Reset Form

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

LIFE APPLICATION

Part A1 – Producer

Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

Part A2 – Plan & Rider Information

Plan	Face Amount	Total Premium
	$	$

Rate Class applied for:

❑ Preferred Non-Tobacco ❑ Preferred Tobacco
❑ Standard Non-Tobacco ❑ Standard Tobacco
❑ Graded

Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) ❑ Yes ❑ No

Child / Grandchild Rider? $_____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) ❑ Yes ❑ No

Part A3 – Proposed Insured

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

D.O.B. (MM/DD/YYYY)	U.S. State or Country of Birth	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country?_____
		If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number_____

Gender	SSN	Phone Number for Interview	Best time to call
		( )	a.m. p.m.

Part A4 – Owner (If Other Than Proposed Insured)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Phone Number	D.O.B. (MM/DD/YYYY)	Gender	Are you a citizen of the United States? ❑ Yes ❑ No If "NO," what Country?_____
( )			If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No If "YES," VISA type and number_____

SSN	Relationship to Insured

Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)

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

Part A6 – Existing Insurance

1) Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? ❑ Yes ❑ No

2) Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? ❑ Yes ❑ No

If answer is yes for questions 1 and/or 2, submit the state required forms and please provide company name and policy number.

_____

3) Is this to be a 1035 exchange? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

Part B1 – Initial Premium Payment Method

❑ By check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual.

Is the check for initial premium payment on the same account as monthly EFT payments? ❑ Yes ❑ No

❑ By payroll deduction or allotment.

❑ Draft initial premium upon receipt from the account below.

❑ Draft initial premium at future date from the account below. Please indicate the month and day (mm/dd): _____/_____

Month **Day (1st thru 28th only)**

If you select an initial premium draft date in the future, it may not be greater than 30 days after the application date and the recurring draft date below must be the same day of the month as the initial premium draft date. If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

Part B2 – Premium Payment Authorization For Electronic Funds Transfer (EFT): Payor's Authorization To Insurance Company

As a convenience to myself, I hereby authorize Transamerica Premier Life Insurance Company to draft premium payments from my financial institution account.

It is understood that credit for payment is conditioned upon the draft being honored when presented for payment. Furthermore, this authorization may be terminated (a) at the option of Transamerica Premier Life Insurance Company if any draft is not honored when presented for payment; or (b) by Transamerica Premier Life Insurance Company, financial institution or the undersigned upon 30 days written notice to the parties hereto.

If this authorization is terminated, the amount due on the policy involved will be billed on a quarterly basis.

❑ Checking ❑ Savings Financial Institution Name: _____ City/State: _____

Account #: | | | | | | | | | | | | | | | | | | |

Routing #: | | | | | | | | | |

No debit card numbers please

Recurring Draft Date (1st-28th):_____ If no recurring draft date is selected, the draft date will be the same day of the month as the Policy Date.

Payor Signature (if other than proposed Insured or Owner)_____ Date: _____

Part B3 – Recurring Payment Method

EFT

❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Payroll Deduction

Special Frequency _____

❑ List Bill ❑ Civil Service Allotment ❑ Military Allotment

Requested Effective Date _____

Automatic Premium Loan provision (if available)? ❑ Yes ❑ No

Part B4 – Payor Information

The Payor is the ❑ Proposed Insured ❑ Owner ❑ Other (If Other, please provide the following information:)

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)	
SSN	Relationship to Insured	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part B5 – Secondary Addressee

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)

Last Name and Last 4 Digits of SSN: _____

Part C1

Within the last 12 months has the proposed Insured used tobacco products in any form? ❑ Yes ❑ No

If a policy cannot be issued as applied for, would you accept a rated policy if available? ❑ Yes ❑ No

If 'yes,' adjust face amount to premium? ❑ Yes ❑ No

Part C2

1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care, or has the proposed Insured been advised or is the proposed Insured planning to have inpatient surgery? ❑ Yes ❑ No
2) Has the proposed Insured **ever**:
   a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's, dementia, memory loss, organic brain disease, mental incapacity, Lou Gehrig's disease (Amyotrophic Lateral Sclerosis), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months? ❑ Yes ❑ No
   b) Tested positive for the antibodies to the AIDS virus or been medically diagnosed with or received treatment for HIV (Human Immunodeficiency Virus), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ Yes ❑ No
   c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ❑ Yes ❑ No
   d) Received or been advised to receive an organ transplant other than corneal? ❑ Yes ❑ No
3) Within the past **2 years** has the proposed Insured:
   a) Had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
   b) Undergone testing by a medical professional for which the results have not been received or been advised to have any surgical operation, diagnostic testing other than for routine screening purposes, treatment, hospitalization or other procedure which has not been done? ❑ Yes ❑ No

Part C3

4) Has the proposed Insured been diagnosed with diabetes (other than gestational diabetes) before the age of 18? ❑ Yes ❑ No
5) Within the past **4 years** has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)? ❑ Yes ❑ No
6) Within the past **1 year** has the proposed Insured:
   a) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs), or muscular dystrophy? ❑ Yes ❑ No
   b) Had more than 12 seizures; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ❑ Yes ❑ No
   c) Had, been diagnosed with, been treated for or advised to receive treatment for aneurysm or angina; or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant? ❑ Yes ❑ No
   d) Had a heart attack, stroke (Cerebrovascular Accident), or transient ischemic attack (TIA)? ❑ Yes ❑ No
   e) Used oxygen to assist in breathing (including Sleep Apnea); received kidney dialysis; or had, been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder? ❑ Yes ❑ No
7) Within the past 2 years has the proposed Insured used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance. ❑ Yes ❑ No

Part C4

8) Within the past **2 years** has the proposed Insured:
   a) Had, been diagnosed with, been treated for or advised to receive treatment for angina (chest pain); aneurysm; vascular, circulatory or blood disorder; heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or irregular heart rhythm such as atrial fibrillation? ❑ Yes ❑ No
   b) Had a heart attack, stroke (Cerebral Vascular Accident) or transient ischemic attack (TIA)? ❑ Yes ❑ No
   c) Had more than 12 seizures; used insulin; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease? ❑ Yes ❑ No
   d) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs)? ❑ Yes ❑ No
9) Within the past **4 years** has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for kidney disease? ❑ Yes ❑ No
10) Has the proposed Insured **ever** been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease? ❑ Yes ❑ No

Part C5 – Nursing Home Option

Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home? ❑ Yes ❑ No

Last Name and Last 4 Digits of SSN: _____

AGREEMENT / AUTHORIZATION

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S) –Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are representations and not warranties. 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 Transamerica Premier Life Insurance Company can change the terms of this application or the terms of any insurance issued by Transamerica Premier Life Insurance 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 Transamerica Premier Life Insurance Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

I have received the MIB Disclosure Notification, Notice to Persons Applying For Insurance, Accelerated Death Benefit Disclosure and Conditional Receipt.

I hereby authorize any licensed physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, health maintenance organization or other medical or medically related facility, insurance company, MIB, Inc. ("MIB"), employer, consumer reporting agency, or government body or institution that has any records or knowledge of me or my health, to give personal information to Transamerica Premier Life Insurance Company, or its reinsurers. Personal information includes health records (including mental health records), criminal and driving records, prescription drug records, alcohol or drug use records, insurance claim and application records and financial and employment records. Any personal information provided may be used for purposes of underwriting, claim and contestability review(s), including determining eligibility for insurance. I authorize Transamerica Premier Life Insurance Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB. A photographic copy of this authorization shall be as valid as the original.

This authorization will be valid for 30 months from the date of signature, but I understand that I may revoke it at any time by giving written notice to Transamerica Premier Life Insurance Company at the above address. I understand that there are limitations on my right to revoke this authorization. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. If this authorization is used to collect information in connection with a claim for benefits, it will be valid for the duration of the claim. If the law of my state so provides, my authorization may not be revoked during a contestable investigation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by Transamerica Premier Life Insurance Company (or Transamerica Premier Life Insurance Company becomes obligated to report such codes to MIB) while this authorization is in force. I understand that I have or my authorized representative has the right to receive a copy of the authorization if requested.

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, subject to any incontestability provision of such insurance.

FRAUD WARNING: 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 the state law.

Signed Date _____ Signed at City _____ State _____

_____ _____

Proposed Insured Signature Owner Signature (If Owner other than Insured)

_____

Producer Signature

Does the proposed Insured have existing life insurance policies or annuity contracts? ❑ Yes ❑ No

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

_____

Producer Signature

If the EFT premium payment method is chosen, please tape a voided check in this box.

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name:______________________ Social Security Number: ______________________

Additional Information

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

Additional Information

Child / Grandchild Rider Information

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

Contingent Owner

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

Signed Date______________ Signed at City______________ State ______________

____
Proposed Insured Signature

____
Owner Signature (If Owner other than Insured)

____
Producer Signature

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of Transamerica Premier Life Insurance Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment. Upon written request, you are entitled to receive a copy of the investigative consumer report.

You have the right to be interviewed as part of any investigative consumer report that may be prepared. If you desire to be interviewed, you must indicate this to Transamerica Premier Life Insurance Company. You also have the right to request access to, and correction and amendment of, any personal information collected. Additionally, you are entitled to receive a description of procedures which allow access to and correction of personal information which may be obtained, the nature and scope of the investigation requested, and a description of the circumstances under which personal information may be disclosed without prior authorization. Your written request should be addressed to:

TRANSAMERICA PREMIER LIFE INSURANCE COMPANY
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Transamerica Premier 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 Premier 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.

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CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by Transamerica Premier Life Insurance Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to Transamerica Premier Life Insurance Company under its rules, limits and underwriting standards for the plan and for the amount applied for, without modification of plan, premium rates or amount of coverage.

Effective Date

If all of the above conditions are met, insurance in the amount applied for or $50,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed Insured dies prior to a future date selected for draft of the initial premium or if the proposed Insured dies by suicide, this receipt provides no coverage, and the liability of Transamerica Premier Life Insurance Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date Transamerica Premier Life Insurance Company sends written notice that the receipt is terminated.

Last Name and Last 4 Digits of SSN: _____

Agent's Report

Existing insurance? ❑ Yes ❑ No

I represent that:

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

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

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

_____

Producer Signature

RESET

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

1. Last Name	First Name	2. Soc. Sec. # Last 4 Digits

OWNER - if other than Primary Insured

1. Last Name	First Name	2. Tax Identification #/Soc. Sec. # Last 4 Digits

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

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

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

Name / Address	Date of Birth	Percent	Relationship	Phone # / Soc. Sec. # / Tax Identification #

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

Name / Address	Date of Birth	Percent	Relationship	Phone # / Soc. Sec. # / Tax Identification #

AGENT

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

Date

Producer or Agent Signature

Owner Signature

RESET

Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier 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, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier 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, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

Issue ages 45 - 85

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with <u>every</u> application)

Agent Information		
Agent ID	Agent Name (Print)	Agent Phone ( )
Agent Email		Agent Fax ( )
Case Manager Name	Case Manager Phone ( )	
Case Manager Email Address		
Proposed Insured Information		
Insured's name (Print)		Last 4 digits of Insured's social security #

Required Disclosures with Application:

❑ HIPAA Authorization Form

Other Disclosures (if applicable):

❑ Accelerated Death Benefit Disclosure Form ❑ Replacement Form(s)

Submitting Applications: ***(Faxing is the preferred method)***

If faxing, fax to **1-866-834-0437** and enter date faxed_____ . **Do Not** mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

4333 Edgewood Road NE, Cedar Rapids, IA 52499

If a case manager is listed, please follow your General Agency's submission process with sending the signed application packet.

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:** _____

REPLACEMENT ADVERTISING
AGENT STATEMENT

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

a. I have used only company approved sales advertising.

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

_____ _____

DATE **AGENT SIGNATURE**

Reset Form

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

☐ **Transamerica Life Insurance Company** ☐ **Western Reserve Life Assurance Co. of Ohio**

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

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

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

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

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

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

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

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

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

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

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

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

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

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

_____ _____
Applicant’s Signature and Printed Name Date

_____ _____
Producer’s Signature and Printed Name Date

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

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older – are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expenses and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
[Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.]

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax-free exchange? (See your tax advisor)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

30 DAY RIGHT TO CANCEL

In the event of a replacement transaction, you may cancel this policy by delivering or mailing a written request to the Company. You must return the policy to the Company before midnight of the thirtieth day after the day you receive it. You will receive an unconditional full refund of all premiums or considerations paid on it, less any withdrawals and indebtedness, including any policy fees or charges or, in the case of a variable or market value adjustment policy, payment of the cash surrender value provided under the policy plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy. Your written request given by mail and return of the policy by mail are effective on being postmarked, properly addressed and postage prepaid.

REPLACEMENT ADVERTISING
AGENT STATEMENT

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

a. I have used only company approved sales advertising.

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

_____ _____

DATE **AGENT SIGNATURE**

Schedule Of Social Security Benefit Payments 2014

JANUARY 2014						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

FEBRUARY 2014						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	

MARCH 2014						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

APRIL 2014						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

MAY 2014						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

JUNE 2014						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

JULY 2014						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

AUGUST 2014						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

SEPTEMBER 2014						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

OCTOBER 2014						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

NOVEMBER 2014						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

DECEMBER 2014						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

Benefits paid on	Birth date on
Second Wednesday	1st – 10th
Third Wednesday	11th – 20th
Fourth Wednesday	21st – 31st

●	Supplemental Security Income (SSI)
☐	Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

Please allow three additional mailing days before contacting the Social Security Administration to report nonreceipt of your payment.

Social Security Administration
SSA Publication No. 05-10031
ICN 456100
Unit of Issue - HD (one hundred)
January 2014 (Recycle prior editions)

www.socialsecurity.gov

Schedule Of Social Security Benefit Payments 2015

JANUARY 2015

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

FEBRUARY 2015

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28

MARCH 2015

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

APRIL 2015

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

MAY 2015

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

JUNE 2015

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

JULY 2015

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

AUGUST 2015

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

SEPTEMBER 2015

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

OCTOBER 2015

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

NOVEMBER 2015

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

DECEMBER 2015

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
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□	Beneficiaries receiving benefits prior to May 1997 or receiving both Social Security benefits and SSI payments

Please allow three additional mailing days before contacting the Social Security Administration to report nonreceipt of your payment.

Social Security Administration
SSA Publication No. 05-10031
ICN 456100
Unit of Issue - HD (one hundred)
January 2014 (Recycle prior editions)

www.socialsecurity.gov

☐ **Transamerica Financial Life Insurance Company**
440 Mamaroneck Avenue, Harrison, NY 10528
☐ **Transamerica Life Insurance Company**
☐ **Transamerica Premier Life Insurance Company**
☐ **Stonebridge Life Insurance Company**
Administrative Office: 4333 Edgewood Road N.E., Cedar Rapids, IA 52499

SOCIAL SECURITY BENEFIT BILLING AUTHORIZATION FORM

POLICY NUMBER_____

SOCIAL SECURITY BENEFIT PAYMENT PAID ON:

Box A - Required

Please select only one box to indicate the DEPOSIT/WITHDRAWAL options:

☐ Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)
☐ Benefits paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)
☐ Benefit paid on Second Wednesday (Option C)
☐ Benefit paid on Third Wednesday (Option D)
☐ Benefit paid on Fourth Wednesday (Option E)

Initial Draft Month_____ (Cannot exceed one benefit payment cycle past application date)

INITIAL AND RECURRING PREMIUM PAYMENTS for Social Security Benefit Billing options: (Complete Box B or Box C)

Box B - Bank Withdrawal Account

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____

_____ _____
Financial Institution Name, Office or Branch — Financial Institution Address City, State, Zip

_____ Check One: ☐ Checking ☐ Savings $ _____
List All Authorized Account Holders — Premium amount

_____ _____ _____
Transit Routing Number — Account Number — Account Holder Signature

Box C - Direct Express MasterCard

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____

5332 48 __ __ __ __ __ __ __ __ __ __ __ __
Direct Express MasterCard Account Number

_____ $ _____
Cardholder Signature — Date — Premium amount

_____ _____
Card Expiration Date Mo/Yr — Cardholder Name (Please Print)

I, the undersigned Cardholder or Accountholder, hereby authorize any of the Companies named above to make charges from my card or withdrawals from my account with the financial institution named above for: premiums becoming due and/or such other payments as I may authorize the Companies to make. I request the charges or withdrawals be on or before the day(s) when payments fall due. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal or change later made to the policy(ies). I understand that if a charge or withdrawal is not honored for payment, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

As a convenience to me, I hereby request MasterCard and the financial institution named above (and its successors and assigns) to accept and honor the charges or withdrawals made by the Companies from my card or account. I agree MasterCard and the financial institution shall be fully protected in honoring such charges or withdrawals.

This authorization shall take effect when recorded and processed by the Companies and financial institution and will remain in effect until I notify the Companies or the financial institution in writing to terminate and the Companies or financial institution have a reasonable time to act on the termination request. I hereby terminate any prior authorization of the Companies to initiate charges to my card or withdrawals from this account for the above policy(ies) effective the date on which the initial charge or withdrawal is made under this authorization. I also understand and agree that if a charge or withdrawal is not honored by the financial institution for any reason, the Companies may cease attempting to make charges or withdrawals through the use of this authorization.

_____ _____
Signature of Authorized Account Holder — Date

Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office:
4333 Edgewood Rd NE
Cedar Rapids, IA 52499
(800) 238-4302

(Referred to as the Company, we, our or us)

ACCELERATED DEATH BENEFIT RIDER DISCLOSURE

Receipt of the Accelerated Death Benefit may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements. In addition, receipt of the Accelerated Death Benefit may be taxable and assistance should be sought from a personal tax advisor.

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

Qualifying Event: A "Qualifying Event" means a medical condition from injury or illness which, as determined by a Physician:

(1) can reasonably be expected to result in death within 12 months from the date of the Physician Statement; or
(2) has required or requires extraordinary medical intervention, including but not limited to major organ transplant or continuous artificial life support, without which the Insured would die; or
(3) usually requires continuous confinement in an Eligible Institution as defined in the Rider if the Insured is expected to remain there until his or her death; or
(4) would result in a drastically limited life span of 12 months or less in the absence of extensive or extraordinary medical treatment. Such conditions include, but are not limited to:
    a. coronary artery disease resulting in an acute infarction or requiring surgery;
    b. permanent neurological deficit resulting from cerebral vascular accident;
    c. end-stage renal failure; or
    d. Acquired Immune Deficiency Syndrome.

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

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

We will determine the interest rate, but it will not exceed the greater of:

(1) the current yield on 90-day treasury bills; or
(2) the current maximum statutory adjustable policy loan interest rate.

The Accelerated Death Benefit will never be less than the net cash value on the Acceleration Date.

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

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

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

_____ _____

Date Owner's (Applicant's) Signature

_____ _____

Date Agent's Signature

Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office:
4333 Edgewood Rd NE
Cedar Rapids, IA 52499
(800) 238-4302

(Referred to as the Company, we, our or us)

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(1) can reasonably be expected to result in death within 12 months from the date of the Physician Statement; or
(2) has required or requires extraordinary medical intervention, including but not limited to major organ transplant or continuous artificial life support, without which the Insured would die; or
(3) usually requires continuous confinement in an Eligible Institution as defined in the Rider if the Insured is expected to remain there until his or her death; or
(4) has required the Insured to be continuously confined in an Eligible Nursing Home for 90 days and a Physician certifies that the Insured is expected to remain continuously confined in an Eligible Nursing Home until his or her death; or
(5) would result in a drastically limited life span of 12 months or less in the absence of extensive or extraordinary medical treatment. Such conditions include, but are not limited to:
    a. coronary artery disease resulting in an acute infarction or requiring surgery;
    b. permanent neurological deficit resulting from cerebral vascular accident;
    c. end-stage renal failure; or
    d. Acquired Immune Deficiency Syndrome.

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

_____ _____

Date Owner's (Applicant's) Signature

_____ _____

Date Agent's Signature