Reset Form

Transamerica 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
❑ Standard Non-Tobacco ❑ Standard Tobacco
❑ 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? _____
Gender / SSN	Phone Number for Interview ( ) / Best time to call a.m. p.m.	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.

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? _____
SSN	Relationship to Insured		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.

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 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 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 #: | | | | | | | | | | | | | | | | | | |

No debit card numbers please

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

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 hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care, or has the proposed Insured been advised by a member of the medical profession or is the proposed Insured planning to have inpatient surgery? ❑ Yes ❑ No

2) To the best of your knowledge and belief has the proposed Insured **ever**:
   a) Been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for Alzheimer's, dementia, memory loss, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic 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
   b) 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
   c) Been in a diabetic coma or had or been advised by a member of the medical profession to have an amputation due to disease or disorder? ❑ Yes ❑ No
   d) Received or been advised by a member of the medical profession to receive an organ transplant other than corneal? ❑ Yes ❑ No

3) Within the past **2 years** has the proposed Insured:
   a) Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
   b) Undergone testing by a medical professional for which the results have not been received or been advised by a member of the medical profession to have any surgical operation, diagnostic testing other than for routine screening purposes, treatment, hospitalization or other procedure which has not been done? ❑ Yes ❑ No

Part C3

4) Has the proposed Insured been diagnosed with diabetes (other than gestational diabetes) before the age of 18? ❑ Yes ❑ No

5) Within the past **4 years** has the proposed Insured had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No

6) Within the past **1 year** has the proposed Insured:
   a) Used illegal drugs or been diagnosed with, been treated for or been advised by a member of the medical profession to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs), or muscular dystrophy? ❑ Yes ❑ No
   b) Had more than 12 seizures; or had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ❑ Yes ❑ No
   c) Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for aneurysm or angina; or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant? ❑ Yes ❑ No
   d) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)? ❑ Yes ❑ No
   e) Used oxygen to assist in breathing (including Sleep Apnea); received kidney dialysis; or had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for kidney failure due to a disease or disorder? ❑ Yes ❑ No

7) Within the past 2 years has the proposed Insured 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

- If all questions in Part C3 are answered "No," proceed to Part C4.
- If one question in Part C3 is answered "Yes," the proposed Insured is potentially eligible for the Graded Death Benefit product.
- If two or more questions in Part C3 are answered "Yes," the proposed Insured is not eligible for any coverage.

Part C4

8) Within the past **2 years** has the proposed Insured:
   a) Had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for angina (chest pain); aneurysm; vascular, circulatory or blood disorder; heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or irregular heart rhythm such as atrial fibrillation? ❑ Yes ❑ No
   b) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)? ❑ Yes ❑ No
   c) Had more than 12 seizures; used insulin; or had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ❑ Yes ❑ No
   d) Used illegal drugs or been diagnosed with, been treated for or been advised by a member of the medical profession to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs)? ❑ Yes ❑ No

9) Within the past **4 years** has the proposed Insured had, been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for kidney disease? ❑ Yes ❑ No

10) Has the proposed Insured **ever** been diagnosed with, been treated for or advised by a member of the medical profession to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ❑ Yes ❑ No

- If all questions in Part C4 are answered "No," the proposed Insured is potentially eligible for the Preferred product.
- If one question in Part C4 is answered "Yes," the proposed Insured is potentially eligible for the Standard product.
- If two or more questions in Part C4 are answered "Yes," the proposed Insured is potentially eligible for the Graded Death Benefit product.

Last Name and Last 4 Digits of SSN: _____

AGREEMENT / AUTHORIZATION

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct to the best of my knowledge and belief. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (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 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 all proposed Insured(s) and while all proposed Insured(s) are in good health; 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, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance and Conditional Receipt.

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 the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal/protected 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.

If I have qualified for the graded death benefit policy, I understand that I may qualify for a full death benefit policy, which provides full benefits from inception from another life insurance company.

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.

FRAUD WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signed Date _____ Signed at City _____ State _____

_____ _____

Proposed Insured Signature Owner Signature (If Owner other than Insured)

_____

Producer Signature

If the EFT premium payment method is chosen, please tape a voided check in this box.

Schedule Of Social Security Benefit Payments 2017

JANUARY 2017						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY 2017						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

MARCH 2017						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

APRIL 2017						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

MAY 2017						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

JUNE 2017						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

JULY 2017						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

AUGUST 2017						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

SEPTEMBER 2017						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

OCTOBER 2017						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER 2017						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

DECEMBER 2017						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

Benefits paid on	Birth date on
Second Wednesday	1st – 10th
Third Wednesday	11th – 20th
Fourth Wednesday	21st – 31st

●	Supplemental Security Income (SSI)
□	Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.

www.socialsecurity.gov

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☐ **Transamerica Financial Life Insurance Company**
440 Mamaroneck Avenue, Harrison, NY 10528
☐ **Transamerica Life Insurance Company**
☐ **Transamerica Premier Life Insurance Company**
Administrative Office: 4333 Edgewood Road N.E.
Cedar Rapids, IA 52499

SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM

POLICY NUMBER_____

SOCIAL SECURITY BENEFIT PAYMENT PAID ON:

Box A - Required

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

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

Initial Draft Month_____ (Cannot exceed one benefit payment cycle past application date)

INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)

Box B - Bank Withdrawal Account

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____
☐ Survivor Account

_____ _____
Financial Institution Name, Office or Branch — Financial Institution Address City, State, Zip

_____ Check One: ☐ Checking ☐ Savings $ _____
List All Authorized Account Holders — Premium amount

_____ _____ _____
Transit Routing Number — Account Number — Account Holder Signature

Box C - Direct Express MasterCard

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____
☐ Survivor Account

5332 48 __ __ __ __ __ __ __ __ __ __ __ __
Direct Express MasterCard Account Number

_____ $ _____
Cardholder Signature — Date — Premium amount

_____ _____
Card Expiration Date Mo/Yr — Cardholder Name (Please Print)

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. 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 charge or withdrawal is not honored for payment, 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 MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

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

_____ _____
Signature of Authorized Account Holder — Date