

SERFF Tracking Number: AEGE-126008726 State: Arkansas
Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Supplemental Questionnaires
Project Name/Number: Questionnaires/EM ALQ 1008

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Supplemental Questionnaires SERFF Tr Num: AEGE-126008726 State: Arkansas
TOI: L08 Life - Other SERFF Status: Closed-Approved State Tr Num: 41948
Sub-TOI: L08.000 Life - Other Co Tr Num: State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird
Author: Dawn Radack Disposition Date: 01/30/2009
Date Submitted: 01/27/2009 Disposition Status: Approved
Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Questionnaires Status of Filing in Domicile: Authorized
Project Number: EM ALQ 1008 Date Approved in Domicile: 01/16/2009
Requested Filing Mode: Domicile Status Comments:
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Group Market Size:
Overall Rate Impact: Group Market Type:
Filing Status Changed: 01/30/2009 Explanation for Other Group Market Type:
State Status Changed: 01/30/2009
Deemer Date: Created By: Dawn Radack
Submitted By: Dawn Radack Corresponding Filing Tracking Number:

Filing Description:

These are new forms and are intended to replace forms EM ALQ 0804, EM AVQ 0804, EM DRQ 0804, EM RAQ 0804, and EM TBQ 0804 previously approved by your Department on 09/03/2004. These forms are submitted in final print and are subject to only minor modifications in paper size and stock, ink, border, Company logo and adaptation to computer printing.

The only changes between the previously approved questionnaires and the new questionnaire pertain to the company names at the top of the form. Life Investors Insurance Company of America and Transamerica Occidental Life Insurance Company have merged into one of our other companies and therefore needed to be removed from the form.

These forms are questionnaires that may need to be completed by the Insured when a related question on the application for insurance has been answered affirmatively. These forms will be used with our life portfolio which

SERFF Tracking Number: AEGE-126008726 State: Arkansas
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Supplemental Questionnaires
 Project Name/Number: Questionnaires/EM ALQ 1008

includes non variable and variable life forms, individual and group.

Company and Contact

Filing Contact Information

Dawn Radack, Forms Filing Manager dradack@Aegonusa.com
 4333 Edgewood Rd. NE 319-355-4266 [Phone]
 Cedar Rapids, IA 52499 319-355-6292 [FAX]

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
4333 Edgewood Rd. NE	Group Code: 468	Company Type: Life
Cedar Rapids, IA 52499	Group Name:	State ID Number:
(319) 369-2419 ext. [Phone]	FEIN Number: 39-0989781	

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 5 questionnaires files.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$100.00	01/27/2009	25302940

SERFF Tracking Number: AEGE-126008726

State: Arkansas

Filing Company: Transamerica Life Insurance Company

State Tracking Number: 41948

Company Tracking Number:

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Product Name: Supplemental Questionnaires

Project Name/Number: Questionnaires/EM ALQ 1008

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	01/30/2009	01/30/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Alcohol Questionnaire	Dawn Radack	01/28/2009	01/28/2009
Form	Aviation Questionnaire	Dawn Radack	01/28/2009	01/28/2009
Form	Drug Questionnaire	Dawn Radack	01/28/2009	01/28/2009
Form	Racing Questionnaire	Dawn Radack	01/28/2009	01/28/2009
Form	Tobacco Questionnaire	Dawn Radack	01/28/2009	01/28/2009

SERFF Tracking Number: *AEGE-126008726* *State:* *Arkansas*
Filing Company: *Transamerica Life Insurance Company* *State Tracking Number:* *41948*
Company Tracking Number:
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *Supplemental Questionnaires*
Project Name/Number: *Questionnaires/EM ALQ 1008*

Disposition

Disposition Date: 01/30/2009

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGE-126008726 State: Arkansas
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Supplemental Questionnaires
 Project Name/Number: Questionnaires/EM ALQ 1008

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Form (revised)	Alcohol Questionnaire		Yes
Form (revised)	Aviation Questionnaire		Yes
Form (revised)	Drug Questionnaire		Yes
Form (revised)	Racing Questionnaire		Yes
Form (revised)	Tobacco Questionnaire		Yes
Form	Alcohol Questionnaire	Replaced	Yes
Form	Aviation Questionnaire	Replaced	Yes
Form	Drug Questionnaire	Replaced	Yes
Form	Racing Questionnaire	Replaced	Yes
Form	Tobacco Questionnaire	Replaced	Yes

SERFF Tracking Number: AEGE-126008726 State: Arkansas
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Supplemental Questionnaires
 Project Name/Number: Questionnaires/EM ALQ 1008

Amendment Letter

Submitted Date: 01/28/2009

Comments:

The form number on the original submission was listed incorrectly.

Thanks,
 Dawn Radack

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
EM ALQ 1008	Application/EAlcohol nrollment Form	Questionnaire	Revised		EM ALQ 0804	EM ALQ 1008	57.300	EMALQ1008.pdf
EM AVQ 1008	Application/EAviation nrollment Form	Questionnaire	Revised		EM AVQ 0804	EM AVQ 1008	69.200	EMAVQ1008.pdf
EM DRQ 1008	Application/EDrug nrollment Form	Questionnaire	Revised		EM DRQ 0804	EM DRQ 1008	57.500	EMDRQ1008.pdf
EM RAQ 1008	Application/ERacing nrollment Form	Questionnaire	Revised		EM RAQ 0804	EM RAQ 1008	59.300	EMRAQ1008.pdf
EM TBQ 1008	Application/ETobacco nrollment Form	Questionnaire	Revised		EM TBQ 0804	EM TBQ 1008	66.000	EMTBQ1008.pdf

SERFF Tracking Number: AEGE-126008726 State: Arkansas
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Supplemental Questionnaires
 Project Name/Number: Questionnaires/EM ALQ 1008

Form Schedule

Lead Form Number: EM ALQ 1008 et al

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	EM ALQ 1008	Application/ Alcohol Enrollment Questionnaire Form	Revised	Replaced Form #: EM ALQ 1008 Previous Filing #: EM ALQ 0804	57.300	EMALQ1008.pdf
	EM AVQ 1008	Application/ Aviation Enrollment Questionnaire Form	Revised	Replaced Form #: EM AVQ 1008 Previous Filing #: EM AVQ 0804	69.200	EMAVQ1008.pdf
	EM DRQ 1008	Application/ Drug Questionnaire Enrollment Form	Revised	Replaced Form #: EM DRQ 1008 Previous Filing #: EM DRQ 0804	57.500	EMDRQ1008.pdf
	EM RAQ 1008	Application/ Racing Enrollment Questionnaire Form	Revised	Replaced Form #: EM RAQ 1008 Previous Filing #: EM RAQ 0804	59.300	EMRAQ1008.pdf
	EM TBQ 1008	Application/ Tobacco Enrollment Questionnaire Form	Revised	Replaced Form #: EM TBQ 1008 Previous Filing #: EM TBQ 0804	66.000	EMTBQ1008.pdf

- Transamerica Life Insurance Company
 - Western Reserve Life Assurance Co. of Ohio
- 4333 Edgewood Rd. N.E.
Cedar Rapids, Iowa 52499

Supplement to Application dated _____

ALCOHOL QUESTIONNAIRE

1. Do you currently use alcohol? Yes Type _____ Amount/frequency _____
 No Sobriety date _____

2. Have you ever received outpatient and/or inpatient treatment for alcohol abuse/alcoholism? Yes No
 (a) Dates treated _____
 (b) Type of treatment _____
 (c) Name of facility _____

3. Are you active in a support group (i.e. AA)? Yes No
 (a) Date last attended _____
 (b) How long have you attended _____

4. Do you or have you ever used marijuana, cocaine, or any other drug? Yes No
 If yes, please provide details: _____

5. Additional comments: _____

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true, and I agree that they shall form a part of the application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____, _____.

Witness

Signature of Proposed Insured

- Transamerica Life Insurance Company
 - Western Reserve Life Assurance Co. of Ohio
- 4333 Edgewood Rd. N.E.
Cedar Rapids, Iowa 52499

Supplement to Application dated _____

AVIATION QUESTIONNAIRE

Name of Proposed Insured		Date of Birth	
Do you desire aviation coverage if an extra premium is necessary? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, complete the questions below. If no, will you accept an aviation exclusion? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Type of License Now Held (ex: commercial, private, student)		Date of Issue	Date of Last Renewal
Are you Instrument Flight Rated? <input type="checkbox"/> Yes <input type="checkbox"/> No # of IFR hours	Have you ever been offered a certificate with a physical waiver? If yes, explain below.		
If expired, do you intend to renew? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you or do you intend to take instruction as a pilot? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Total solo hours flown as pilot.	Date of last flight as pilot.		
Have you ever had an airplane accident? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain below.	Have you ever been grounded or had license revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain below.		
Do you intend to fly outside the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain where and number of hours below.	Is the aircraft you fly kept at an airport with suitable maintenance facilities? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, explain below.		
Do any of your duties require you to make flights? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain below.			
TYPE OF FLYING	HOURS AS PILOT OR CREW MEMBER		
	One or Two Years Ago	Past 12 Months	Contemplated Next 12 Months
Scheduled Airline			
Non-scheduled Airline			
Non-scheduled Business			
Personal/Pleasure/Business			
As instructor			
As student			
Testing, experimental, prospecting or crop dusting			
Others-give details			
Military or Naval <i>See questions below.</i>			
Member of what military organization	Rank or grade	Flight status	
Describe duties and type of aircraft used. (Also complete if crew member or airborne personnel.)			
Space for further explanation of answer to any question.			

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true, and I agree that they shall form a part of the application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____, _____.

Witness Signature of Proposed Insured

- Transamerica Life Insurance Company
 - Western Reserve Life Assurance Co. of Ohio
- 4333 Edgewood Rd. N.E.
Cedar Rapids, Iowa 52499

Supplement to application dated _____

DRUG QUESTIONNAIRE

Name of Proposed Insured		Date of Birth	
In the past 7 years has the Proposed Insured named above used:	Barbiturates, sedatives or tranquilizers habitually?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	LSD, marijuana, or any amphetamine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cocaine, Heroin, morphine, or other narcotic drug?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
List the types taken and the periods of use:	Type	Dates Used From _____ to _____	Frequency
	Type	Dates Used From _____ to _____	Frequency
	Type	Dates Used From _____ to _____	Frequency
	Type	Dates Used From _____ to _____	Frequency
	Type	Dates Used From _____ to _____	Frequency
A. Sobriety Date _____			
B. Have you received any inpatient and/or outpatient therapy?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, details _____			
C. Are you active in a support group (i.e. AA, NA)?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, details _____			
D. Do you currently use alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No Type _____ Amount/Frequency _____			
E. Additional Details:			

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true, and I agree that they shall form a part of the application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____, _____.

Witness

Signature of Proposed Insured

- Transamerica Life Insurance Company
- Western Reserve Life Assurance Co. of Ohio
4333 Edgewood Rd. N.E.
Cedar Rapids, Iowa 52499

Supplement to Application dated _____

RACING QUESTIONNAIRE

Name of Proposed Insured				Date of Birth	
		Last 12 Months			Contemplated Next 12 Months
What type of vehicle do you race?	What division /series do you race?	Number of Races	Average Speed of Fastest Race	Fastest Speed Attained	Number of Races
<i>Examples: Automobile - midget, sportscar, stock car, championship, drag, kart. Motorcycle - hill climbing, cross country, circular track. Motorboat - unmodified, modified, experimental Unlimited hydroplane - jet, other.</i>	<i>Examples: USAC, Indy Cars, Winston Racing Series, Formula, etc.</i>				
Has your vehicle been modified in any way?					
How long have you been racing?					
Have you ever competed or do you contemplate competing outside the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details.					
Over what type track do you race? (e.g., oval, simulated road.)					
What size of track do you race on?					
Do you race professionally?					
Additional remarks clarifying answers to above questions:					

I hereby represent, to the best of my knowledge and belief, that all the above statements are complete and true, and I agree that they shall form a part of the application and become a part of any contract of insurance issued on such application.

Dated at _____ this _____ day of _____, _____.

Witness

Signature of Proposed Insured

- Transamerica Life Insurance Company
 - Western Reserve Life Assurance Co. of Ohio
- 4333 Edgewood Rd. N.E.
Cedar Rapids, Iowa 52499

TOBACCO QUESTIONNAIRE

Have you used tobacco or any nicotine product in the last 5 years? Yes No

If Yes please indicate:

Type	Amount used	Date last use
<input type="checkbox"/> Cigarettes		
<input type="checkbox"/> Chewing Tobacco		
<input type="checkbox"/> Snuff		
<input type="checkbox"/> Pipe		
<input type="checkbox"/> Cigar		
<input type="checkbox"/> Nicotine patch/gum		

Comments:

I represent, to the best of my knowledge and belief, that all the answers to all the above questions are complete and true. I agree that this supplement shall form a part to the application and become a part of any contract for insurance issued as a result of such application.

Dated at _____ this _____ day of _____, 2_____.

Signature of Proposed Insured

Signature of Agent

SERFF Tracking Number: AEGE-126008726 State: Arkansas
Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
Company Tracking Number:
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Supplemental Questionnaires
Project Name/Number: Questionnaires/EM ALQ 1008

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Flesch Certification

Comments:

Flesch Certification is attached.

Attachment:

Flesch Cert.pdf

Item Status: **Status**
Date:

Satisfied - Item: Application

Comments:

The questionnaires may need to be completed by the Insured when a related question on the application for insurance has been answered affirmatively. The attached applications were approved by your department 8/30/2005.

Attachments:

GI APP1 0305 STD.pdf

MI APP1 0305 STD.pdf

SI APP1 0305 STD.pdf

**TRANSAMERICA LIFE INSURANCE COMPANY
WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO**

FLESCH READABILITY CERTIFICATION

<u>Policy or Rider Form Number</u> (Form Numbers May Vary By State)	<u>Flesch Score</u>
EM ALQ 1008	57.3
EM AVQ 1008	69.2
EM DRQ 1008	57.5
EM RAQ 1008	59.3
EM TBQ 1008	66.0

I certify that the machine scored Flesch readability score(s) for the above mentioned forms(s) is/are accurate.



Matthew A. Monson
Vice President

- TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY
- LIFE INVESTORS INSURANCE COMPANY OF AMERICA
- WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
- TRANSAMERICA LIFE INSURANCE COMPANY

Hereafter known as the Company
 ADMINISTRATIVE OFFICE: 4333 EDGEWOOD ROAD NE, CEDAR RAPIDS, IOWA 52499

APPLICATION FOR LIFE INSURANCE - PART I

OWNER INFORMATION

NAME _____

ADDRESS (Street, City, State, Zip) _____

RELATIONSHIP TO INSURED _____ TAX ID # _____

PRIMARY BENEFICIARY _____

RELATIONSHIP TO INSURED _____

POLICY INFORMATION:

PRODUCT NAME _____

FACE AMOUNT INFORMATION
 See attached Census
 Face Amount \$ _____
 Is this an increase to an existing policy? Yes No

PLANNED PREMIUM \$ _____	FREQUENCY _____
DEATH BENEFIT OPTION: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3	

COMPLETE FOR ALL VARIABLE PRODUCTS

FUND ELECTION:	Percentage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

LIFE INSURANCE COMPLIANCE TEST:
 Guideline Premium Cash Value Accumulation

RIDERS

PERSONAL FINANCIAL STATEMENT

(a) Gross Income Current Year	\$	_____
(b) Marginal Tax Bracket	\$	_____
(c) Assets	\$	_____
(d) Liabilities	\$	_____
(e) Net Worth	\$	_____
(f) Net Worth (exclusive of home furnishings, automobiles)	\$	_____

COMPLETE FOR CORPORATION, PARTNERSHIP, PENSION OR TRUST

(a) Current estimated value	\$	_____
(b) Assets	Liquid	\$ _____
	Nonliquid	\$ _____
(c) Liabilities		\$ _____

For over \$1 million applied coverage complete a separate financial questionnaire.

ADDITIONAL INFORMATION

SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY

Complete for all variable products:

- (a) Have you, the Applicant, received the current Prospectus for the policy? Yes No
- (b) DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE AMOUNT OF DEATH BENEFIT AND THE ENTIRE AMOUNT OF THE POLICY CASH VALUE MAY INCREASE OR DECREASE DEPENDING UPON INVESTMENT EXPERIENCE? Yes No
- (c) With this in mind, is the policy in accord with your insurance objectives and your anticipated financial needs? Yes No

Will life insurance or annuity with any company be replaced or changed if insurance applied for is issued? Yes No

FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below.

For applicants in ARKANSAS, LOUISIANA

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.

For applicants in COLORADO

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

For applicants in KENTUCKY and OHIO

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

For applicants in MAINE, TENNESSEE and DISTRICT OF COLUMBIA

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

For applicants in NEW JERSEY

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

For applicants in NEW MEXICO

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

TAXPAYER IDENTIFICATION NUMBER STATEMENT

Under penalties of perjury, I hereby certify (1) that the Social Security or Taxpayer I.D. number on this application is correct and (2) that I am currently not subject to backup withholding. [Cross out (2) if not correct.]

The Internal Revenue Service does not require your consent to any provision of this document other than certifications required to avoid backup withholding.

AGREEMENT

I certify that I have insurable interest in all employees being insured under this application (see census), that all said employees have consented to be insured and are "actively at work" being defined as having worked for not less than 30 hours per week and not having been absent from work due to accident, illness or other condition for more than four consecutive days within the last 90 days prior to the date of this application.

I agree that I have read and understand all statements and answers in this application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded whether written in my own hand or not.

I also agree that:

1. There will be no liability under this application until the policy is delivered to and accepted by the Owner and the full first premium due is paid while the Proposed Insured is alive and his/her state of health is as favorable as described in this application.
2. No modification may be made to the policy and no right of the Company may be waived unless agreed to in writing and signed by:
 - A. The President; B. The Vice President; or C. The Secretary of the Company.

Signature of Owner _____ Date _____

Signed at (City and State) _____

PRODUCER INFORMATION AND SIGNATURE

For Producer . . . Will the insurance being applied for replace or change any existing insurance or annuity?

YES NO If yes, what company and policy no.? _____

Print name and account number of, and percentages for producer or producers who are to receive credit and commission.

	Producer Number	% if Split First Year	% if Split Renewal
_____ Signature of Producer _____ on behalf of _____ (if applicable)	_____	_____	_____
_____ Print Name			
_____ Signature of Producer _____ on behalf of _____ (if applicable)	_____	_____	_____
_____ Print Name			
_____ Signature of Producer _____ on behalf of _____ (if applicable)	_____	_____	_____
_____ Print Name			
_____ Signature of Producer _____ on behalf of _____ (if applicable)	_____	_____	_____
_____ Print Name			

- TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY
- LIFE INVESTORS INSURANCE COMPANY OF AMERICA
- WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
- TRANSAMERICA LIFE INSURANCE COMPANY

Hereafter known as the Company
 ADMINISTRATIVE OFFICE: 4333 EDGEWOOD ROAD NE, CEDAR RAPIDS, IOWA 52499

APPLICATION FOR INSURANCE

PROPOSED INSURED INFORMATION

Name (First, M.I., Last)				Mailing Address			
Home Telephone No. ()		Work Telephone No. ()		Birth Date	Birth Place (State or Country)		E-Mail Address
Height	Weight	Marital Status		Sex	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, give immigration status/type of visa:
Occupation & Duties			Gross Income Current Year _____			Social Security No. or Tax I.D. No.	
			Marginal Tax Bracket _____				
			Assets _____				
			Liabilities _____				
			Net Worth _____				
Net Worth (exclusive of home, furnishings, autos) _____			Drivers License No./ State				
Have you used any tobacco within the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list type and when used last _____							

BENEFICIARY (Unless otherwise noted, the beneficiary of Other persons proposed for Coverage will be the proposed insured.)

Primary	Relationship
Primary	Relationship
Primary	Relationship
Contingent	Relationship

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

Name	Relationship to Proposed Insured	Social Security Number
Address	Birth Date	Phone ()

POLICY INFORMATION

Product Name: _____			
Death Benefit Option	<input type="checkbox"/> Option 1	<input type="checkbox"/> Option 2	<input type="checkbox"/> Option 3
Face Amount \$	Planned Premium \$	Frequency	

BENEFIT/RIDERS

	Benefit Units or %		Benefit Units or %
<input type="checkbox"/> Exchange of Insured Rider	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Term Insurance Rider	_____	<input type="checkbox"/> Other	_____
<input type="checkbox"/> Other	_____	<input type="checkbox"/> Other	_____

COMPLETE FOR ALL VARIABLE PRODUCTS

FUND ELECTION	Percentage	FUND ELECTION	Percentage
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ADDITIONAL PRODUCT INFORMATION

SUITABILITY FOR VARIABLE LIFE INSURANCE POLICY

Complete for all variable plans:

- (a) Have you, the Applicant, received the current Prospectus for the policy? Yes No
- (b) DO YOU UNDERSTAND THAT UNDER THE POLICY APPLIED FOR (EXCLUSIVE OF ANY OPTIONAL BENEFITS), THE AMOUNT OF DEATH BENEFIT AND THE ENTIRE AMOUNT OF THE POLICY CASH VALUE MAY INCREASE OR DECREASE DEPENDING UPON INVESTMENT EXPERIENCE? Yes No
- (c) With this in mind, is the policy in accord with your insurance objectives and your anticipated financial needs? Yes No

Name of Other Proposed Insured(s)	Birth Date	Sex	Height	Weight	Social Security Number	Relationship to Insured	Amount of Insurance	Used Tobacco in last 5 years? If yes, list type and when used last
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No
								<input type="checkbox"/> Yes <input type="checkbox"/> No

LIFE INSURANCE IN FORCE

Insured's Name	Company/ Policy Number	Face Amount
		\$
		\$
		\$
		\$

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

1. Will the insurance applied for replace or change any existing insurance or annuity? Yes No
- Have you or any proposed insured,**
2. Had any health, disability or life insurance pending or contemplated with another company? Yes No
3. Been declined, postponed, offered a rated or modified life, health or disability policy or been denied reinstatement? Yes No
4. Within the past 5 years,
 - a. Been cited or convicted of a moving violation, including DUI, or had a driver's license suspended or revoked? (If yes, provide state and drivers license number.) Yes No
 - b. Been or is now fully or partially disabled? Yes No
 - c. Been charged with or convicted of any felony or been on probation? Yes No
5. Within the past 2 years,
 - a. Taken part in any type of racing, mountain climbing, underwater or sky diving, hang gliding or plan to? Yes No
 - b. Flown other than as a passenger, or plan to? (If yes, complete the Aviation Supplement.) Yes No
 - c. Foreign residence or travel contemplated? Yes No
6. Within the past 10 years, used drugs (such as: hallucinogens, barbiturates, excitants or narcotics) except as medication prescribed by a physician, or been treated or counseled for drug or alcohol use? Yes No
7. Family History: Is there a history of cardiovascular disease or cancer in parents/siblings prior to age 60? Yes No
8. Do you exercise? If yes, describe type, how often per week and how long per session. Yes No
9. Do you drink alcoholic beverages? If yes, please provide type of drinks, number of occasions per year and the number of drinks consumed on those occasions. Yes No
10. Have you had any weight change in the past year? Yes No

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

Within the past 10 years, has any proposed insured been treated or diagnosed by a health care professional as having any disease or disorder of the:

1. Blood or circulatory system (such as: heart attack, heart disease, palpitations, heart murmur, or chest pain, high blood pressure, stroke, anemia)? Yes No
2. Respiratory system (such as: emphysema, asthma, shortness of breath, chronic cough or sleep apnea)? Yes No
3. Brain or nervous system (such as seizures, epilepsy, multiple sclerosis, mental illness, depression, suicide attempt, eating disorder, dementia or Alzheimer's disease)? Yes No
4. Sugar, albumin, or blood in urine, or other illness or disease of the kidneys, bladder, or urinary system, prostate, breast, sexually transmitted disease or any other reproductive disorder? Yes No
5. Stomach, intestine, liver (such as: ulcer, colitis, Crohn's disease or hepatitis)? Yes No
6. Endocrine system, muscles or bone (such as diabetes, thyroid, lupus, arthritis, or back problems)? Yes No
7. Cancer, tumor, polyps, melanoma or other malignancy? Yes No
8. Had or been advised to have a check-up, consultation, lab test, EKG, X-ray or other diagnostic test? Yes No
9. Are you currently under the observation of a physician or taking medication? Yes No

PERSONAL PHYSICIAN(S)

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

FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below.

For applicants in **ARKANSAS, LOUISIANA**

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.

For applicants in **COLORADO**

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

For applicants in **FLORIDA**

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

For applicants in **KENTUCKY, OHIO, and PENNSYLVANIA**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

For applicants in **MAINE, VIRGINIA, TENNESSEE and DISTRICT OF COLUMBIA**

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

For applicants in **MINNESOTA**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For applicants in **NEW JERSEY**

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

For applicants in **NEW MEXICO**

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

For applicants in **OKLAHOMA**

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

PRODUCER INFORMATION & SIGNATURE

Print name and account number of, and percentages for producer or producers who are to receive credit and commission.

Signature of Producer _____ on behalf of _____ (if applicable) _____
Producer Number % if Split % if Split
First Year Renewal

Print Name _____
Signature of Producer _____ on behalf of _____ (if applicable) _____
Producer Number % if Split % if Split
First Year Renewal

Print Name _____
Signature of Producer _____ on behalf of _____ (if applicable) _____
Producer Number % if Split % if Split
First Year Renewal

Print Name _____
Signature of Producer _____ on behalf of _____ (if applicable) _____
Producer Number % if Split % if Split
First Year Renewal

Print Name _____
Signature of Producer _____ on behalf of _____ (if applicable) _____
Producer Number % if Split % if Split
First Year Renewal

Do you have any knowledge or reason to believe that the insurance applied for will replace or change any existing insurance or annuity? Yes No

If yes, what company? _____ Policy # _____

SUBMIT SPECIAL REPLACEMENT FORM IF REQUIRED IN YOUR STATE

ILLUSTRATION CERTIFICATION

I certify that no illustration was used by me or any other authorized producer of the Company in the sale of the life insurance to _____ APPLICANT on this date. An illustration conforming to the requirements of the _____ STATE state regulation on illustrations will be delivered to this applicant no later than the policy delivery date.

DATE PROUDER

I acknowledge that no illustration conforming to the policy applied for was provided to me at the point of sale. I understand an illustration conforming to the policy as issued will be provided to me no later than at the time of policy delivery.

DATE APPLICANT

PRODUCER'S REPORT

How well do you know proposed insured? _____
Yes No

Do you know of any information not given in the application which might affect the insurability of any person proposed for insurance?
(If "yes", explain in Remarks Section)

Is this case personal business? (Is it written on your life, spouse, child, grandchild, parent, or spouse's parent?)
(If "yes", explain in Remarks Section)

Did you see all of those to be insured on the date the application was written?
(If "no", explain in Remarks Section)

Is insurance being applied for with any other company?
(If "yes", give details in Remarks Section)

Did you witness the signing of the application?
(If "no", explain in Remarks Section)

Did you ask each question in this application exactly as printed?
(If "no", explain in Remarks Section)

If application is approved other than as requested:
 Adjust to premium
 Issue face amount as shown

Is applicant being examined by a medical doctor?

Is an EKG being arranged?

Is an exercise EKG being arranged?

Is a blood profile being arranged?

COMPLETE ONLY IF OWNER IS OTHER THAN INSURED

OWNER IS: Corporation Partnership
 Individual Sole Proprietorship Trust

Purpose of Policy
 Personal Needs Analysis Estate Liquidity
 Mortgage Buy-Sell
 Retirement Key Employee
 Education Other

If application is for key-man insurance, on what basis was the applicant's value to the business determined?

Who will pay the premium? _____

Total of other insurance on proposed insured payable to business. _____
If partnership, give names of all partners.

Are all other partners insured? If not, explain.

Relationship of owner to Insured?

How much life insurance is carried by
(a) Father _____ b) Mother _____
(c) If this application is greater than a or b above
(Explain in Remarks Section)

If the Proposed Insured is under age 15, list age of brothers and sisters and amount of insurance on each of their lives
(in Remarks Section)

ADDITIONAL REMARKS/AND OR SPECIAL INSTRUCTIONS

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

Signature of Writing Producer

Detach and leave with applicant if cash is paid with application

LIFE INSURANCE CONDITIONAL RECEIPT, the Company

Please read this carefully. All premium checks must be made payable to the Company. Do not make check payable to producer or leave payee blank.

Received from _____ the sum _____ paid with a life insurance application to the Company. The application bears the same date as this receipt. There will be no coverage if the sum received is paid by a check which is uncollectible upon initial deposit. The full initial premium payment for the mode of payment chosen is required for this conditional receipt to be effective.

The person(s) proposed to be insured is (are) _____

No producer or broker is authorized to alter the terms of this Receipt, waive any requirements, or pass on insurability.

Dated at (City and State)	On (Date)	Producer's Signature
---------------------------	-----------	----------------------

The life insurance contract you have applied for with the Company will not become effective unless and until a contract is delivered to you. Subject to the conditions and limitations of this Receipt, conditional insurance as provided by the terms and conditions of the policy applied for will become effective prior delivery. No insurance will be provided under this Receipt unless and until all the following requirements are fulfilled during the lifetime of the person(s) proposed to be insured:

- **As of the effective date herein defined, each person proposed to be insured is found to be insurable exactly as applied for in accordance with the Company's underwriting rules and standards, without any modifications as to plan, amount, or premium rate;**
- **The payment taken for this Receipt is not less than the full initial premium for the mode of payment chosen in the application;**
- **All medical examinations, tests, and other screenings required by the Company are completed and received at our Home Office within 60 days from the date of the completion of the application; and**
- **As of the effective date, the state of health and all factors affecting the insurability of each person proposed to be insured are stated in the application.**

Detach and leave with applicant

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION to Proposed Insured And Other Proposed to be Insured, If Any

We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report. Ordinarily, it will be provided to third parties only if you authorize us in writing to do so. In rare instances, we may be required to provide some or all of the information without your consent.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information on your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs, sport, hobby or aviation activities, and marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know. If you feel any information in our file is incorrect or incomplete, you may ask us to review it. If we agree, we will make any necessary corrections and inform anyone who received such information within the past two years. If we do not agree, you may file a statement of dispute with us. We will send that statement to anyone receiving such information in the past two years. We will also include it in any future disclosure of the disputed information.

Detach and leave with applicant if cash is paid with application

LIFE INSURANCE CONDITIONAL RECEIPT (CONTINUED)

If all requirements are not met, or the person(s) to be insured dies by suicide, the liability of the Company shall be limited to a refund to the applicant of the payment made for this receipt.

This receipt will provide insurance starting at the effective date. The effective date is the latest date of the following events:

- Signing of all parts of the application, any supplemental application or addendum to application, or any medical examination.
- Date requested in the application that is acceptable to the Company.
- The last required test(s) and medical examination(s) are performed.
- The full initial premium for the mode of payment chosen is received at our Home Office.
- Any additional information required by us is received at our Home Office.

This Receipt will terminate on the earliest of: (a) 60 days from the date this Receipt was signed; (b) the date the Company mails notice to the applicant of the rejection of the application for insurance and refunds the premium paid; (c) the day before the date insurance goes into effect under the policy applied for; or (d) the date the Company offers insurance other than as applied for.

The aggregate amount of life insurance on each person proposed to be insured which may become effective under this Receipt and any other conditional Receipt issued by the Company will be the lesser of the amount applied for or \$500,000 of the life insurance. This Receipt provides no insurance for riders or additional benefits.

If one or more of this Receipt's conditions have not been met exactly, the Company will be free from any liability except to return the premium payment.

The Company does not approve and accept the application for insurance within 60 days from the date this Receipt was signed, the application will be deemed to have been rejected by the Company and the Company shall have no liability except to return any payment made for this Receipt on surrender of this Receipt to the Company.

Detach and leave with applicant

MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION to Proposed Insured And Other Persons Proposed to be Insured, If Any information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make brief report thereon to the Medical Information Bureau, Inc., 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 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: Post Office Box 105; Essex Station; Boston, Massachusetts 02122; telephone number 866 692-6901 (TTY 866 346-3642 for hearing impaired).

We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage to which a claim may be submitted.

- TRANSAMERICA OCCIDENTAL LIFE INSURANCE COMPANY
- LIFE INVESTORS INSURANCE COMPANY OF AMERICA
- WESTERN RESERVE LIFE ASSURANCE CO. OF OHIO
- TRANSAMERICA LIFE INSURANCE COMPANY

Hereafter known as the Company
 ADMINISTRATIVE OFFICE: 4333 EDGEWOOD ROAD NE, CEDAR RAPIDS, IOWA 52499

APPLICATION FOR LIFE INSURANCE - PART II

INSURED INFORMATION

PROPOSED INSURED (First, Middle, Last)	SEX	AGE	BIRTHDAY (Mo-Day-Yr)
_____	<input type="checkbox"/> Female	_____	_____
	<input type="checkbox"/> Male		
RESIDENCE ADDRESS (Street, City, State, Zip)	PLACE OF BIRTH (State)	SOCIAL SECURITY NUMBER	
_____	_____	_____	

PLEASE READ CAREFULLY AND COMPLETE ALL APPLICABLE INFORMATION

- | | | |
|---|--------------------------|--------------------------|
| 1. Have you been ACTIVELY-AT-WORK*? | YES | NO |
| *ACTIVELY-AT-WORK is defined as: Performing all normal duties of the position on a full-time basis for not less than 30 hours per week and not absent from work due to accident, illness or other condition for more than four consecutive days within the last 90 days prior to the date of this application. The Company reserves the right to request recertification of the above information for deaths occurring within two years of the application date or any increase thereafter and to contest any claim during that period. | | |
| | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you used tobacco in the last 12 months?
If yes, what type(s)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Will the insurance being applied for replace or change any existing insurance or annuity?
If yes, please give company name and policy number. _____ | <input type="checkbox"/> | <input type="checkbox"/> |

PLEASE COMPLETE ONLY IF EVIDENCE OF INSURABILITY IS REQUIRED

1. a. Name of Insured's Personal Physician: _____
- b. Date and Reason Last Consulted: _____
2. HEIGHT: _____ Feet _____ Inches WEIGHT: _____ pounds
- | | | |
|--|--------------------------|--------------------------|
| 3. EVIDENCE OF INSURABILITY | YES | NO |
| a. Have you been hospitalized for a total of 7 or more days due to sickness in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Do you have or have you had in the last ten years, heart murmur, coronary artery disease, congestive heart failure, heart or circulatory surgery, stroke; emphysema, or other lung disease; diabetes, kidney disease, cirrhosis or other liver disease; mental or psychiatric disease or other disorders of the nervous system; cancer; or sought treatment for alcoholism or drug abuse? | <input type="checkbox"/> | <input type="checkbox"/> |

For yes answers, give full details in the space provided on the next page.

FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement. Please refer to the fraud warning statement for your state as indicated below.

For applicants in **ARKANSAS, LOUISIANA**

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.

For applicants in **COLORADO**

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

For applicants in **KENTUCKY and OHIO**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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.

For applicants in **TENNESSEE and DISTRICT OF COLUMBIA**

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

For applicants in **MINNESOTA**

A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For applicants in **NEW JERSEY**

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

For applicants in **NEW MEXICO**

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

For applicants in **OKLAHOMA**

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

AGREEMENT

I agree that I have read and understand all statements and answers in this application; that they are complete and true to the best of my knowledge and belief, and are correctly recorded whether written in my own hand or not.

I also agree that:

1. There will be no liability under this application until the policy is delivered to and accepted by the Owner and the full first premium due is paid while the Proposed Insured is alive and his/her state of health is as favorable as described in this application.
2. No modification may be made to the policy and no right of the Company may be waived unless agreed to in writing and signed by:
 - A. The President; B. The Vice President; or C. The Secretary of the Company.

AUTHORIZATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, any consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid, from the date signed below, for a period of two and one half years. I understand that I may revoke this authorization by sending a specific written request to the Company at 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499. I acknowledge receipt of the MIB Disclosure Notice and Fair Credit Reporting Act Notice.

Dated at _____ this _____ day of _____, _____

Signed: _____
Proposed Insured Signature

PRODUCER INFORMATION AND SIGNATURE

For Producer...Will the insurance being applied for replace or change any existing insurance or annuity?

YES NO If yes, what company and policy no.? _____

_____ On behalf of _____
LICENSED PRODUCER SIGNATURE (Print Last Name) (If Applicable)

_____ PRODCER NUMBER _____ LICENSE NUMBER _____ TELEPHONE NUMBER _____

Detach and leave with applicant

MEDICAL INFORMATION BUREAU, INC., (MIB) PRE-NOTIFICATION to Proposed Insured And Other Persons Proposed to be Insured, If Any
Any information regarding your insurability will be treated as confidential. We or our reinsurer(s) may, however, make brief report thereon to the Medical Information Bureau, Inc., 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 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: Post Office Box 105; Essex Station; Boston, Massachusetts 02122; telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired).

We or our reinsurer(s) may also release information in our file to other insurance companies to which you may apply for life or health insurance coverage to which a claim may be submitted.

Detach and leave with applicant

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION to Proposed Insured And Other Proposed to be Insured, If Any
We may ask for an investigative consumer report in connection with your application. In addition, a report may be requested to update our records if you apply for more coverage. You may ask to be interviewed when such a report is being prepared. We will, upon your written request, let you know whether a report was requested and, if so, give you the name, address and telephone number of the agency making the report. By contacting that agency and giving proper identification, you may inspect or obtain a copy of the report. Ordinarily, it will be provided to third parties only if you authorize us in writing to do so. In rare instances, we may be required to provide some or all of the information without your consent.

Typically, the report will contain information as to character, general reputation, personal characteristics, health, job and finances. When applicable, it will contain information on your: past and present employment record (including job duties); driving record; health history; use of alcohol or drugs, sport, hobby or aviation activities, and marital status. The agency may get information by talking to you or members of your family, business associates, financial sources, neighbors and others you know. If you feel any information in our file is incorrect or incomplete, you may ask us to review it. If we agree, we will make any necessary corrections and inform anyone who received such information within the past two years. If we do not agree, you may file a statement of dispute with us. We will send that statement to anyone receiving such information in the past two years. We will also include it in any future disclosure of the disputed information.

SERFF Tracking Number: AEGE-126008726 State: Arkansas
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 41948
 Company Tracking Number:
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: Supplemental Questionnaires
 Project Name/Number: Questionnaires/EM ALQ 1008

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
01/27/2009	Form	Alcohol Questionnaire	01/28/2009	EMALQ1008.pdf
01/27/2009	Form	Aviation Questionnaire	01/28/2009	EMAVQ1008.pdf
01/27/2009	Form	Drug Questionnaire	01/28/2009	EMDRQ1008.pdf
01/27/2009	Form	Racing Questionnaire	01/28/2009	EMRAQ1008.pdf
01/27/2009	Form	Tobacco Questionnaire	01/28/2009	EMTBQ1008.pdf