Reset Form

TRANSAMERICA®

# HIPAA Authorization for Release of Health-Related Information

☐ **Transamerica Life Insurance Company** ☐ **Transamerica Premier Life Insurance Company**

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

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

| Name of Primary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
|---|---|---|
| Name of Secondary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
| Name(s) of Unemancipated Minors | Date(s) of birth | Last four digits of SSN(s) |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

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

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

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

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

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

Policy or contract number (if known): _____

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

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# HIPAA Authorization for Release of Health-Related Information

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| Name of Primary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
|---|---|---|
| Name of Secondary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
| Name(s) of Unemancipated Minors | Date(s) of birth | Last four digits of SSN(s) |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

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

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

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

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

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

Policy or contract number (if known): _____

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

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

$

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## 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**

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## 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.**

**14**

## 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.

Reset Form

# Agent's Report

**1**

| | | | | |
|---|---|---|---|---|
| **Producer 1** → | Writing Agent Name | Agent Number | Profile Number | Percent of Agent's Split |
| **Producer 2** → | Split Agent Name | Agent Number | Profile Number | Percent of Agent's Split |
| **Producer 3** → | Split Agent Name | Agent Number | Profile Number | Percent of Agent's Split |
| **Producer 4** → | Split Agent Name | Agent Number | Profile Number | Percent of Agent's Split |

**2**

## Agent Disclosure

How long have you known the Proposed Primary Insured?

Relationship to Proposed Primary Insured

Are you financially responsible for the Proposed Primary Insured?

☐ **Yes** ☐ **No**

Are you or any of your family members named as a beneficiary on this policy application?

☐ **Yes** ☐ **No**

**If yes** →

If, yes what insurable interest do you/your family member have in the life of the insured(s)?

Do you intend to submit multiple applications on any of the proposed insureds?

☐ **Yes** ☐ **No**

Is the Agent or Split Agent also the Owner, Applicant or Payor?

☐ **Yes** ☐ **No**

Is the Proposed Primary Insured or owner related to any affiliated Broker/Dealer office or employee?

☐ **Yes** ☐ **No**

**If yes** →

Name and address of Broker/Dealer

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

Did you provide the "Notice of Disclosure" to the Proposed Primary Insured?

☐ **Yes** ☐ **No** ☐ **N/A**

**Please indicate how this sale was taken:**

☐ In person ☐ Phone or Video Call (Skype, FaceTime, etc.) ☐ Other _____

Was the identification of the Proposed Primary insured verified during the sale?

☐ **Yes** ☐ **No**

Type of Government issued photo ID

| Issuer of Identification Document | Number | Expiration Date |
|---|---|---|
| | | |

## 3 Correspondence Information

Case Manager Name (if applicable)

| Agent/Case Manager Email | Office ID |
|---|---|
| | |

| Agent/Case Manager Phone Number | Agent/Case Manager Fax Number |
|---|---|
| | |

## 4 Signature

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of the person(s) seeking to open this policy and verified that person seeking to open this policy is the same person in the documents reviewed. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action or prosecution for violation of state or federal criminal laws.

**Payment with application not accepted if the primary proposed insured total coverage over $1,000,000.00, age 76 and over, or treated for or experienced heart trouble, stroke or cancer within the past 12 months.**



__ __ / __ __ / __ __ __ __

**Signature of Writing Agent/ Registered Representative** Date (mm/dd/yyyy)

Reset Form

TRANSAMERICA®

# Electronic Payment

○ **Transamerica Financial Life Insurance Company**
Home Office: Harrison, New York
○ **Transamerica Life Insurance Company**
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
○ **Transamerica Premier Life Insurance Company**
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

## Policy/Certificate Information

**If you have more than five policies, please attach an additional sheet.**

| Policy/Certificate Number | Insured Name | Premium Payment | Loan Payment (If Applicable) |
|---|---|---|---|
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |
| | | $ | $ |

## Initial Payment (ONLY for new policy applications, otherwise skip this section)

☐ **Check:** Check this box if you are submitting a check for the initial modal premium. The check will be deposited 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:** Check this box to have the initial premium paid through the account specified in the "Account Information" section below. By checking this box, you agree to have the amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium may not equal the amount reflected in the chart above. 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. You 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.

## Future Recurring Payment

Select Mode: ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

☐ Withdraw on day of the month matching the policy's effective date. This will be the default election if no box is checked.

☐ Withdraw on this day of the month (choose a day between 1 and 28): _____

**If you need to change or cancel your bank draft, please notify us five (5) business days before your withdrawal date so we can process your request. Visit www.transamerica.com for details on how to contact us.**

## Past Due Premium

**By signing this form, you authorize the Company to bring your policy current, which will pull past premiums due from your bank account. (Note: You can call us to verify the total overdue premiums.)**

☐ Check here if you are providing us with a separate premium payment. Please write the policy/certificate number on the check.

Check amount: $_____ Date: _____

**Continued on next page**

## Payor's Authorization to Insurance Company

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

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

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

## Bank Account Information

**Please enclose a voided check or complete this section with your financial institution information.**

Please select the type of account: ☐ **Checking** ☐ **Savings**

| Account Holder First Name | Account Holder Last Name |
|---|---|
| | |

Trust or Entity *If entity, show title of officer and name of entity. If trust, show trustee's name.*

Financial Institution Name

| Location City | State | Zip Code |
|---|---|---|
| | | |

| Routing Number | Account Number |
|---|---|
| | |

| Account Holder Relationship to Insured | Insured Name |
|---|---|
| | |



**Account Holder(s) Signature(s)** Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

*Complete pages 1 and 2, and <u>return both pages</u> to the Company*

# Schedule of Social Security Benefit Payments 2019

| JANUARY 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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 2019 | | | | | | |
|---|---|---|---|---|---|---|
| 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)
- Social Security benefits prior to May 1997; or if receiving both Social Security and SSI, Social Security is paid on the third

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

Securing today and tomorrow

**SocialSecurity.gov**

**Social Security Administration**
Publication No. 05-10031
ICN 456100 | Unit of Issue — HD (one hundred)
July 2018 (Recycle prior editions)
Schedule of Social Security Benefit Payments 2019
Produced and published at U.S. taxpayer expense

Reset Form

TRANSAMERICA®

# Social Security Benefit Billing Authorization Form

○ **Transamerica Financial Life Insurance Company**
Home Office: Harrison, New York
○ **Transamerica Life Insurance Company**
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
○ **Transamerica Premier Life Insurance Company**
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**POLICY #**_____ **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 (Note: this card starts with 5332)**

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____

PCI Token # _____ ☐ Survivor Account $ _____
Premium amount
***(Please visit https://creditcardtoken.transamerica.com/ to get a secure token number.)***

Card Expiration _____ Cardholder Name (Please print) _____
MM/DD/YYYY

Cardholder Signature _____ Date _____

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 near the date selected above even if it is before premiums 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