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

APPLICATION FOR LIFE INSURANCE

[ ]

PROPOSED INSURED INFORMATION

1. Name *(First, M.I., Last)*			2. Mailing Address (Cannot be a P.O. Box) City, State, Zip		
3. Home Telephone No. ( )	4. Work Telephone No. ( )		5. Birth Date	Age	6. Birth State / Country
7. Height	8. Weight	9. Marital Status	10. Sex ☐ Male ☐ Female	11. U.S. Citizen ☐ Yes ☐ No	12. *If no, give immigration status/type of visa:*

13. Occupation & Duties	14. Annual Income Current Year ______	15. Social Security No. or Tax I.D. No.
	Annual Income Previous Year ______	16. Drivers License No./ State
	Net Worth ______	17. E-mail Address

18. Have you used any tobacco or nicotine products within the last 5 years? ☐ Yes ☐ No If yes, list type and when used last

BENEFICIARY AND OWNER DESIGNATION *(Unless otherwise noted, the beneficiary of other persons proposed for Coverage will be the proposed Insured.)*

19. Primary	Relationship	Primary	Relationship
Primary	Relationship	20. Contingent	Relationship

OWNER *(Unless otherwise noted, the Owner will be the Insured.)*

21. Name	a. Relationship to Proposed Insured	b. Social Security Number
c. Address (Cannot be a P.O. Box)	d. Birth Date	e. Phone ( )

f. Are you a citizen of ☐ USA ☐ Other Country ______ ☐ Type of VISA ______

POLICY INFORMATION

22. Plan: UL ______ ☐ Level ☐ Increasing	Term ______ Guarantee Period ______	23. Amount of Insurance $	24. Planned Premium $

25. Mode of Payment (for bank draft, complete authorization, and collect initial payment.)
☐ Monthly Bank Draft ☐ Quarterly ☐ Semiannually ☐ Annually ☐ Other ______

26. ADDITIONAL BENEFITS and AMOUNTS

☐ Additional Insured Rider (AIR) $______
☐ Base Insured Rider (BIR) $______
☐ Children's Benefit Rider $______
☐ Accidental Death Benefit Rider (ADB) $______
☐ Disability Income Rider Monthly Payout $______
☐ Guaranteed Insurability Rider (GIR) $______

☐ Waiver of Premium Benefit Rider (WP)
☐ Waiver of Monthly Deduction
☐ Disability Income Rider (AIR) Monthly Payout $______
Occupation/Income ______
☐ Critical Illness Rider $______
☐ Other ______ $______

27. Name of Proposed Additional Insured(s) including any children applying	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco or nicotine products in last 5 years? If yes, list type and when used last.
								☐ No ☐ Yes ______
								☐ No ☐ Yes ______
								☐ No ☐ Yes ______
								☐ No ☐ Yes ______

28. LIFE INSURANCE IN FORCE If none check this box ☐

Insured's Name	Company (only need if replacing)	Policy Number (only need if replacing)	Face Amount
			$
			$
			$

29. DISABILITY INCOME - INSURANCE IN FORCE If none check this box ☐ *Complete only if applying for Disability Rider.*

Insured's Name	Company	Policy Number	Monthly Amount	Benefit Period	Elimination Period

30. GENERAL QUESTIONS Complete the following. *For YES answers, give full details in the space provided in Section 52.*

31. Will the insurance applied for replace or change any existing insurance or annuity? ☐ Yes ☐ No

Have you or any proposed Additional Insured (including any children applying),

32. Had any health, disability or life insurance pending or contemplated with another company? ☐ Yes ☐ No
33. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? ☐ Yes ☐ No
34. Within the past 5 years,
    a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? ☐ Yes ☐ No
    (If yes, provide state and drivers license number.)
    b. Been or is now fully or partially disabled? ☐ Yes ☐ No
    c. Been charged with or convicted of any felony or been on probation? ☐ Yes ☐ No
35. Within the past 2 years, (if yes, complete the Aviation and Avocation Questionnaire)
    a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? ☐ Yes ☐ No
    b. Flown other than as a passenger, or plan to? ☐ Yes ☐ No
36. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? ☐ Yes ☐ No
37. Family History: Is there a history of cardiovascular disease (including coronary artery disease, stroke or transient ischemic attack), internal cancer or melanoma in parents/siblings prior to age 60? If yes, please provide details including, type of cancer (if applicable) and if there was a death due to this condition. ☐ Yes ☐ No
38. Have you or any proposed Additional Insured sought protection from creditors within the past 5 years? ☐ Yes ☐ No
39. Do you or any proposed Additional Insured currently or within the past two years consume six or more alcoholic beverages per week? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. ☐ Yes ☐ No
40. Have you or any proposed Additional Insured had any weight change of 10 or more pounds in the past year? ☐ Yes ☐ No

41. MEDICAL QUESTIONS Each question must be individually asked and answered. *For YES answers, give full details in the space provided in Section 52.*

42. Have you or any proposed Additional Insured (including any children applying) EVER been diagnosed as having or been treated by a member of the medical profession for AIDS, or AIDS Related Complex (ARC)? ☐ Yes ☐ No

(Questions 43 to 49) Within the past 10 years, have you or any proposed Additional Insured (including any children applying) been treated or diagnosed by a health care professional as having any disease or disorder of the:

43. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? ☐ Yes ☐ No
44. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? ☐ Yes ☐ No
45. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? ☐ Yes ☐ No
46. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? ☐ Yes ☐ No
47. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? ☐ Yes ☐ No
48. Endrocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? ☐ Yes ☐ No
49. Cancer, tumor, polyps, melanoma or other malignancy? ☐ Yes ☐ No
50. Have you or any proposed Additional Insured (including any children applying) had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? ☐ Yes ☐ No
51. Are you or any proposed Additional Insured (including any children applying) currently under the observation of a physician or taking medication? ☐ Yes ☐ No

52. ADDITIONAL INFORMATION *Explain all "yes" answers below. If additional space required, use Supplemental Form SA-ADINFO.*

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

53. PERSONAL PHYSICIAN(S) *If additional space required, use Supplemental Form SA-ADINFO.*

Name of Proposed Insured	Personal Physician(s) Name, Address, Phone Number	Date Last Visited, Reason, Result

SECTION 54. ILLUSTRATION CERTIFICATION (Universal Life only)

The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

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 undersigned applicant is the premium payor and Owner of the policy applied for.

I authorize MIB Group, Inc. and its members or affiliates, my employer or former employer, any consumer reporting agency or governmental agency, medical provider, or any insurer or reinsurer to provide medical or personal information about me that is reasonably required for the purposes stated in this authorization to Transamerica Life Insurance Company, its administrators, representatives or its reinsurers. I understand the information obtained by use of the authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance, and eligibility for benefits under an existing policy. This authorization will expire 24 months from the date signed. A copy of this authorization shall be as valid as the original. Either my authorized representative or I may receive a copy of this authorization upon request.

The Company shall have sixty 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 applicant 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 (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Group, Inc. Pre-Notification, (3) Notice of Insurance Information Practices, and (4) Disclosure for Accelerated Terminal Illness Benefit, if required. 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.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

Please make checks payable to Transamerica Life Insurance Company. Do not make checks payable to the agent or leave the payee space blank on your check.

Amount paid with application: $ ______________ **Best time for a personal history interview:** ________ **a.m. / p.m. Okay to contact at work?** ☐ **Yes** ☐ **No**

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.

Dated at ______________________________ this ________________ day of ______________ , ____________
City State Month Year

____
Signature of proposed Insured (if age 15 or over)

____
Signature of proposed Owner (if other than proposed Insured)

____
Signature of Parent or Legal Guardian (if proposed Insured is under 18 and Parent/Guardian has not signed as Owner)

____
Signature of Additional Insured

SECTION 55. TAX NOTICE AND TAXPAYER IDENTIFICATION NUMBER 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 I am not subject to backup withholding because I am an exempt recipient; 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.

Signature of Proposed Owner ______________________________ **Date** ______________

SECTION 56. AGENT INFORMATION & SIGNATURE

Signature of Agent	(Print First and Last Name)	Agent #
( ) Telephone Number	( ) Agent Fax #	Agent E-mail Address
Split Agent Signature (If Applicable)	(Print First and Last Name)	Agent #
( ) Telephone Number	( ) Agent Fax #	Agent E-mail Address

- Did you ask all questions on the application in the presence of all proposed Insureds, record the answers as given, and witness all signatures? ☐ Yes ☐ No
  If not, please provide details. ______________________________
- Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? ☐ Yes ☐ No
  (If yes, submit the state required forms.)

CONDITIONAL RECEIPT

(Detach and leave with applicant only if money is submitted with application. **If within the past 12 months any proposed Insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.** Do not accept money unless all required signatures below are obtained.)

PLEASE READ THIS CAREFULLY

No coverage will become effective prior to the delivery of the policy applied for unless and until all conditions of this receipt have been fulfilled exactly. No agent or field representative is authorized to waive or modify any of the provisions of the Conditional Receipt.

Make all checks payable to the Company. Do not make checks payable to the agent or leave the payee blank or you may jeopardize the insurance for which you have applied.

Received from ____, the sum of $______________________________ for the insurance application dated ________________, with ____________________________________ as the proposed Insured(s). The policy you applied for will not become effective unless and until a policy contract is delivered to you and all other conditions of coverage are met. However, subject to the conditions and limitations of this Receipt, conditional insurance under the terms of the policy applied for may become effective as of the later of (1) the date of application and (2) the date of the last medical examination, tests, and other screenings required by the Company, if any (the "Effective Date"). Such conditional insurance will take effect as of the Effective Date, so long as all of the following requirements are met:

1. Each person proposed to be insured is found to have been insurable as of the Effective Date, exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;
2. As of the Effective Date, all statements and answers given in the application must be true;
3. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
4. All medical examinations, tests, and other screenings required of the proposed Insured by the Company are completed and the results received at our Administrative Office within 60 days of the date the application was completed; and
5. All parts of the application, any supplemental application, questionnaires, addendum and/or amendment to the application are signed and received at our Administrative Office.

Any conditional coverage provided by this Receipt will terminate on the earliest of: (a) 60 days from the date the application was signed; (b) the date the Company either mails notice to the applicant of the rejection of the application and/or mails a refund of any amounts paid with the application; (c) when the insurance applied for goes into effect under the terms of the policy applied for; or (d) the date the Company offers to provide insurance on terms that differ from the insurance for which you have applied.

If one or more of this Receipt's conditions have not been met exactly, or if a proposed Insured dies by suicide, the Company will not be liable except to return any payment made with the application.

If the Company does not approve and accept the application for insurance within 60 days of the date you signed the application, 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(s) you have made upon return of this Receipt to the Company.

The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company shall be limited to the lesser of the amount(s) applied for or $500,000 of life insurance. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

Authorization (Signatures Required)
I certify that I have read and reviewed the Conditional Receipt and the acknowledgment of the applicant and proposed Insured in the application. The terms and conditions of the conditional receipt have been explained to me fully by the agent and I understand them.

Dated at ____ on _______________ ____

City State Date Signature of Agent or Authorized Company Rep

____ ____

Signature of proposed Insured Signature of Applicant (if other than proposed Insured)

DETACH AND LEAVE THIS PAGE WITH APPLICANT

**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

To proposed Insured: Information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make a brief report on this information to MIB Group, Inc., a non-profit membership organization of insurance companies that 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 may, upon request, 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. 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, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 866-692-6901 (TTY 866-346-3642 for hearing impaired).

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual 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 THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

AGENT'S REPORT

How well do you know proposed Insured? ____________________

	Yes	No
Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance? *(If "yes", explain in Remarks Section)*	☐	☐
Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?) *(If "yes", explain relationship ____________________)*	☐	☐
Did you see all of those to be insured on the date the application was written? *(If "no", explain in Remarks Section)*	☐	☐

Rate Class:

- ☐ Preferred Elite
- ☐ Preferred Plus
- ☐ Preferred
- ☐ Non-Tobacco
- ☐ Preferred Tobacco
- ☐ Tobacco

	Agent No.	% if Split
1. Agent's Name		
2. Agent's Name		

COMPLETE ONLY IF THE OWNER OR PAYOR IS OTHER THAN INSURED

What is the relationship of the Owner to the primary Insured (please explain)?

____

What is the relationship of the Payor to the primary Insured (please explain)?

____

ADDITIONAL REMARKS

I submit this application assuming full responsibility for delivery of any policy issued and for payment to the company of the first premium, when collected. I know of no condition affecting the insurability of the proposed Insured not fully set forth herein. I will not deliver the policy if the health of the Insured has changed.

____

Signature of Writing Agent

PRE-AUTHORIZED WITHDRAWAL PLAN

I/we, the undersigned, hereby authorize and request ______________________________ to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my/our account indicated on the attached check (or the information provided below) for premiums and other such payments that may become due in any amount under this policy. I/we request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I/we agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I/we understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This Authorization may be terminated by either party by giving written notice to the other.

INITIAL PAYMENT (MUST CHECK ONE BOX)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we 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.

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.

ACCOUNT INFORMATION

TAPE VOIDED CHECK HERE
(Place tape along TOP of check)

If not attaching void check or if withdrawing from Savings Account, complete the following information

____
Bank Name, Office or Branch

____
Bank Address | City | State | Zip Code

Check one: ☐ Checking ☐ Savings

____
Payor Name(s)

______________________________ ______________________________
Transit Routing Number | Account Number

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

Premium to Withdraw	
$ ______________	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked) ☐ Withdraw on a different day of the month; choose a day between 1 and 28 __________

SIGNATURE

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X______________________________ **Date:** ______________

Life Investors Insurance Company of America
Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
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 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.

Please return this original copy to Company

Life Investors Insurance Company of America
Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
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 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.

Applicants should retain this signed copy for their records

☐ **Life Investors Insurance Company of America**
☐ **Monumental Life Insurance Company**
☐ **Stonebridge Life Insurance Company**
☐ **Transamerica Life Insurance Company**
☐ **Western Reserve Life Assurance Co. of Ohio**

4333 Edgewood Road NE, Cedar Rapids, IA 52499

Notice and Consent for HIV-Related Testing GEORGIA

Notice And Consent For FDA Approved Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing

To determine your insurability, the Insurer designated above ("the Insurer") has requested that you provide a sample of your blood, urine and/or other bodily fluid(s) for FDA approved testing and analysis. All tests will be performed by a licensed laboratory.

Tests may be performed to determine the presence of antibodies or antigens to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the insurer, the insurer may disclose test results to others such as its affiliates, reinsurers, independent contractors, and its employees to whom disclosure is reasonably necessary in the ordinary course of business to carry out the purposes for which that disclosure is authorized or required. If the insurer is a member of the Medical Information Bureau ('MIB, Inc'.), and if the test results for HIV antibodies/ antigens are other than normal, the insurer will report to the MIB, Inc., a generic code which signifies only a nonspecific test abnormality. The test results may also be disclosed to any member company that receives an application for health or life insurance on your life. If your HIV test is normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc., in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

I have read and I understand this *Notice and Consent for HIV-Related Testing Which May Include AIDS Virus (HIV) Antibody/Antigen Testing*. I voluntarily consent to provide a sample of blood, urine and/or bodily fluid(s), the FDA approved testing of that sample and the disclosure of the test results as described above. I understand that this consent shall be valid for thirty (30) months following the date shown below.

I understand that I have the right to request and receive a copy of this authorization. A photocopy or transmitted facsimile of this form will be as valid as the original. I also have the right, upon written request, to an insurance institution (insurers), agent, or insurance support organization for access to recorded personal information and copy of same within thirty (30) business days from the date such request is received. I have the right to request, in writing, that any recorded personal information be corrected, amended, or deleted within thirty (30) business days from the date of receipt of my written request by an insurance institution, agent, or insurance support organization. If my request is not honored, I have the right to file a concise statement of the correct, relevant or fair information; and the reasons why I disagree with such refusal to correct, amend, or delete recorded personal information.

Proposed Insured (Please Print)	Date of Birth
Signature of Proposed Insured or Parent/Guardian	Date Signed
	State of Residence

- ❑ Life Investors Insurance Company of America
- ❑ Western Reserve Life Assurance Co. of Ohio
- ❑ Transamerica Life Insurance Company
- ❑ Peoples Benefit Life Insurance Company
- ❑ Monumental Life Insurance Company
- ❑ Stonebridge Life Insurance Company

Terminal Illness Accelerated Death Benefit Disclosure Form

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy to not more than 24 months from the date of the physician's statement. The company requires proof of a terminal condition, including an attending physician's statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy's specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

By signing below, you agree that you have read and received a copy of this disclosure form.

____
Date

____
Owner's (Applicant's) Signature

____
Agent's Signature

IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.