Transamerica Premier Quick Reference Tips

Takes Direct Express Cards

Min Face Amount: $1,000
Max Face Amount ranges:
45-55yrs $1,000-50,000 **56-65yrs $40,000**
66-75yrs $30,000 **76-85yrs $25,000**

NO HEIGHT & WEIGHT REQUIREMENTS

How to quote with the Cardinal SB quoting App
Underwriting Type: Full
Product Type: Level

There are **TWO** different
1st day Level coverage rates we use:
PREFERRED
STANDARD

TRANSAMERICA LIFE INSURANCE...
Preferred ← 1ST FROM THE TOP
Premium: $50.00/mo*
Face Value: $21,378.00
Annual Fee: $42.00

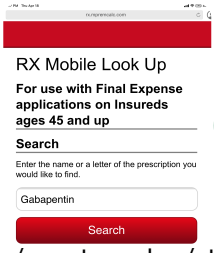
TRANSAMERICA LIFE INSURANCE...
Standard ← 2nd FROM THE TOP
Premium: $50.00/mo*
Face Value: $17,642.00
Annual Fee: $42.00

Page 3 Part C4 is particularly useful for **1ST DAY COVERAGE** at **STANDARD** rates, **HOWEVER**, you can only have **ONE** yes answer in C4 (usually COPD question (#10) or Insulin question (8c))

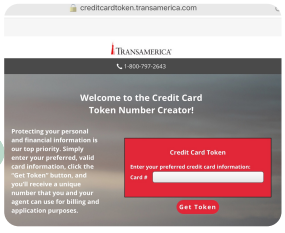
Part C4

8) Within the past **2 years** has the proposed Insured:
   a) Had, been diagnosed with, been treated for or advised by a medical doctor 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 medical doctor 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 medical doctor 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 medical doctor to receive treatment for kidney disease? ❑ Yes ❑ No
10) Has the proposed Insured **ever** been diagnosed with, been treated for or advised by a medical doctor 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

To look up **Meds your not sure about** for Transamerica use this website (their med look-up search engine):
http://rx.mpremcalc.com/search.aspx



For **DIRECT EXPRESS,** you'll have to create a **'Token'** at this website to enter on the app**:**
https://creditcardtoken.transamerica.com/

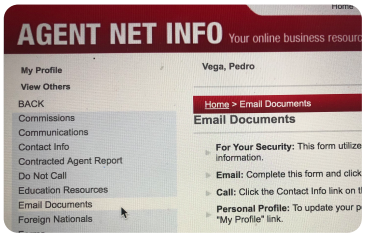


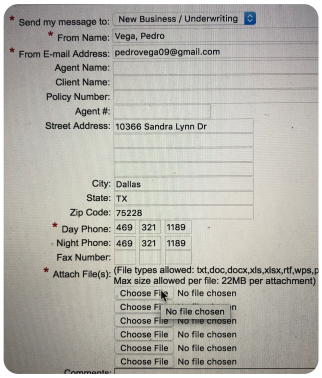
Filling Out Application
Fill out red highlighted boxes with your signature/agent number/etc. Make copy after filling out red highlighted boxes. Always make a duplicate copy of file ***BEFORE*** filling out application with client info Re-title file with clients first and last name
Fill out yellow highlighted boxes with client info
Make sure name is spelled the same way in every box it asks for it
A1 Split is 100%
A2 Plan Name is "Immediate Solution" or "Ten Year Pay"
A3 Best time to call just put 10 am
A6 Make sure answers here match answers in "Agent cReport"
B2 Only needs to be filled out if not doing social security billing
C4 Can only have one mark and qualify for standard rates. Don't forget insulin is a mark.
Supplemental information page - need to have their name written next to each medication, write name of medication, dosage, approximate amount of years client has taken it

How to submit app:
Fax pdf to 1-866-834-0437

-OR-

Upload application through agentnetinfo.com (Trans Agent portal)
Login: Click 'email document,' on the left, then choose file to upload
-OR-





Upload through the Cardinal Senior Benefits Submission Link:
https://www.cognitoforms.com/Access15/cardinalseniorbenefitsapplicationsubmissionform

Issue ages 45 - 85

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 (DMF 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
❑ 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

Gender

SSN

Phone Number for Interview ( )

Best time to call a.m. p.m.

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.

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

SSN

Relationship to Insured

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.

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 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 #: | | | | | | | | | | | | | | | | | | |
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 medical doctor or is the proposed Insured planning to have inpatient surgery? ❑ Yes ❑ No
2) Has the proposed Insured **ever**:
   a) Been diagnosed with, been treated for or advised by a medical doctor 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) Been diagnosed as having or been told by a medical doctor that you have AIDS, HIV, or ARC disorders? ❑ Yes ❑ No
   c) Been in a diabetic coma or had or been advised by a medical doctor to have an amputation due to disease or disorder? ❑ Yes ❑ No
   d) Received or been advised by a medical doctor 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 medical doctor to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
   b) Undergone testing by a medical doctor for which the results have not been received or been advised by a medical doctor 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 medical doctor 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 medical doctor 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 medical doctor 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 medical doctor 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 medical doctor 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, proceed to Part C5.
- 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 medical doctor 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 medical doctor 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 medical doctor 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 medical doctor to receive treatment for kidney disease? ❑ Yes ❑ No
10) Has the proposed Insured **ever** been diagnosed with, been treated for or advised by a medical doctor 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, proceed to Part C5.
- If one question in Part C4 is answered "Yes," the proposed Insured is potentially eligible for the Standard product, proceed to Part C5.
- If two or more questions in Part C4 are answered "Yes," the proposed Insured is potentially eligible for the Graded Death Benefit product.

Part C5 – 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

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. 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, Accelerated Death Benefit Disclosure 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.

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

Signed 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.

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: ______________________ Social Security Number: ______________

Additional Information

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

Additional Information

Child / Grandchild Rider Information

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

Contingent Owner

Name (First, M.I., Last, Suffix)	SSN	Gender	Relationship to Insured	Phone Number ( )	D.O.B. (MM/DD/YYYY)
Address, City, State, Zip Code (If different from Insured) (cannot be a P.O. Box)				Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?	

Signed Date ______________ Signed at City ______________ State ______________

______________________ Proposed Insured Signature

______________________ Owner Signature (If Owner other than Insured)

______________________ Producer Signature

Last Name and Last 4 Digits of SSN: _____

Agent's Report

Existing insurance? ❑ Yes ❑ No

Is the policy applied for in this application intended to replace any insurance or annuity now in force? ❑ Yes ❑ No

I represent that:

1) I have personally seen the proposed Insured. ❑ Yes ❑ No

2) I have truly and accurately recorded on this application the information as supplied by the Owner and the proposed Insured. ❑ Yes ❑ No

Is the person proposed for insurance related to you? ❑ Yes ❑ No Relationship _____

_____

Producer Signature

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

1. Last Name	First Name	2. SS# Last 4 Digits

OWNER - if other than Primary Insured

1. Last Name	First Name	2. TIN/SS# Last 4 Digits

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Home Phone ( )	4. Social Security Number

PRIMARY BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#

CONTINGENT BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#

AGENT

❑ I attest that, on behalf of the Company, I requested all information above and the applicant provided the information completed on the form. The applicant was unable/declined to provide any information missing from the form.

Date

Producer or Agent Signature

Owner Signature

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

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.

REPLACEMENT ADVERTISING
AGENT STATEMENT

I, _____, have complied with the following in connection with the replacement sales transaction:

a. I have used only company approved sales advertising.

b. I have given a copy of all sales advertising used during the presentation to the applicant, including printed copies of any electronically presented sales materials.

_____ _____

DATE **AGENT SIGNATURE**

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

Administrative Office located at: 4333 Edgewood Road N.E., Cedar Rapids, Iowa 52499. Telephone: (319) 355-8511

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy, to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO**

2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___NO**

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy number or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. [If you request one, an in-force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer.] Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____.
I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

_____ I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

The acceleration-of-life-insurance benefits offered under this rider may or may not qualify for favorable tax treatment under the Internal Revenue Code of 1986. Whether such benefits qualify depends on factors such as your life expectancy at the time benefits are accelerated or whether you use the benefits to pay for necessary long-term care expenses, such as nursing home care. If the acceleration-of-life-insurance benefits qualify for favorable tax treatment, the benefits will be excludable from your income and not subject to federal taxation. Tax laws relating to acceleration-of-life-insurance benefits are complex. You are advised to consult with a qualified tax advisor about circumstances under which you could receive acceleration-of-life-insurance benefits excludable from income under federal law.

Receipt of acceleration-of-life-insurance benefits may affect your, your spouse or your family's eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), and drug assistance programs. You are advised to consult with a qualified tax advisor and with social service agencies concerning how receipt of such a payment will affect you, your spouse and your family's eligibility for public assistance.

Description of Benefit: Upon receipt of proof acceptable to us of the Insured's Qualifying Event, the Owner may choose to receive the Accelerated Death Benefit while the Insured is alive and the Rider is In Force.

Qualifying Event: An event defined in the Rider, which allows for payment of the Accelerated Death Benefit.

Accelerated Death Benefit Amount: The Accelerated Death Benefit shall be equal to:

1. the Policy Death Benefit that would be In Force at the end of the 12 month period following the Acceleration Date, before deduction of any outstanding Loan Balance; less
2. a discount on the Accelerated Death Benefit calculated for the 12 month period using the current interest rate; less
3. any outstanding policy loans, including accrued interest until the end of the 12 months following the Acceleration Date; less
4. any premiums which would be required to keep the Policy In Force for the 12 month period following the Acceleration Date for the Policy Amount of Insurance reduced by an appropriate discount using the current interest rate.

Termination of Coverage: The Accelerated Death Benefit Rider will automatically terminate when the Policy to which it is attached terminates or lapses or matures or is continued under one of the nonforfeiture options; or when the Accelerated Death Benefit is paid; whichever occurs first.

Impact on the Policy's Death Benefit: The Policy to which the Rider is attached will terminate on the date the Accelerated Death Benefit is paid.

By signing below, you agree that you have read and received a copy of this summary and disclosure statement at the time of application.

Date	Owner's (Applicant's) Signature
Date	Agent's Signature

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

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 $ _____
(Please visit https://creditcardtoken.transamerica.com/ to get a secure token number.) Premium amount

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 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