Issue ages 0 - 44

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with <u>every</u> application)

Agent Information		
Agent ID	Agent Name (Print)	Agent Phone ( )
Agent Email		Agent Fax ( )
Case Manager Name	Case Manager Phone ( )	
Case Manager Email Address		

Proposed Insured Information	
Insured's name (Print)	Last 4 digits of Insured's social security #

Required Disclosures with Application:

❑ HIPAA Authorization Form ❑ Beneficiary/Additional Insured Information Form

Other Disclosures (if applicable):

❑ Accelerated Death Benefit Disclosure Form ❑ Replacement Form(s)

Submitting Applications: ***(Faxing is the preferred method)***

If faxing, fax to **1-866-834-0437** and enter date faxed_____ . **Do Not** mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

4333 Edgewood Road NE, Cedar Rapids, IA 52499

If a case manager is listed, please follow your General Agency's submission process with sending the signed application packet.

Transamerica Premier Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

LIFE APPLICATION

Part A1 – Producer

Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

Part A2 – Plan & Rider Information

Plan	Face Amount	Total Premium
	$	$

Rate Class applied for:

❑ Preferred Non-Tobacco ❑ Preferred Tobacco ❑ Preferred Juvenile
❑ Standard Non-Tobacco ❑ Standard Tobacco ❑ Standard Juvenile
❑ Graded

Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) ❑ Yes ❑ No

Child / Grandchild Rider? $ _____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) ❑ Yes ❑ No

Part A3 – Proposed Insured

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

D.O.B. (MM/DD/YYYY)	U.S. State or Country of Birth	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.

Gender	Height	Weight	SSN

Driver's License Number State	Phone Number for Interview	Best time to call	Occupation
	( )	a.m. p.m.	

Part A4 – Owner (If Other Than Proposed Insured)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Phone Number	D.O.B. (MM/DD/YYYY)	Gender	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.
( )			

SSN	Relationship to Insured

Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)

Primary Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured
Contingent Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured

Part A6 – Existing Insurance

Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? ❑ Yes ❑ No

Is this insurance intended to replace or change any existing life insurance or annuity contract in force with the company or any other company? ❑ Yes ❑ No

If yes, submit the state required forms and please provide company name and policy number. _____

Is this to be a 1035 exchange? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

Part B1 – Initial Premium Payment Method

❑ By check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual.
Is the check for initial premium payment on the same account as monthly EFT payments? ❑ Yes ❑ No

❑ By payroll deduction or allotment.

❑ Draft initial premium upon receipt from the account below.

❑ Draft initial premium at future date from the account below. Please indicate the month and day (mm/dd): _____/_____
Month **Day (1st thru 28th only)**

If you select an initial premium draft date in the future, it may not be greater than 30 days after the application date and the recurring draft date below must be the same day of the month as the initial premium draft 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.

Part B2 – Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Transamerica Premier Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of the Company if any draft is not honored when presented for payment; or (b) by the Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

❑ Checking ❑ Savings Financial Institution Name: _____ City/State: _____

Account #: | | | | | | | | | | | | | | | | | | |

Routing #: | | | | | | | | | |

No debit card numbers please

Recurring Draft Date (1st-28th):_____ If no recurring draft date is selected, the draft date will be the same day of the month as the Policy Date.

Payor Signature (if other than proposed Insured or Owner)_____ Date:_____

Part B3 – Recurring Payment Method

EFT

❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Payroll Deduction

Special Frequency _____

❑ List Bill ❑ Civil Service Allotment ❑ Military Allotment

Requested Effective Date _____

Automatic Premium Loan provision (if available)? ❑ Yes ❑ No

Part B4 – Payor Information

The Payor is the ❑ Proposed Insured ❑ Owner ❑ Other (If Other, please provide the following information:)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)	
SSN	Relationship to Insured	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part B5 – Secondary Addressee

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Last Name and Last 4 Digits of SSN: _____

Part C1

Within the last 12 months has the proposed Insured used tobacco products in any form? ❑ Yes ❑ No

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

Part C2 – If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.

1) Is the proposed insured currently:
   a. Hospitalized or bedridden; or been advised, planning or scheduled to have inpatient surgery? ❑ Yes ❑ No
   b. On parole or probation? ❑ Yes ❑ No
2) Within the **past 2 years** has the proposed insured:
   a. Had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than Basal Cell carcinoma)? ❑ Yes ❑ No
   b. Had a stroke (CVA), transient ischemic attack (TIA), heart attack, cardiovascular surgery including bypass, angioplasty, stent implant or pacemaker implant; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure? ❑ Yes ❑ No
   c. Used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance. ❑ Yes ❑ No
   d. Used oxygen to assist in breathing (including oxygen use for Sleep Apnea)? ❑ Yes ❑ No
   e. Used illegal drugs (other than marijuana); or been diagnosed with, been treated for or advised to receive treatment for alcoholism, alcohol use/abuse or drug use/abuse (including prescription drugs)? ❑ Yes ❑ No
   f. Undergone testing by a medical professional for which the results have not been received; or been advised to have any surgical operation, diagnostic testing (other than for routine screening purposes), treatment, hospitalization or other procedure that has not been completed? ❑ Yes ❑ No
   g. Resided in a nursing home, assisted or long term care facility; or received hospice or home health care? ❑ Yes ❑ No
   h. Been diagnosed with Crohn's disease, Multiple Sclerosis or Parkinson's disease? ❑ Yes ❑ No
   i. Had, been diagnosed with, been treated for or advised to receive treatment for Hepatitis C, Tuberculosis (TB) or Lupus? ❑ Yes ❑ No
   j. Been incarcerated; or been convicted of a felony or misdemeanor; or been convicted of 2 or more DUI's/DWI's or 3 or more moving violations? ❑ Yes ❑ No
3) Has the proposed insured **ever**:
   a. Had, been diagnosed with, been treated for or been advised to receive treatment for Alzheimer's, dementia, memory loss, any cognitive disorder, organic brain disease, mental incapacity, Lou Gehrig's (ALS), Downs Syndrome, Huntington's, Spina Bifida not surgically corrected, Sickle Cell anemia, Cystic Fibrosis or Cerebral Palsy? ❑ Yes ❑ No
   b. 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
   c. Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ Yes ❑ No
   d. Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ❑ Yes ❑ No
   e. Received or been advised to receive an implanted defibrillator or an organ transplant (other than corneal)? ❑ Yes ❑ No

Part C3 - For All Questions Answered "Yes" In This Section Give Details On The Supplemental Information To The Application.

1) Does the proposed Insured take any prescription medication? ❑ Yes ❑ No
2) Within the last **10 years**, has the proposed Insured had or received medical treatment for any of the following conditions:
   Any disease or disorder of the blood, heart or circulatory system such as heart attack, stroke or transient ischemic attack (TIA) ❑ Yes ❑ No
   Respiratory Disease ❑ Yes ❑ No
   Kidney/Liver/Digestive Disorder ❑ Yes ❑ No
   Epilepsy/Seizures ❑ Yes ❑ No
   Mental/Nervous Disorder ❑ Yes ❑ No
   Cancer/Leukemia ❑ Yes ❑ No
   High Blood Pressure ❑ Yes ❑ No
   If yes, last reading: _____/_____ Medication: _____
   Diabetes ❑ Yes ❑ No
   If yes, age at onset: _____ Medication: _____ Avg. blood sugar reading: _____
3) Within the last **5 years**, has the proposed Insured:
   a) Had one or more DUI(s), been charged with, or convicted of a felony OR been on probation/parole? ❑ Yes ❑ No
   b) Illegally used any drug or controlled substance or been treated/counseled for drug or alcohol abuse? ❑ Yes ❑ No

Part C4 – Nursing Home Option - If The Following Question Is Answered "Yes", The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ❑ Yes ❑ No