

Universal Life Insurance

PROVIDES A BENEFIT TO A LOVED ONE IN THE EVENT OF A FATAL OCCURRENCE

This is your opportunity to apply for additional insurance to supplement your core benefits.

These insurance policies can help protect your financial future. Enroll today!

Universal Life rates are projected to stay the same throughout the life of your policy.

Other insurance plans (such as term life) increase in price on a regular basis.

- Guaranteed insurance benefits among the highest in the industry
- Benefit Flexibility select what fits your budget
- Cash Value Accumulation account enables policy flexibility
- Portability Keep the plan if you leave your employer with no change in the rate
- Ability to purchase insurance on dependents
- Includes Accidental Death and Dismemberment, which doubles your insurance in the event of an accidental death*

Guaranteed Acceptance

No Medical Questions as a NEW employee!

Employee - \$150,000

Spouse - \$15,000

Child - \$25,000

- You may apply for up to \$500,000 (up to 5 times your annual salary)
- If you apply for benefits greater than 5 times your annual salary, your benefit will be reduced to match what you are eligible for.
- If you are applying for:
 - Over \$150,000 for yourself OR
 - Over \$15,000 for your spouse

You will need to complete a medical questionnaire. Please contact the representative below.

Accidental Death and Dismemberment is available to employees under age 70.

If you have questions about your enrollment, need help with the application or pricing or are applying for more that the guaranteed issue amounts for you or your spouse, please contact your HR department.



Transamerica Life insurance Company ("Insurer") Home Office: Cedar Rapids, IA Administrative Office: P.O. Box 8063 Little Rock, AR 72203-6063

TransElite Universal Life Application

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	bility Questions	THIN TO	mıs "Civil Union" ol	LADMOSIIC PAN	niet. aus vo	u recognized hi	ali slutas			
1.	Employer Groups: Are you actively	r at work of	r a full-time bas	is and able l	o perfora	n the duties o	of your	occupation?		
	Member Groups: Are you a memb If "no", you and your depend	er in good	slandino and ai	ole to perford	n the non	mal activities	of son	neone of like ag	je?	☐No ☐Yes
2.	If applying for dependent coverage If "yes", list names	, is any pro	posed insured	currently dis	abled?	who ar	a jon s	ligible for cover	age.	□No □Yes

If you answer "no" to question tist, 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.

A SVI (LENI)	of Insurability Gue	ations Part 1. Please answer the following questions to the best of your knowledge and belief.	
] 3. In th	ıə past six monthe, h	as any proposed insured been hospitalized (inputient or outpatient) or missed more than five	
cans	secutive days of world If "yes", fisl name	k due to any accident or sickness, except for normal pregnancy?	□No □Yes
4. In th	e past five years, ha	s who do not qualify for coverage. s any proposed insured had an actual diagnosts or treatment by a member of the medical profession	a teritorial security of the state of the st
for A	Acquired Immune De	ficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	
(Res	ildents of OA: Celifor Aning health insuranc	nia law prohibits an HIV test from being required or used by health insurance companies as a condition of	and the second tree
(Res	ittents of FL: In the p	past five years, has any proposed insured been tested positive for exposure to the HIV infection or	INO II Yes
i beek	n diagnosed as havir	19 ARC or AfDS caused by the HIV infection or other sickness or condition derived from such infection?	ı
Arivon	if "yos": list name e named as not qualifying	s for coverage Will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded	and the state of t
1 1119 021	Residents of MO t	annot be notomětodky excluded – You múst sign an endorsement form acknowledging these exclusione before coverege cán be is	sued.
Evidence	Militarica Billio One	stions Part 2: Please answer the following questions to the best of your knowledge and belief.	
5. India	cate Height and Weig	tht; Applicant	
Commentation parties with Windson		Spouse of Civil Union/Domesile Partner	Control of the Contro
6, In th	o past five years, ha	s any proposed insured been diagnosed or treated by a member of the medical profession for any	
resp	r (morgany neart arc iratory, rhaumatoid,	aok), circulatory, vascular (including stroke), blood, brain, digestive, kidney, liver, lung, musculoskeletal, neurological, pancreas, reproductive, or other major organ disorders, cancer or malignancy in any form	
(exc	ept non-melanoma s	kin cancer), diabetes, Optic Neuritis, blood transfusion, chronic fatique syndrome, fibromyaldia, high	port to a port to the same
bloo	d pressure requiring	more than two medications to control, or been treated or counseled in the past two years for alcohol or	□No □Yes
	abuse? Idents of FL: disanos	od ortreated <u>by a licensed physician)</u> (Residents of ME; exclude HIV related diseases)	
gray was good bell and such a philipsium	If "yes", list name:). Who do not qualify for coverage. (or coverage will have coverage reduced to the Suaranteet Issue amount, or, if Guaranteet Issue in not available, will be exclude	
Anyon	e named as not qualifying Residents of MD o	l or coverage will have coverage reduced to the Gueranbeet Issue amount, or, if Quaranteed Issue is not available, will be exclude annot be automatically excludedYou must sign an endorsement form acknowledging (bese exclusions before coverage can be is	d from coverage". smet
Marita en autoria de la francesa de la marita		Name of the state	and water
	For further cons	ideration for anyone who falls to qualify for coverage above, provide details of all 'yes' enswers 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, F	Result, Current Health
Guestary	(भव्या । एव	Status, Prognosis, Name & Address of Doctor or Hospital. For Fligh Blood Pressure, please indicate most reading, name of any medications and dosage,	ecent picea pressure
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	Foliation A. AZ. CO	, HI, IA, LA, MD, ME, MS, MT, NG, NE, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI, or WV:	
Answ	er question i.t. If "y	es", complete a life replacement form for your state and return with this application.	
Resident	s of AR: Answerque	astions 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 applic	atlon.
li. Do	you currently have a	any other existing life insurance policies or contracts? 🛘 🖂 No 🖂 Yes	
L2, Is		applied for Intended to replace or change any existing life insurance coverage? ☐ No ☐ Yes (provi	de detalls)
Which	h product(s)	Name of existing insurance company Policy/certificate #	
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l certify th	ant a life insurance	e Musication Acknowledgement Musication showing non-guaranteed values was not used during the sale of the Insurance cover	áde l am abolvíno
for on this	s application. Lund	erstand that if my application is approved, an illustration conforming to the policy/certificate as issued wil	I be delivered to me
no later th	an when I receive my	y policy/certificate. I understand that any hon-guaranteed elements contained in any litustration are subj and that they are not guaranteed. I will review the illustration, sign the acknowledgment, and will return	ect to change and
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Life Acce	erater Dealissere	fit Disclosure Acknowledgement	
If applying	for an Accelerated t	Death Benefit Rider, dld you receive the applicable Disclosure, if required in your state?	lende i 2 - Sente S. Is
ADB for	unronic Condition Ri	der ☐ Yes ☐ No. ADB for Critical Condition Rider ☐ Yes ☐ No. ADB for Terminal Condition Rider	·∐Yes □No

Applicant Statement and Agreement

Signed in (City/State)

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 be 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.
- <u>MJ</u>: 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.
- <u>VA</u>: 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 faise 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.

Date:

Signatures				
	Applicant	Ad	ult Dependents (where requi	ired)
Licensed Agent/Representative	Statement and becaused			
I certify that I have accurately recitive completed application.	orded on this application all of the info	rmation supplied by the applicant.	The applicant has rea	d or had read to him/her
(For applications written in No	tot replace or change any existing life lorth Carolina – To the best of your k LTYes If yes, be sure the applicant Itah – I certify that I am not aware of t	nowledge, does any applicant cun t completes a life replacement form	rently have any other e n for your state and ret	xisting life insurance um with this application.
	ation was not used in connection with			
I certify that I have provided any	applicable outline of coverage and life	accelerated death benefit disclosu	ire forms.	
Name	Signature	A	gent#	_ License #
CUL-AP-04-00	Pac	19 3 of 4		

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 of 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 effender 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 amargency services; ilcensed police officers, firefighters, parametics, emergency medical technicians, licensed nuises, rescue squad personnel or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; orime lab personnel, correctional guards (including security guards at the Minnesota security hospital) who experience a significant exposure to an immate who is transported to a fecility 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 quality for immunity under the good Semarifan 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 of 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 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		i
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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 Sureau, a non-profit membership organization of life insurence companies, which operates an information exchange on behalf of its members. If you apply to enother 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 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 health insurance, or to whom a claim for benefits may be submitted.

TransElite HFA - Universal Life Insurance Form: CPGUL300

With Riders: TI, WML, ADD

Non-Tobacco Death Benefit Option: A ÉTRANSAMERICA"

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[†] Face Amount is insufficient to require the minimum planned premium.

Solve for Parget Premium - A 100

^{*} Guaranteed values are based on the minimum interest rate of 3.00% and maximum face and charges. Non-Quaranteed values are based on a current illustrated interest rate of 5.25% and current fees and charges and are not guaranteed. Values are affected by the actual interest rates or dited and cost of instrumed rates charged. Non-Quaranteed character are subject to change by the company. Actual results may be more or less favorable than shown. WML not included in Issue Ages 56+. Issue Ages 66+ do not include the ADD Rider. Tr. LBR, EXT, RES not included in Issue Ages 76+. The Child Term Rider may be added for additional premium of \$1.15 BiWeekly26 per \$10,000.

TransElite HFA - Universal Life Insurance Form: CPGUL300

With Riders: TI, WML, ADD

Tobacco Douth Benefit Option: A



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[†] Face Amount is insufficient to require the minimum planted premium.

Solve for Turget Premium - A100

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A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

- TransElite HFA Universal Life Insurance: HFA policies have flexible premiums and an accumulation value to provide the greatest death benefit amount per premium dollar and are ideal for those who want a higher death benefit, but are not interested in a high cash value accumulation. The premium is expected to provide coverage to the later of age 80 or 10 years, with no cash value expected at the coverage period's end. HFA policies have a minimum guaranteed interest rate and a maximum guaranteed cost of insurance. The premium is expected to sustain the policy to the later of age 80, or 10 years however, skipped or reduced premium payments, changes in the non-guaranteed interest rate or charges, or acquiring a policy loan, a partial surrender, or a face amount increase could require additional payments. Coverage may be extended to age 100 and could require additional payments.
- Accelerated Death Benefit for Terminal Condition Rider (Form CRLT1100): Lets the insured "tap into" life insurance in the event of a future terminal condition diagnosis and still provides a benefit for the beneficiary.
- WML Waiver of Monthly Deductions Due to Layoff or Strike Rider (Form CRLWL100): Protects life insurance from lapsing for up to six months if the insured (employee only) is involuntarily laid off.
- ACCIdental Death and Dismemberment Rider (Form CRLAD100): Provides an additional death benefit if the insured employee or spouse dies as the result of an accidental bodily injury. A specified percentage (25% to 100%) of the accidental death benefit, is payable for specific dismemberments caused by a covered accidental bodily injury. As an added benefit under the rider, where permitted, we will pay 3% of the AD&D death benefit-up to \$3,500-for qualified elder care, surviving spouse job training, surviving child education, and surviving child care. The AD&D benefit amount is the same as the face amount of the base Certificate, up to a maximum AD&D coverage amount of \$150,000. (This benefit is in addition to any life insurance death benefit.)



TransElitesM universal life insurance, underwritten by Transamerica Life Insurance Company

Child Rate Sheet
Monthly Premium for \$25,000 Child/Grandchild Co.

	Policy	for \$25,0 Policy	
ξE	Monthly	Bi-Weeky Premium	
0	\$13.00	\$6.00	
1	\$13.00	\$6.00	
2	\$13.00	\$6.00	
3	\$13.00	\$6.00	- prie file angles en la
4	\$13.00	\$6.00	7/95
5	\$13.00	\$6,00	
6	\$13.00	\$6.00	NAME OF TAXABLE PARTY.
7	\$13.00	\$6.00	- Warper colored and distributed in the
8	\$13.00	\$6.00	Market State Section
9	\$13.00	\$6.00	enegativa de Julia da Cilippen
10	\$13.00	\$6.00	
11	\$13.26	\$6.12	The state of the s
12	\$13.69	\$6.32	
13	\$14.29	\$6.60	And the Parish of the Parish o
14	\$14.74	\$6.80	Distanting the Party of
15	\$15.36	\$7.09	
16	\$15.64	\$7.22	Side introduces personal and
17	\$15.92	\$7.35	and the same of th
18	\$16.22	\$7.49	And the second
19	\$16.52	\$7.62	
20	\$16.85	\$7.78	migraphic prospilation with these extensions over
21	\$17.18	\$7.93	
22	\$17.55	\$8.10	100 4 4 4 4 4 4 4 5 5 5 6 6 6 6 6 6 6 6 6 6
23	\$17.93	\$8.28	The state of the s
24	\$18.33	\$8.46	to provide a series of the second section of
25	\$18.75	\$8.65	
26	\$19.21	\$8.87	