initial** ☐ **Recurring**	Complete the SSB Option info on the next page. To pay by SSB Card, tokenize the card # and fill out the Credit Card Payment section; or for direct SSB account draft, fill out the Bank Draft Payment section.
Credit Card	☐ **Initial** ☐ **Recurring**	Tokenize your card number, and complete the Credit Card Payment section below
Check	☐ **Initial**	No additional form required; mail your check to the address at the top of this form
Direct Bill	☐ **Recurring**	No additional form required; this method only available quarterly, semiannually, or annually.

If using Social Security Benefits for either form of payment, please enter payer date of birth and then select one:

Payer date of birth

__/__/__

☐ Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)

☐ Benefit Paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)

☐ Benefit Paid on Second Wednesday (Option C)

☐ Benefit Paid on Third Wednesday (Option D)

☐ Benefit Paid on Fourth Wednesday (Option E)

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 at left.)*

Cardholder First Name

Cardholder Last Name

Card Exp.Date __/__

Payment Amount $

The cardholder is the (choose one):

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

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

X _____

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

Bank Draft (ACH/EFT) Payment Information

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

Account Holder First Name

Account Holder Last Name

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

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

The account holder is the (choose one):

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

Account Holder Signature:

X _____

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

Consents

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

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

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

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

Bank Account Will be Subject to Identity Verification
To help ensure the security of your funds, if bank account information is provided, the Company may obtain a consumer report from a Consumer Reporting Agency (“CRA”) to help verify the validity and accuracy of the account information provided. If I have provided the company with bank account information, I authorize the Company to obtain a consumer report from the CRA as described above, and acknowledge that I: (1) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA; and (2) consent to such sharing, retention, and use.

Reset Form

TRANSAMERICA LIFE INSURANCE COMPANY

Premium Payor Supplement

TRANSAMERICA®

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

"Company," "We," "Our," and "Us" all refer to Transamerica. Unless otherwise stated, "You" refers to the Payor.

This form is only required when the Premium Payor is not the Insured or Owner.

1. PAYOR INFORMATION

Name (first, middle, last) | Policy Number (if available)

Social Security Number/ITIN | Date of Birth (mm/dd/yyyy)

Physical Address | Apartment/Unit

City | U.S. State/Territory | Zip Code | Country

Phone Number ☐ Mobile | Email Address

Payor's Relationship to Insured:

☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Domestic Partner ☐ Other: _____

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

☐ Green Card

Green Card Number and Expiration Date | Country of Citizenship

2. AUTHORIZATION AND SIGNATURE

As a convenience to me, I request and authorize the Company name above to make withdrawals, by draft or electronic transfer, from my account with the financial institution name 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 the 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: (1) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA; and (2) consent to such sharing, retention, and use.

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

The **USA PATRIOT ACT** requires all financial institutions to obtain, verify, and maintain information that identifies each person who opens a new account with the Company, or assumes ownership of an existing policy or contract. To meet this federal obligation, we will ask for your name, address, date of birth, or articles of incorporation or similar documents and other information, including a driver's license or other government-issued identification that will allow us to verify your identity. This process may include the use of third-party sources to verify the information provided.

Payor Signature	Date