Reset Form

TRANSAMERICA LIFE INSURANCE COMPANY

TRANSAMERICA LIFE INSURANCE COMPANY
Home Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499

LIFE INSURANCE POLICY APPLICATION FOR ONE LIFE/BASE INSURED ONLY PART 1

SECTION 1 - POLICY INFORMATION

☐ Transamerica Journey℠ ☐ TransNavigator℠ IUL | Face Amount $

SECTION 2 - DEATH BENEFIT OPTION

☐ Level ☐ Increasing ☐ Graded

SECTION 3 - LIFE INSURANCE COMPLIANCE TEST

☐ Guideline Premium Test ☐ Cash Value Accumulation Test (CVAT)

SECTION 4 - ADDITIONAL BENEFITS

Not applicable with all products

☐ Base Insured Rider $ _____
☐ Accidental Death Benefit Rider $ _____
☐ Long Term Care Rider (complete Supplemental Application)
☐ Disability Waiver of Monthly Deductions Rider
☐ Disability Waiver of Premium Rider
☐ Income Protection Option (complete Supplemental Application)

SECTION 5 - PROPOSED BASE INSURED/OWNER

If non-medical face amount, please complete Non-medical Part 2.
If proposed Contingent Owner is named, please complete section 8.

1. Last Name | First Name | M.I.
2. Address (Cannot be a P.O. Box) | Apt# | City
State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. E-mail Address
6. Sex ☐ Male ☐ Female | 7. Date of Birth M M - D D - Y Y Y Y | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number
11. Marital Status | 12. Driver's License Number | State
13. Employer | #Years
14. Employer's Address and Phone Number | 15. Occupation & Duties

16. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ No ☐ Yes Date last used _____
17. Class of Risk: ☐ Select Non-Smoker ☐ Preferred Non-Smoker ☐ Standard Non-Smoker ☐ Preferred Smoker ☐ Standard Smoker ☐ Juvenile
18. Are you a U.S. citizen? ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire.
19. How many years have you resided in the USA? _____
20. Are you a member of the armed forces including reserves? Intend to become a member? On alert or have deployment orders outside U.S.? ☐ Yes ☐ No If yes, please provide full details. _____

SECTION 6 - PERSONAL FINANCIAL STATEMENT FOR PROPOSED BASE INSURED

All financial information on non-juvenile business must be that of the proposed base Insured, not the Owner.

A) Gross Income Current Year $ _____ B) Current Net Worth $ _____

NOTE: Complete a Personal Financial Supplement for coverage over $5,000,000 for ages 18 through 60, $1,000,000 for ages 61 through 70 and $500,000 for ages 71 and up. For business coverage complete a Personal Financial Supplement.

SECTION 7 - APPLICANT/OWNER IF OTHER THAN THE PROPOSED BASE INSURED

If owner is a corporation, partnership or institutional body, please complete an entity certification form. If owner is a trust, please complete a trust certification form.

1. Last Name | First Name | M.I.
2. Address (Cannot be a P.O. Box) | Apt# | City
State | Zip Code | 3. Home Phone ( ) | 4. E-mail Address
5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date M M - D D - Y Y Y Y | 7. Relationship to proposed base Insured | 8. Social Security Number / Tax ID #
9. Are you a U.S. citizen? ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire.

SECTION 8 - PROPOSED CONTINGENT OWNER **If owner is a corporation, partnership or institutional body, please complete an entity certification form. If owner is a trust, please complete a trust certification form.**

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Home Phone ( )	4. E-mail Address

5. Sex ☐ Male ☐ Female	6. Date of Birth/Trust Date M M - D D - Y Y Y Y	7. Relationship to proposed base Insured	8. Social Security Number / Tax ID #

9. Are you a U.S. citizen? ☐ Yes ☐ No If no, complete Residency & Travel Questionnaire.

SECTION 9 - PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If beneficiary is a corporation, partnership or institutional body, please complete an entity certification form. If beneficiary is a trust, please complete a trust certification form.

Name	%	Relationship	DOB	SSN/Tax ID#	Phone # / Address
Total	**100**				

SECTION 10 - CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	%	Relationship	DOB	SSN/Tax ID#	Phone # / Address
Total	**100**				

SECTION 11 - OTHER INSURANCE IN FORCE

A) Have you ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain. _____ ☐ Yes ☐ No

_____

B) Is there an application for life, accident or sickness insurance now pending or contemplated on the proposed Insured in this or any other company? If yes, please explain. _____ ☐ Yes ☐ No

_____

C) Will the insurance applied for on the proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No

D) Do you have existing life insurance policies or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Amount of Insurance	Issue Date	Replacement?
			MM-DD-YYYY	☐ Yes ☐ No
			MM-DD-YYYY	☐ Yes ☐ No
			MM-DD-YYYY	☐ Yes ☐ No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No

Anticipated Cash Value Transfer $ _____

SECTION 12 - PREMIUM ALLOCATION OPTIONS

☐ **I have completed and signed the allocation form. Please allocate funds accordingly.**

SECTION 13 - GOAL TRACKER

I have requested the Goal Tracker option and the completed illustration number is _____

SECTION 14 - SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY (FOR VUL ONLY)

A) Have you, the proposed base Insured, and Applicant/Owner, if other than the proposed base Insured, received the current Prospectus for the policy? ☐Yes ☐No

B) **Do you understand that the Death Benefit may be variable or fixed under specified conditions?** ☐Yes ☐No

C) **DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE ENTIRE AMOUNT OF THE POLICY VALUE MAY INCREASE OR DECREASE DEPENDING UPON THE INVESTMENT EXPERIENCE?** ☐Yes ☐No

D) With this in mind, is the policy in accordance with your insurance objectives and your anticipated financial needs? ☐Yes ☐No

SECTION 15 - TRANSFER AUTHORIZATION – TO BE COMPLETED BY APPLICANT/OWNER (FOR VUL ONLY)

(See Prospectus for transfer procedures.)

Your policy applied for, if issued, will automatically include transfer privileges described in the applicable prospectus. These privileges allow the Owner and the Producer of record to make transfers and to change the allocation of future payments unless declined below.

Transamerica Life Insurance Company will not be liable for complying with transfer instructions it reasonably believes to be authentic, nor for any loss, damage, costs or expense in acting on such instructions, and Policy Owners will bear the risk of any such loss. Transamerica Life Insurance Company will employ reasonable procedures to confirm that transfer instructions are genuine. If Transamerica Life Insurance Company does not employ such procedures, it may be liable for losses due to unauthorized or fraudulent instructions. These procedures include but are not limited to requiring forms of personal identification prior to acting upon such transfer instruction, providing written confirmation of such transactions to the Owner and/or tape recording of telephone transfer request instructions received.

☐The Producer does **not** have authority to make transfers or change payment allocations on my behalf.

SECTION 16 - PREMIUMS PAYABLE

Initial Planned Premium $_____ ☐Electronic (bank draft) _____ Draft Date (1st through 28th) ☐Direct Bill

☐Single Premium ☐Annually ☐Semiannually ☐Quarterly ☐Monthly ☐Other _____

Source of Funds ☐Employment ☐Retirement ☐Inheritance ☐1035 Exchange ☐Other_____

Premium Payor (If other than Owner)

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Home Phone	4. E-mail Address
		( )	

5. Social Security Number/Tax ID #	6. Relationship to proposed base Insured

SECTION 17 - SECONDARY ADDRESSEE Applicant may specify a Secondary Addressee to receive copies of notices and letters regarding possible lapses in coverage.

1. Last Name	First Name	M.I.

2. Address (Cannot be a P.O. Box)	Apt#	City

State	Zip Code	3. Phone Number	4. E-mail Address
		( )	

SECTION 18 - DRIVING AND PUBLIC RECORDS

A) Have you had your driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? ☐Yes ☐No If yes, give reason: _____

B) Have you in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? ☐Yes ☐No If yes, give reason: _____

C) Are you currently in bankruptcy or have you been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? ☐Yes ☐No If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any. _____

SECTION 19 - RESIDENCY AND FOREIGN TRAVEL

Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? ☐Yes ☐No If yes, complete Residency & Travel Questionnaire.

SECTION 20 - SPECIAL ACTIVITIES

A) Except as a passenger on a regularly scheduled flight, have you flown within the past 2 years, or do you have plans to fly in the next 2 years? If yes, complete the Avocation & Aviation Questionnaire. ☐Yes ☐No

B) In the past 2 years have you participated in or do you intend within the next 2 years to engage in organized racing (automobile, truck, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Sports & Hazardous Activities Questionnaire. ☐Yes ☐No

SECTION 21 - 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 Part 1, Part 2, 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) except as provided in the Conditional Receipt, if issued with the same proposed 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 proposed Owner must have personally received and accepted the policy during the lifetime of each proposed Insured and there must have been no change in the insurability of any proposed 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 applicant 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, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 30 months, but I understand that I may revoke it at any time by giving written notice to the Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in force.

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

I acknowledge receipt of the Notice of Disclosure for (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. 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 I am not subject to backup withholding because I am an exempt recipient; 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.

Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____ (city) _____ (state) on _____ (month/day/year)

Signature of proposed base Insured/Owner (Child age 16 and over must sign)

Print Producer Name

Signature of Applicant/Owner if other than the proposed base Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

Producer Number

Signature of Parent or Legal Guardian of Children age 15 and under

Signature of Producer

Signature of Producer (Split)

SECTION 22 - OTHER INSURANCE – TO BE COMPLETED BY THE PRODUCER

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

B) Does the proposed Insured have existing life insurance policies or annuity contracts with the company or any other company? ☐ Yes ☐ No

C) If replacement of existing insurance is involved, have you complied with all state requirements, including any Disclosure and Comparison Statements? If No, explain _____ ☐ N/A ☐ Yes ☐ No

D) Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

Signature of Producer _____

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Tobacco Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed it, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a notice and/or a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,000,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance for a class of risk with extra ratings regardless of age.

There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a proposed primary Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed primary Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

X _____
Signature of Proposed Owner

_____ , 20 _____
Date

_____
If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust.

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

Submit this completed and signed document with the application and payment.

Company

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Tobacco Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed it, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a notice and/or a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,000,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance for a class of risk with extra ratings regardless of age.

There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a proposed primary Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed primary Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in the application have been met.

Dated at _____ on _____ ,20____ X _____

City, State | Date | Insurance Producer or other Company Authorized Rep

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

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

Proposed Owner

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. Transamerica Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act (www.ftc.gov). The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE 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.

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL: _____

PRODUCER 1: _____ | _____ SHARE %: _____
LAST FIRST

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

PRODUCER 2: _____ | _____ SHARE %: _____
LAST FIRST

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

PRODUCER 3: _____ | _____ SHARE %: _____
LAST FIRST

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

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

What is the purpose for insurance? _____

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

How long have you known the Proposed Insured? _____

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

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

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

X _____
Signature of Producer

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

Authorization to Insurance Company

The Premium Payor hereby authorizes Transamerica Life Insurance Company to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Administrative Office of the Company or until the Pre-Authorized Check/ Withdrawal Plan is terminated in a manner provided below. I (We) expressly agree to all conditions applicable to the Pre-Authorized Check/ Withdrawal Plan including those appearing below.

Authorization to Financial Institution

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other orders whether by electronic or paper means, with such debits made to my account and drawn or directed by Transamerica Life Insurance Company to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders, shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

Initial Payment (Must Check One Box)

- ☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.
- ☐ AUTOMATIC WITHDRAWAL WHEN APPLICATION IS RECEIVED: Check this box to have the initial modal premium withdrawn from the account listed below upon receipt of the application by the Company. **Initial premium will be withdrawn upon receipt of the application by the Company** and not on the day of the future recurring monthly payment stated below.
- ☐ AUTOMATIC WITHDRAWAL WHEN POLICY IS PLACED IN FORCE: Check this box to have the initial modal premium withdrawn from the account listed below upon receipt of all delivery requirements by the Company. Initial premium will be withdrawn upon receipt of all delivery requirements by the Company **and not on the day of the future recurring monthly payment stated below.**

By checking **one of the Automatic Withdrawal boxes,** I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Account Information

TAPE VOIDED CHECK HERE

If not attaching void check or if withdrawing from Savings Account, complete the following information

_____
Bank Name, Office or Branch

_____ Check one: ☐ Checking ☐ Savings
Payor Name(s)

_____ _____
Transit Routing Number Account Number

Complete the Following Information for Future Recurring Payments

Premium to Withdraw	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
$ _____	☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

Signature

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X _____ **Date:** _____

Conditions Applicable to Pre-Authorized Check/ Withdrawal Plan

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Pre-Authorized Check/ Withdrawal Plan may be terminated by either party by giving written notice to the other.

The Pre-Authorized Check/ Withdrawal Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.