TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

TransElite Universal Life Application

☐ First Application ☐ Add Dependents – Contract # _____ ☐ Increase Coverage – Contract # _____

Group Name | Group Number | Location

Applicant Information
required for all coverage

Name *(Last, First, M.I.)*	☐ Male ☐ Female	Social Security No.	Date of birth	Cell or home phone
Home address		City	State	Zip code
Email address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No		Tobacco user in the last year? ☐ No ☐ Yes *Answer if rates are tobacco distinct.*	
Date of hire	Weekly hours worked	Annual salary	Occupation	Applicant ID	Work phone/ext.

Protection against unintended lapse: I understand I have the right to designate at least one person other than myself to receive notice of lapse or termination of this coverage for nonpayment of premium. I understand notice will not be given until thirty days after premium is due and unpaid.
☐ I elect NOT to designate any person to receive such notice.

Secondary Addressee Name	Home Address	City	State	Zip code

Dependent Information
if applying for dependent coverage

Name *(Last, First, M.I.)*	Gender	Relationship to applicant	Date of birth	Social Security No.	Tobacco user in the last year? *Answer for Spouse or Civil Union/Domestic Partner**
	☐ M ☐ F				☐ No ☐ Yes
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				

Beneficiary

Name *(Last, First, M.I.)*	Address	Relationship	Phone #	Social Security No.
Primary				
Contingent				

Applicant will be the beneficiary for any dependent coverage

Benefit Selections

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Universal Life

☐ TransElite Universal Life Option: ☐ A (level) ☐ B (increasing)	Universal Life Face Amount	Automatic Increase Option Rider	Premium
☐ Applicant	$	☐ Yes ☐ No	$
☐ Spouse or Civil Union/Domestic Partner	$	☐ Yes ☐ No	$
☐ Children	$		$
*Attach Child Term Rider to ☐ Applicant ☐ Spouse or Civil Union/Domestic Partner			$

Term Rider* Face Amount	Premium
$	$
$	$
$	$
	$

Dependents can be covered under UL or Term Rider, but not both

Total Premium $

Life Insurance Owner (if different than Applicant)	Address	Relationship	Social Security No.

**The terms "Civil Union" or "Domestic Partner" are not recognized in all states.*

Eligibility Questions

1. *Employer Groups:* Are you actively at work on a full-time basis and able to perform the duties of your occupation? *Member Groups:* Are you a member in good standing and able to perform the normal activities of someone of like age? If "no", you and your dependents are not eligible for coverage.	☐ No ☐ Yes
2. If applying for dependent coverage, is any proposed insured currently disabled? If "yes", list names _____, who are not eligible for coverage.	☐ No ☐ Yes

If you answer "no" to question #1, no coverage will be issued. Anyone named as being ineligible on question 2 will be automatically excluded from coverage.*
**Residents of MD and NH cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions Part 1: Please answer the following questions to the best of your knowledge and belief.	
3. In the past six months, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any accident or sickness, except for normal pregnancy? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes
4. In the past five years, has any proposed insured had an actual diagnosis or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? *(Residents of CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.)* *(Residents of FL:* In the past five years, has any proposed insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded – You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions Part 2: Please answer the following questions to the best of your knowledge and belief.	
5. Indicate Height and Weight: Applicant	/
Spouse or Civil Union/Domestic Partner	/
6. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession for any heart (including heart attack), circulatory, vascular (including stroke), blood, brain, digestive, kidney, liver, lung, musculoskeletal, respiratory, rheumatoid, neurological, pancreas, reproductive, or other major organ disorders, cancer or malignancy in any form (except non-melanoma skin cancer), diabetes, Optic Neuritis, blood transfusion, chronic fatigue syndrome, fibromyalgia, high blood pressure requiring more than two medications to control, or been treated or counseled in the past two years for alcohol or drug abuse? *(Residents of FL: diagnosed or treated by a licensed physician) (Residents of ME: exclude HIV related diseases)* If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

For further consideration for anyone who fails to qualify for coverage above, provide details of all "yes" answers to questions 2, 3, 4, & 6.
(Residents of FL: Do NOT provide details regarding "yes" answers to question 4)
Anyone found to be acceptable will be added to your coverage via an endorsement.

Question #	Name	Please list: Illness, Injury, Condition, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Life Replacement

Residents of AL, AK, AZ, CO, HI, IA, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI, or WV:
Answer question L1. If "yes", complete a life replacement form for your state and return with this application.

Residents of AR: Answer questions L1 and L2. If "yes" to question L2, complete a life replacement form for your state and return with this application.

Residents of all other states: Answer question L2. If "yes", complete a life replacement form for your state and return with this application.

L1. Do you currently have any other existing life insurance policies or contracts? ☐ No ☐ Yes

L2. Is the insurance being applied for intended to replace or change any existing life insurance coverage? ☐ No ☐ Yes (provide details)

Which product(s)	Name of existing insurance company	Policy/certificate #

Universal Life and Whole Life Illustration Acknowledgement

I certify that a life insurance illustration showing non-guaranteed values was not used during the sale of the insurance coverage I am applying for on this application. I understand that if my application is approved, an illustration conforming to the policy/certificate as issued will be delivered to me no later than when I receive my policy/certificate. I understand that any non-guaranteed elements contained in any illustration are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgment, and will return a copy of the signed illustration to the Insurer.

Life Accelerated Death Benefit Disclosure Acknowledgement

If applying for an Accelerated Death Benefit Rider, did you receive the applicable Disclosure, if required in your state?
ADB for Chronic Condition Rider ☐ Yes ☐ No ADB for Critical Condition Rider ☐ Yes ☐ No ADB for Terminal Condition Rider ☐ Yes ☐ No

Applicant Statement and Agreement

I have read or had read to me the completed application. I represent *(Residents of MN and VA: I certify)* that all statements and answers made on or attached to this application are true to the best of my knowledge and belief. I realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

AL, DC, LA, & RI: 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.

CA: I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.

FL: I understand that 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.

KS: 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 may be guilty of insurance fraud as determined by a court of law.

KY: 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, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

MA, NC & OR: I understand that 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, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

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

NJ: I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OK: 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.

TN & WA: It is a crime to knowingly present 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.

VA: I understand that any person who, with the 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 may have violated state law.

VT: I understand that 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, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

ME and all other states: 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.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage. I understand that coverage will take effect only if this application is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate to which this application is attached.

Signed in (City/State) _____ Date: _____

Signatures _____ _____

Applicant Adult Dependents (where required)

Licensed Agent/Representative Statement and Agreement

I certify that I have accurately recorded on this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

I certify that this insurance does not replace or change any existing life insurance coverage, except as noted under Life Replacement.

(For applications written in North Carolina – To the best of your knowledge, does any applicant currently have any other existing life insurance policies or contracts? ☐ No ☐ Yes If yes, be sure the applicant completes a life replacement form for your state and return with this application.

(For applications written in Utah – I certify that I am not aware of any existing life insurance coverage, except as noted under Life Replacement.)

I certify that a life insurance illustration was not used in connection with this application (but a company-provided rate sheet may have been used and no non-guaranteed values were shown to the applicant)

I certify that I have provided any applicable outline of coverage and life accelerated death benefit disclosure forms.

Name _____ Signature _____ Agent # _____ License # _____

Authorization to Release Information

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Insurer, or its reinsurers, any such information.

Residents of MN: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Emergency medical personnel includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards (including security guards at the Minnesota security hospital) who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan Law.

I hereby authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to the Medical Information Bureau*. I understand the information obtained by use of this Authorization will be used by Insurer to determine eligibility for insurance. Any information obtained will not be released by Insurer to any person or organization except to reinsuring companies, the Medical Information Bureau*, 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 authorize. I know that I, or any person authorized by me, may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for 24 months from the date shown below. *(Residents of MN: I agree that this Authorization shall be valid as long as any proposed insured is continually insured with Transamerica Life Insurance Company.)* I understand that I may revoke this authorization at any time by sending written notice to Transamerica Life Insurance Company.

Signed in (City/State) _____ Date: _____ Signatures _____ _____
Applicant Adult Dependents

*Information regarding your insurability will be treated as confidential. The Insurer, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Insurer, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.