Reset Form

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

GA # 10916

Change/Conversion Application
Individual Life Insurance - Part 1

Primary Insured:	Owner(s) of Record on Contract:
Primary Insured's Address: (Cannot be a P.O. Box)	Address of Owner(s) (if other than Primary Insured): (Cannot be a P.O. Box)
Primary Insured's Social Security No:	E-Mail Address:(Not for Policy/Billing Notices)
Primary Insured's Birthdate:	TIN or Soc. Sec. No. of Owner(s):
Joint Insured (For Joint Contract Only):	Birthdate(s) of Owner(s):
Joint Insured's Birthdate:	Joint Insured's Social Security No:

SECTION I - TYPE OF CHANGE REQUEST (Evidence of insurability may be required)

1. List the contract number(s) which you, the Owner, wish to change: _____

2. Check those boxes that describe the type of proposed change:

A) Each of the following proposed changes require full new business evidence, completion of Section IV, a signed Authorization to Obtain Information and the requirements indicated. Additional requirements may be requested by the Company. If the contract involves a joint plan, full evidence is required on both lives.

❑ 1) Non-contractual rewrite (replacement of an existing Transamerica contract with a new Transamerica contract when not guaranteed by the existing contract). Also complete Section II.

❑ 2) Face increase. Enter the new face amount applied for
Specify current face amount + amount of increase $ _____
Submit full new business evidence for the amount of the increase.

B) The following proposed changes require completion of Section IV (except if indicated differently below), a signed Authorization to Obtain Information and the requirements indicated. Additional requirements may be requested by the Company.

❑ 1) Reduce to non-nicotine rate class. Arrange for current Home Office urine specimen and complete Question 12 in Section IV.

❑ 2) Rate class improvement. Provide information detailing the aspect(s) of the risk that has/have changed that might warrant a rate class improvement (example: sustained weight loss, improved lab values, cessation of aviation activities, etc.)

_____

_____

❑ 3) Add a rider/benefit. Check the box/boxes that apply.

- ❑ Waiver of Premium/Waiver Provision. Complete a Non-Medical Health History form on the Primary Insured.
- ❑ Accident Indemnity - Amount: $_____ Complete a Non-Medical Health History form on the Primary Insured and Question 4 in Section IV.
- ❑ Guaranteed Insurability Rider - Amount: $_____ Complete a Non-Medical Health History form on the Primary Insured.

❑ Children's Insurance Rider - Number of units applied for: _____
Complete an Application Supplement for Children's Insurance Rider and a Non-Medical Health History form on the Primary Insured.

❑ Family Insurance Rider - Number of units applied for: _____
❑ 1 Parent ❑ 2 Parent

Spouse proposed to be insured under the Family Rider:

Spouse's Name: _____ Spouse's Date of Birth _____
Spouse's Sex: ❑ Male ❑ Female
U.S. Citizen ❑ Yes ❑ No If no, complete Residency & Travel Questionnaire.

Complete an Application Supplement for Children's Insurance Rider and submit. Complete Non-Medical Health History forms for both the Primary Insured and the spouse proposed to be added under the rider. If more than 20 units are requested, submit full new business evidence on the spouse, a Non-Medical Health History form on the Primary Insured and an Application Supplement for Children's Insurance Rider.

C) Other changes. These changes require those items indicated. Additional requirements may be requested by the Company.

❑ 1) Exercise Option for Additional Insurance (OAI) - Amount: $ _____
Please check one:
❑ Issue new contract for OAI amount.
❑ Increase face amount of original contract to add OAI amount (if available).

❑ Yes ❑ No a) If the original contract has a Waiver of Premium/Waiver Provision rider, should a Waiver of Premium/Waiver Provision rider also be included on this new amount?

Complete the following and a signed Authorization to Obtain Information if the Primary Insured was issue age 51 or older at original contract issue. Provide details of yes answers in the Comments section.

❑ Yes ❑ No a) Is the Primary Insured now so disabled by sickness or injury as to be unable to perform any of the duties of his/her normal job?

❑ Yes ❑ No b) Within the past five years, has the Primary Insured had high blood pressure, heart disease, diabetes, or cancer?

❑ 2) Change of Death Benefit option (UL Plans only). Contact the administrative office for requirements.
Change to Option: ❑ Level ❑ Plus ❑ Plus-Premium ❑ Other _____

❑ 3) Exercise Guaranteed Insurability Rider (GIR) - Amount: $ _____
❑ Regular option date
❑ Alternate option date. Provide date and type of occasion that qualifies this for an alternate option date.

_____

❑ Yes ❑ No a) If the original contract has a Waiver of Premium/Waiver Provision rider, should a Waiver of Premium/Waiver Provision rider also be included on this new amount?

☑ 4) Other change (Review the Policy Service Request form before completing):

Lower Death Benefit to $25,000 and continue with no premiums. Use current Cash Value to run out as per attache
illustration from the Home Office.

Comments: _____

_____

_____

_____

3. Conversion (Also complete Section II and III). Producer must provide an illustration for the additional amount if keeping the same contract or for the total amount if a new contract is desired. Additional requirements for conversion to variable universal life will apply.

❑ Conversion of a term contract or rider to a whole life or universal life or variable universal life contract or rider. Please check one:

❑ Full conversion
❑ Partial conversion. Amount to be converted: $ _____

SECTION II - DETAILS OF THE NEW CONTRACT

Complete for non-contractual rewrites and conversions

1. Plan applied for: _____ Kind Code: _____
2. Risk Classification: ❑ Preferred Plus/Select ❑ Preferred ❑ Standard Plus ❑ Standard ❑ Other _____
   ❑ Extra Rating of: _____
3. Nicotine Classification: ❑ Nicotine ❑ Non-Nicotine
4. Amount Applied for: $ _____
5. Additional Benefits by Rider:
   ❑ Waiver of Premium/Waiver Provision ❑ Accident Indemnity $_____ ❑ Other (include details)
   _____
6. Special dating instructions, if any. (Example: Date to save age) _____
7. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ❑ Yes ❑ No
   (APL will be in effect unless no is checked.)

For conversions only:

8. Continue existing riders if allowed by contract?
   ❑ No ❑ Yes, all riders ❑ Yes, but only those listed here
   _____
9. Any remaining coverage under present contract is to be:
   ❑ Continued ❑ Terminated
10. Any remaining coverage under present rider is to be:
    ❑ Continued ❑ Terminated
11. If evidence of insurability is required for continuation of disability benefits, is the Primary Insured now able to perform all the duties of his/her occupation?
    ❑ Yes ❑ No If no, provide explanation below.

Any new plan shall have the same beneficiary as the present contract. If a different beneficiary designation is desired, please complete the Beneficiary Designation Form for Life Insurance Policies as instructed on that form.

Comments: _____

_____

_____

_____

12. Complete for Flexible Premium Plans:

Required Premium Per Year (RAP)	$	_____
Planned Periodic Premium	$	_____
Plus Initial Lump Sum	+ $	_____
Equals Total Initial Payment	= $	_____

14. Mode of Premium Payment:

- ❑ Annually
- ❑ Semi-Annually
- ❑ Quarterly
- ❑ Monthly

13. Dividend Option (Participating Plans Only):

- ❑ Cash ❑ Paid-Up Additions
- ❑ Premium Reduction ❑ Accumulation
- ❑ One-Year Term
- ❑ Other (specify) _____

_____

_____

15. Billing Type

- ❑ Direct Collection (not available for monthly)
- ❑ Pre-Authorized Withdrawal (Quarterly & Monthly Only)
- ❑ Salary Deduction No. _____
- ❑ Government Allotment

Unless a Conditional Receipt was issued along with this application, I/we agree that no payment will be made or taken for the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in this application have been met.

SECTION III - INSTRUCTIONS TO TERMINATE EXISTING LIFE INSURANCE COVERAGE

Transamerica Life Insurance Company (the Company)
Existing contract(s)/coverage(s) for which a change or termination is requested will remain in effect only until the contract(s)/change(s) applied for is/are effective in accordance with this application and all contract terms.

❑ Upon issuance of contract applied for, terminate contract number(s) _____
❑ Upon issuance of contract applied for, change contract number(s) _____

Additional instructions: _____

_____

I/WE, THE OWNER(S), UNDERSTAND THAT THE COMPANY MAKES NO REPRESENTATIONS AND ASSUMES NO LIABILITY FOR THE TAX IMPLICATIONS, IF ANY, OF THIS TRANSACTION.

NOTICE TO CONSUMER: The death benefit on many business related life insurance policies will be taxable to the extent it exceeds the premiums and other considerations paid by you for the policy under Section 101(j) of the Internal Revenue Code unless written Notice and Consent is obtained prior to policy issue and certain other requirements are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners. The policy change(s) you have requested may require compliance with Section 101(j), including compliance with the Notice and Consent requirements prior to the effective date of any change, whether or not such section also applied when the policy was originally issued.

You are advised to consult with your qualified tax advisor prior to completing the requested policy acquisitions or change(s).

I/we, the undersigned, hereby represent that the statements and answers given in the Application are true, complete and correctly recorded. **I/we agree**: (1) This Application and any required application supplement(s)/amendment(s), in addition to any evidence of insurability required by the Company for this Application, including Application Part 2, shall be made part of the contract issued pursuant to this Application. (2) Except as otherwise provided in the conditional receipt, if issued, with the same Insured(s) as Part 1 of this Application, any change requested which requires evidence of insurability shall not take effect until after all of the following conditions have been met: (a) Any required payment for the change is paid in full, (b) The change is approved by the Company at its Administrative Office during the lifetime of all persons insured, (c) The Owner has personally received the contract during the lifetime of and while person(s) to be covered by such contract is/are in good health, and (d) All of the statements and answers given in this Application continue to be true and complete as of the date of Owner's personal receipt of the contract, and that the contract will not take effect if the facts have changed. (3) Any change requested which does not require evidence of insurability which is provided by the contract or is allowed by the Company shall be effective from the date determined by the Company unless a different date is specifically indicated and is allowed by the Company. (4) Until the change requested becomes effective, the contract without change shall continue subject to its provisions. (5) The Company may deposit or cash any payment without prejudice to its right to decline the request for change. (6) Unless the requested change is specifically allowed under the provisions of the contract, the Company may require satisfactory evidence of insurability before allowing the change. (7) No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

I/we understand that omissions or misstatements in this Application could cause an otherwise valid claim to be denied under any contract issued from this Application.

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Primary Insured (or parent or guardian if Primary Insured is a minor) Witness to Signature of Primary Insured

X _____ X _____
Signature of Joint Insured or Spouse, if applicable Witness to Signature of Joint Insured or Spouse

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Owner (if other than Primary Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Primary Insured must sign as Owner, give corporate title and full name of corporation below.

_____ X _____
Signature of Licensed Producer

_____

_____

PLEASE MAKE CHECKS PAYABLE TO TRANSAMERICA LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE SPACE BLANK.

Amount paid with this Application: $ _____ ☐ Check # _____

☐ Credit Card Complete Credit Card Order Confirmation Form.

SECTION IV - PARTIAL EVIDENCE OF INSURABILITY

Primary Insured: _____ Contract No.: _____

If evidence of insurability is required, complete this section and the other requirements as indicated in Section I. Complete this section on each person to be covered under the contract.

1) Occupation: _____ 2) Employer: _____

3) Annual income: $ _____

4) Do you have any existing life insurance or annuities? ☐ Yes ☐ No

Total insurance in force with all companies: Life Insurance $ _____ Accidental Death $ _____

Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? ☐ Yes ☐ No

If yes, give company name(s) and policy no(s): _____

Waiver of Premium/Waiver Provision Coverage now in force: $ _____

Yes	No		
☐	☐	5)	Is any application for life insurance on any person to be covered pending in any other company? If yes, provide name of company, name of Proposed Insured and amount applied for in Remarks.
☐	☐	6)	Within the next two years does any person to be insured intend to participate in hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
☐	☐	7)	Has any person to be insured ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☐	8)	Is any person to be insured a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☐	9)	Does any person to be insured intend to fly other than as a passenger? Flown other than as a passenger within the past two years? If yes, complete Aviation Questionnaire.
☐	☐	10)	Does any person to be insured plan to travel outside the U.S., Canada, W. Europe, Hong Kong, Australia or New Zealand, for business or pleasure, within the next 12 months? If yes, complete Residency & Travel Questionnaire.
		11)	Driving Record: Driver's license number: _____ State: _____ Within the past five years has any person to be insured been convicted of or pleaded guilty to:
☐	☐		a) Moving violations? If yes, give dates and type: _____
☐	☐		b) Driving under the influence of alcohol and/or other drugs? If yes, give dates: _____
☐	☐		c) Reckless driving? If yes, give dates: _____
		12)	Has any person to be insured used nicotine at any time?
☐	☐		a) Cigarettes Date Last Used _____
☐	☐		b) Cigar/Pipe/Chewing Tobacco Date Last Used _____
☐	☐		c) Other Date Last Used _____
☐	☐		d) Has any person to be insured been advised to discontinue nicotine use by a physician? If yes, provide details including name and address of the physician, date, and reason.
☐	☐		e) Has any person to be insured been diagnosed with or been told by a physician that he/she has emphysema, chronic bronchitis, any other disease or disorder of the respiratory system, cancer or heart disease? If yes, provide complete details including name and address of physician, date last consulted, reason, etc.

REMARKS: (Specify Question number, name of person(s) to which the answer applies and details)

FRAUD WARNING

The following state(s) and U.S. territories require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state or U.S. territory as indicated below.

ARKANSAS, LOUISIANA and WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: 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.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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

NEW MEXICO: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PUERTO RICO: Any person who knowingly, and with the intention to defraud, includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony, and if found guilty, shall be punished for each violation with a fine of no less than five thousand dollars ($5000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

TENNESSEE , VIRGINIA and WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

ALL OTHER STATES: 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.

ACKNOWLEDGEMENT

I/we, the undersigned, hereby represent that the statements and answers given in the application are true, complete and correctly recorded.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. ☐ Yes ☐ No

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Primary Insured (or parent or guardian if Primary Insured is a minor) Witness to Signature of Primary Insured

X _____ X _____
Signature of Joint Insured or Spouse, if applicable Witness to Signature of Joint Insured or Spouse

Signed at _____ on _____ , _____
City-State Date

X _____ X _____
Signature of Owner (if other than Primary Insured) Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Primary Insured must sign as Owner, give corporate title and full name of corporation below.

_____ X _____
Signature of Producer

_____

_____

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL ADDRESS: _____

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

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

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

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

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

Is a payment submitted with this application? ☐Yes ☐No If yes, complete the following:

$ _____ Check# _____ ☐Credit Card

Attach Check to Page 1 or Complete Credit Card Order Confirmation Form. Do Not Send Cash.

Is contract enclosed? ☐ Yes ☐ No Mail reply to: ☐Agency ☐Contract Owner

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

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

X _____
Signature of Producer

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

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

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

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

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

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

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $250,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age, and $50,000 of Accident Indemnity rider benefits for death by accident. There is no conditional coverage for other riders or any additional benefits, if any, for which you have applied.

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

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

X _____ _____ , 20 _____

Signature of Proposed Owner — Date

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

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

_____ _____

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

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

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

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

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

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

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

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

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $250,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age, and $50,000 of Accidental Indemnity rider benefits for death by accident. There is no conditional coverage for other riders or any additional benefits, if any, for which you have applied.

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

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at_____ on _____ ,20____ X_____

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

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

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

Proposed Owner

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

Unless a Conditional Receipt was issued along with this authorization, I/we agree this authorization shall not become effective for payment of the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

☐ **MONTHLY** (This will be elected if no box is checked)
☐ **QUARTERLY**
☐ **SEMI-ANNUAL**
☐ **ANNUAL**

☐ **PREMIUM**
☐ **LOAN REPAY**
☐ **SAVINGS**
☐ **CHECKING**

☐ **NEW AUTHORIZATION**
☐ **BANK CHANGE**
☐ **ADD TO EXISTING POLICY**
☐ **OTHER** _____

PICK A DATE TO DRAFT (1-28) _____

NAME OF FINANCIAL INSTITUTION: _____
PHONE #: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
ACCOUNT NUMBER: _____
NAME(S) ON BANK ACCOUNT: _____
ROUTING#: _____

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements or riders), or as agreed to by me, and for such other payments as I may authorize the Company to make. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on the earliest due date. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this authorization in no way affects the terms of the policy, other than the mode of payment, and I understand that if the premiums are not paid within the grace period allowed by a policy, as in the event any such withdrawal being dishonored, or for any reason, then the policy shall terminate subject to any nonforfeiture provisions in the policy.

AUTHORIZATION TO HONOR PAC WITHDRAWALS

As a convenience to me, I hereby request the financial institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company and/or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these authorizations.

BANK SIGNATURE(S) OF DEPOSITOR(S) _____ DATE _____ SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR _____

TAPE VOIDED CHECK HERE

NOTICE OF DISCLOSURE OF INFORMATION

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

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

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

Notice to Persons Applying for Insurance: Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

Notice of Insurance Information Practices: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499.