Reset Form

TRANSAMERICA®

Individual Life Insurance Application

Transamerica Life Insurance Company

Home Office: 4333 Edgewood Road NE Cedar Rapids, IA 52499

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

U.S. Social Security Number
__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Place of Birth (State / Territory, Country)

Gender
☐ **Male** ☐ **Female**

Marital Status
☐ **Single** ☐ **Married (including common law)** ☐ **Registered Domestic Partner**

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Years at Address

Mailing Address **(If different from Physical Address)**

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

U.S. Driver's License Number | U.S. State / Territory | Expiration Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Preferred Phone Number ☐ **Mobile**

Alternate Phone Number ☐ **Mobile**

Best Time to Call
☐ **AM** ☐ **PM**

Time Zone

Preferred method of communication
☐ **Mail** ☐ **Phone** ☐ **Email**

Email Address

Occupation

2 U.S Citizenship

If yes, go to next section.

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** → Green Card Number and Expiration

Country of Citizenship

3 Other Insurance

If you are doing an Internal Replacement, please fill out the Full Surrender form.

Do you have any existing life insurance or annuities? **If yes**, please fill out the table for all existing life/annuity coverage and complete the state required forms, if applicable.

If yes ☐ **Yes** ☐ **No**

Will the insurance applied for on your life discontinue, replace or change any existing life or annuity coverage? **If yes**, please note the coverage to be replaced in the table and complete the state required forms, if applicable.

If yes ☐ **Yes** ☐ **No**

Type of Coverage: Personal, Business, Employer Provided, Group

Type of Coverage	Company	Policy #	Face Amount	Replacement?
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No
			$	☐ Yes ☐ No

Is this intended to be a 1035 Exchange? **If yes**, please complete the 1035 supplement.

If yes ☐ **Yes** ☐ **No**

Anticipated Cash Value Transfer

$

4

Owner

Complete this section only if the owner is not the Proposed Primary Insured.

Is the owner a Person or a Trust?

☐ **Person** ☐ **Trust - (go to the Trust questions below)**

If person, complete through Country of Citizenship.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number: __ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

Email Address

Gender: ☐ **Male** ☐ **Female**

Do you have a Contingent Owner? If you have a contingent owner, complete the Contingent Owner Supplement.

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

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

Country | Years at Address | Preferred Phone Number ☐ **Mobile**

Mailing Address **(If different from Physical Address)**

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

Owner's relationship to Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Domestic Partner**

☐ **Child** ☐ **GrandParent** ☐ **Other** _____

If yes, go to next section. →

Is the owner a U.S. citizen? ☐ **Yes** ☐ **No** →

Green Card Number and Expiration (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

United States citizens and valid Green Card holders are eligible.

Country of Citizenship

Complete this section only if the owner is a Trust.

If owner is a trust, complete a Trust Certification.

Trust | Original Trust Date (mm/dd/yyyy): __ __ / __ __ / __ __ __ __

U.S. Tax ID Number: __ __ - __ __ __ __ __ __ __

5 Primary Beneficiaries

Primary Beneficiary 1 Percentage of Death Benefits

_____ %

Total shares between all primary beneficiaries must equal 100%.

If beneficiary is a trust, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable)

Date of Birth or Trust Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person)
__ __ __ - __ __ - __ __ __ __

U.S. Tax ID Number (if a Business Entity or Trust)
__ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**
☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

Continued on next page

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Primary Beneficiaries

continued

Total shares between all primary beneficiaries must equal 100%.

Primary Beneficiary 2 Percentage of Death Benefits

____ %

Total shares between all primary beneficiaries must equal 100%.

If beneficiary is a trust, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**
☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

Primary Beneficiary 3 Percentage of Death Benefits

____ %

Total shares between all primary beneficiaries must equal 100%.

If beneficiary is a trust, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**
☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

If you need space for more primary beneficiaries, complete the Beneficiary Supplement.

6 Contingent Beneficiaries

Total shares between all contingent beneficiaries must equal 100%.

Contingent Beneficiary 1 Percentage of Death Benefits

___ %

Total shares between all contingent beneficiaries must equal 100%.

If beneficiary is a trust, complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

Contingent Beneficiary 2 Percentage of Death Benefits

___ %

Total shares between all contingent beneficiaries must equal 100%.

If beneficiary is a trust, complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

If you need space for more contingent beneficiaries, complete the Beneficiary Supplement.

7 Secondary Addressee

Complete this section if you would like to list an additional person to receive copies of notices and letters regarding possible lapses in coverage.

Legal First Name	Middle Name	Legal Last Name	Suffix

Mailing Address

City	U.S. State / Territory	Zip Code

Email Address	Phone Number
	☐ **Mobile**

8 Product Details

Product Name	Coverage Amount	
	$	*This is the amount of life insurance coverage you are applying for.*

Rate Class Applied for:

☐ **Preferred Non-Tobacco** ☐ **Preferred Tobacco** ☐ **Preferred Juvenile**

☐ **Standard Non-Tobacco** ☐ **Standard Tobacco** ☐ **Standard Juvenile**

☐ **Graded**

If a policy cannot be issued as applied for, would you accept a rated policy if available?

☐ **Yes** ☐ **No**

If yes →

Adjust face amount to premium?

☐ **Yes** ☐ **No**

Automatic Premium Loan (may not be available on all policies).

☐ **Elect** ☐ **Do Not Elect**

Additional Benefits (Not available with all products and not available in all States)

Benefit	Amount
☐ **Accidental Death Benefit Rider**	Coverage amount equal to policy face amount
☐ **Child/Grandchild Rider**	**$**

Complete the **Child/ Grandchild Rider Supplement Application**

9 Premium

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

If the initial draft date is prior to the application date, please complete the Back Date to Save Age Form.

Total Premium

$

Initial Draft Date (MM/DD) *1st thru 28th only*

__ __ / __ __ ☐ **Current Date**

Recurring Payment Frequency

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

Payment Option	Initial / Recurring	Form Information
☐ **EFT**	☐ **Initial** ☐ **Recurring**	For EFT, please complete the Electronic Payment Form.
☐ **Social Security Billing Benefits**	☐ **Initial** ☐ **Recurring**	For Social Security Benefits Billing, please complete the Social Security Benefits Billing Form.
☐ **Check**	☐ **Initial** ☐ **Recurring**	For monthly, please complete the Electronic Payment form for recurring payments.
☐ **1035 Exchange**	☐ **Initial** ☐ **Recurring**	For 1035 Exchange, please complete the 1035 Exchange Form.

10 Premium Payor

A person or Trust paying the premium

Complete this section if the premium payor is different than the owner.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number

__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Trust

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Phone Number ☐ **Mobile**

Continued on next page

10 Premium Payor *continued*

Email Address

Premium Payor's relationship if other than the Proposed Insured

☐ **Spouse** ☐ **Child** ☐ **Domestic Partner** ☐ **Other** _____

☐ **Parent** ☐ **Trust** ☐ **Grandparent**

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

If yes, go to next section.

Country of Citizenship

11 Primary Care Physician

Physician, Hospital or Health Care Provider Name

Phone Number

Address

Date of last visit (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Check this box if you do not have a physician.

☐

12 Lifestyle

A. Within the last 12 months have you used nicotine replacement, smoking or tobacco products in any form including, but not limited to the following: nicotine gum, patch or pills; cigarettes; cigars; pipe; chew; snuff; e-cigarettes; vape; hookah; or have you used marijuana more than 12 times in the last 12 months?

☐ **Yes** ☐ **No**

B. Height (feet and inches)

__ ' __ __ "

C. Current Weight (pounds)

D. Approximate weight a year ago (pounds)

☐ **1-14 lbs. more than current** ☐ **1-14 lbs. less than current** ☐ **Same as current**

☐ **15 lbs. more than current** ☐ **15 lbs. less than current**

If 15 lbs. more or less, proceed to the following two questions.

E. If your weight gain or loss is greater than 15 lbs in the last year, what is the difference in pounds?

_____ **pounds**

F. Explain your weight gain or loss of greater than 15 lbs in the last year. Check all that apply.

☐ **Diet** ☐ **Lifestyle Change** ☐ **Other** _____

☐ **Exercise** ☐ **Illness**

13

Medical History Part 1

Have you had, 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:

A. Currently under the age of 18 with autism, depression, bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

B. Prior to the age of 45 with Heart Failure or Congestive Heart Failure?

☐ **Yes** ☐ **No**

C. Are you **currently** hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care; or been advised or planning to have surgery requiring general anesthesia?

☐ **Yes** ☐ **No**

Home Health Care is defined as: Medical care provided by a medical professional, friends or family member including, but not limited to arranging medications, taking blood pressure or sugar readings, administering medications, wound care, feeding tube, etc.

D. Have you **ever** been diagnosed by a licensed member of the medical profession or tested positive for Acquired Immune Deficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) or tested positive on an AIDS/HIV-related test?

☐ **Yes** ☐ **No**

E. Have you **ever** been the recipient or been given medical advice by a licensed member of the medical profession to be a recipient of stem-cell, tissue, bone marrow, or organ transplant (other than corneal)?

☐ **Yes** ☐ **No**

Have you **ever** had, 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:

F. Alzheimer's, dementia, memory loss, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, pulmonary fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?

☐ **Yes** ☐ **No**

G. Diabetic coma?

☐ **Yes** ☐ **No**

H. Amputation other than at the time of an accident or trauma?

☐ **Yes** ☐ **No**

I. Metastatic cancer, recurrent cancer, multiple cancers or cancer with lymph node involvement?

☐ **Yes** ☐ **No**

13

Medical History Part 1

continued

During the **last 2 years** have you had, 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:

J. Cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

During the **last 2 years** have you:

K. Had testing by a medical professional for which the results have not been received, been non-compliant with physician orders regarding treatment plans, or been advised to have any diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been done?

☐ **Yes** ☐ **No**

L. Attempted suicide; been incarcerated, on probation, on parole, or convicted of or awaiting trial for a felony?

☐ **Yes** ☐ **No**

M. Been convicted for or plead no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) or had 3 or more moving violations?

☐ **Yes** ☐ **No**

If all questions in Part 1 are answered "No," proceed to Part 2.

If any question in Part 1 is answered "Yes", you are not eligible for any coverage.

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Medical History Part 2

Have you had, 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:

A. Prior to the age of 20 with Diabetes (other than gestational diabetes)?

☐ **Yes** ☐ **No**

B. Prior to the age of 26 with Crohn's Disease?

☐ **Yes** ☐ **No**

C. Prior to the age of 45 with Parkinson's Disease; Coronary Artery Disease, Peripheral Vascular Disease, or Cerebral Vascular Disease; Heart Attack, Transient Ischemic Attack (TIA), or Stroke; Cardiac Surgery, Bypass Surgery, Stent Implant, Angioplasty, Pacemaker or Defibrillator Implant, or Heart Valve Replacement?

☐ **Yes** ☐ **No**

Have you **ever** had, 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:

D. Cirrhosis, heart failure, or congestive heart failure (CHF); or an aneurysm that has not been surgically corrected (still present)?

☐ **Yes** ☐ **No**

E. Hepatitis C?

If yes, proceed to E1 & E2. →

☐ **Yes** ☐ **No**

E1. Has the Hepatitis C been cured?

☐ **Cured** ☐ **Not Cured**

E2. If cured, when was the last blood test (RNA PCR Titer) showing the Hepatitis C was cured?

☐ **0-24 months after treatment ended**

☐ **More than 24 months after treatment ended**

If the answer to E2 is 0-24 months, then the best rate class is Graded. If the answer is more than 24 months, then the best rate class is Standard and the answer counts as a "No" when referring to directions below.

F. During the **last 4 years** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a licensed member of the medical profession for cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

G. During the **last 2 years** have you used illegal drugs or had, been diagnosed with, treated for, tested positive for or been given medical advice by a licensed member of the medical profession for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs), muscular dystrophy, or systemic lupus erythematosus (SLE)?

☐ **Yes** ☐ **No**

If SLE has been in remission and there has been no treatment for more than two years, you may then answer this question "No" in regard to only the SLE.

14

Medical History Part 2

continued

During the **last 2 years** have you:

H. Required assistance with activities of daily living (ADL's) such as bathing, dressing, eating, toileting, getting in and out of chair or bed, or do you have ongoing neurological incontinence or, has a medical professional recommended that you be confined to a Nursing Home?

☐ **Yes** ☐ **No**

I. Used a wheelchair, electric scooter or electric cart?

If yes, proceed to I1. →

☐ **Yes** ☐ **No**

I1. If yes, provide details regarding use:

☐ **Currently use or use occasionally at facilities such as, but not limited to, the grocery store, department stores, warehouse stores, airports**

☐ **Reason for use is expected to resolve in the next 3 months or the reason for use has resolved**

If the answer to I1 is "Reason for use...", count I as a "No" when referring to directions below.

During the **last 1 year** have you had, 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:

J. More than 6 seizures; or had, been diagnosed with, been treated for or advised to receive treatment for any liver disease (including but not limited to autoimmune hepatitis) other than cirrhosis or Hepatitis C that should have been noted in a prior question?

☐ **Yes** ☐ **No**

K. Heart attack, stroke (CVA) or transient ischemic attack (TIA)?

☐ **Yes** ☐ **No**

L. Used oxygen to assist in breathing (including for Sleep Apnea); received kidney dialysis; kidney failure or chronic kidney disease (stage 4 or 5); encephalitis; or have you been unemployed or disabled and had, been diagnosed with, treated for or been given medical advice by a licensed member of the medical profession for chronic pain?

☐ **Yes** ☐ **No**

Chronic Pain is defined as: Pain lasting more than 6 months or requiring 6 or more fills of narcotic pain prescriptions in any 12 month period.

If yes for angina, proceed to M1. →

M. Angina (chest pain); or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or had an aneurysm surgically corrected?

☐ **Yes** ☐ **No**

M1. When was the angina (chest pain) first diagnosed?

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

If the answer to M1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count M as a "No" when referring to directions below.

If all questions in Part 2 are answered "No," proceed to Part 3.

If one question in Part 2 is answered "Yes," you are potentially eligible for the Graded Death Benefit product.

If two or more questions in Part 2 are answered "Yes," you are not eligible for any coverage.

15

Medical History Part 3

A. Prior to the age of 45, have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a licensed member of the medical profession for cancer (other than Basal Cell)?

☐ **Yes** ☐ **No**

Have you **ever** had, 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:

B. Bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

C. Parkinson's disease, multiple sclerosis, systemic lupus erythematosus (SLE), sarcoidosis, Crohn's disease, ulcerative colitis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?

☐ **Yes** ☐ **No**

Chronic Asthma is defined as: Using inhalers year round on a daily or weekly basis, or filling prescriptions 6 or more times in any 12 month period.

During the **last 4 years** have you had, 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:

D. Kidney disease (stage 1, 2 or 3) or other kidney disorder?

☐ **Yes** ☐ **No**

E. Used illegal drugs; alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs)?

☐ **Yes** ☐ **No**

During the **last 4 years** have you:

F. Been convicted for or plead no contest to reckless driving or operating while intoxicated (DWI/OWI/DUI) or had 3 or more moving violations?

☐ **Yes** ☐ **No**

During the **last 2 years** have you had, 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:

G. Heart attack, stroke (CVA) or transient ischemic attack (TIA)?

☐ **Yes** ☐ **No**

H. Used insulin; had more than 6 seizures; spina bifida cystica, pancreatitis, tuberculosis; hepatitis B or other liver disease?

☐ **Yes** ☐ **No**

15

Medical History Part 3

continued

During the **last 2 years** have you had, 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:

If yes for angina, proceed to I1.

I. Angina (chest pain); cardiomyopathy; vascular, circulatory or blood disorder (including anemia other than iron deficiency); heart surgery of any kind including bypass surgery, angioplasty, stent implant; irregular heart rhythm such as atrial fibrillation or heart murmur; had an aneurysm surgically corrected; or do you currently have a pacemaker/ defibrillator?

☐ **Yes** ☐ **No**

I1. When was the angina (chest pain) first diagnosed?

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

If the answer to I1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count I as a "No" when referring to directions below.

If all questions in Part 3 are answered "No," you are potentially eligible for the Preferred product.

If one question in Part 3 is answered "Yes," you are potentially eligible for the Standard product.

If two or more questions in Part 3 are answered "Yes," you are potentially eligible for the Graded Death Benefit product.

16

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 acknowledge and agree (A) this application shall consist of the Individual Life Insurance Application, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (B) that the Agent 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) except as provided in the Conditional Receipt, if issued with the same Insured(s) as on this application, 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, hospital, clinic or other medical or medically related facility, wellness/fitness, financial services or insurance company, MIB, Inc. ("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. 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, or the period permitted by applicable law in the state where the policy is delivered or issued for delivery, if shorter. 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.

TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding, or the IRS has notified me I am no longer subject to backup withholding, or I am not subject to backup withholding because I am exempt; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification. You must cross out item (2) if you are currently subject to backup withholding.

16 Authorization to Obtain and Disclose Information

continued

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 (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory

Signature of Parent or Legal Guardian (Of children under age 18)	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory

Signature of Applicant/Owner (If other than Proposed Insured)	Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __	City	U.S. State / Territory

Title of Trust (If owner is trust)	Trustee First Name	Trustee Last Name

Print Agent 1 Name	Agent 1 Number	Florida License ID#	Agent 1 Signature

Print Agent 2 Name	Agent 2 Number	Florida License ID#	Agent 2 Signature

17 Other Insurance (to be completed by the Agent)

Does the Proposed Insured have existing life insurance policies or annuity contracts with the company or any other company?

☐ **Yes** ☐ **No**

Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity?

☐ **Yes** ☐ **No**

If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements? If **no**, explain.

☐ **Yes** ☐ **No** Explain

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.

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 GROUP, INC. (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, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act (www.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 www.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 Agent 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, [4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.]

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

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage 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.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or $50,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies prior to a future date selected for draft of the initial premium or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.