

SERFF Tracking Number: AEGE-126727199 State: Arkansas  
Filing Company: Transamerica Life Insurance Company State Tracking Number: 46303  
Company Tracking Number:  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: Applications - Electronic Signature  
Project Name/Number: /

## Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Applications - Electronic SERFF Tr Num: AEGE-126727199 State: Arkansas

Signature

TOI: L08 Life - Other

SERFF Status: Closed-Accepted State Tr Num: 46303

For Informational Purposes

Sub-TOI: L08.000 Life - Other

Co Tr Num:

State Status: Filed-Closed

Filing Type: Form

Reviewer(s): Linda Bird

Author: Dawn Radack

Disposition Date: 08/04/2010

Date Submitted: 07/23/2010

Disposition Status: Accepted For

Informational Purposes

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 07/19/2010

Requested Filing Mode: Informational

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: 08/04/2010

Explanation for Other Group Market Type:

State Status Changed: 08/04/2010

Deemer Date:

Created By: Dawn Radack

Submitted By: Dawn Radack

Corresponding Filing Tracking Number:

Filing Description:

Applications GI APP 1008, MI APP 1008 and SI APP 1008 were approved by your Department on 6/23/2009. These forms are not being updated at this time. The reason for the filing is to notify you that the manner in which we intend to use them is different than originally stated. For your reference, the tracking number for the original application filing is AEGE-1296191796.

We plan to make this form available electronically. It is our intent to use this form in a variety of electronic environments, including a web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted. The

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information contained in the application, including the electronic signature of the Owner/Applicant (if applicable), will be transmitted to our administrative office electronically. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions Act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the data on the electronic application. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

A copy of the application, identical to the filed form, will be printed and made part of any policy issued.

## 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

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: 1 informational filing  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$50.00	07/23/2010	38244585

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Accepted For Linda Bird Informational Purposes		08/04/2010	08/04/2010

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## Disposition

Disposition Date: 08/04/2010

Implementation Date:

Status: Accepted For Informational Purposes

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		Yes
Supporting Document	Previously approved applications		Yes

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Product Name: Applications - Electronic Signature  
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## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Application

**Comments:**

This is an informational filing with regards to our previously approved applications. The approval dates are 6/23/2009.

GI APP 1008

MI APP 1008

SI APP 1008

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Previously approved applications

**Comments:**

For your reference the previously approved applications have been attached.

**Attachments:**

GI APP 1008 STD.pdf

MI APP 1008 STD.pdf

SI APP 1008 STD.pdf

**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:

Option 1  Option 2  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**

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**

**DISTRICT OF COLUMBIA**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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**

**KENTUCKY**

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**

**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**

**OHIO**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

**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.

**For applicants in**

**TENNESSEE**

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.

## 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 LIFE INSURANCE COMPANY**

Hereafter known as the Company

ADMINISTRATIVE OFFICE: 4333 EDGEWOOD ROAD NE, CEDAR RAPIDS, IOWA 52499

**APPLICATION FOR INSURANCE**

<b>PROPOSED INSURED INFORMATION</b>									
Name ( <i>First, M.I., Last</i> )					Mailing Address				
Home Telephone No. ( )		Work Telephone No. ( )		Birth Date	Birth Place ( <i>State or Country</i> )			E-Mail Address	
Height	Weight	Marital Status		Sex	U.S. Citizen <input type="checkbox"/> Yes <input type="checkbox"/> No		<i>If no, give immigration status/type of visa:</i>		
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 _____									

<b>BENEFICIARY</b> ( <i>Unless otherwise noted, the beneficiary of Other persons proposed for Coverage will be the proposed insured.</i> )	
Primary	Relationship
Primary	Relationship
Primary	Relationship
Contingent	Relationship

<b>OWNER(S)</b> ( <i>Unless otherwise noted, the Owner will be the Insured.</i> )		
Name	Relationship to Proposed Insured	Social Security Number
Address	Birth Date	Phone ( )

<b>POLICY INFORMATION</b>		
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

<b>BENEFIT/RIDERS</b>			
	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	_____

<b>COMPLETE FOR ALL VARIABLE PRODUCTS</b>			
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**

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 **DISTRICT OF COLUMBIA**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 **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 **OHIO**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud.

### 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.

### For applicants in **TENNESSEE**

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.

**Under penalties of perjury, I hereby certify (1) that the Social Security or Taxpayer I.D. number above 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 the certifications required to avoid backup withholding.**

The statements and answers on this Application are true and complete to the best of my knowledge and belief. It is agreed that (a) this application and any amendments hereto, shall be the basis of any insurance granted; (b) no producer has authority to waive the answer to any question in the application, to pass on insurability, to waive any of the other Company's rights or requirements or to make or alter any contract; and (c) no insurance or annuity shall be considered in force unless and until a policy shall have been issued by the Company and said policy manually received and accepted by the Applicant and the full first premium paid thereon, all during the lifetime and before any change in the insurability of any person proposed for insurance from that stated herein.

The Company shall have sixty days from the date hereof within which to consider and act on this application and if within such period a policy has not been received by the Applicant or if notice of approval or rejection has not been given, then this application shall be deemed to have been declined by the Company.

Unless otherwise stated the undersigned Applicant is the Premium Payor and the Owner of the policy applied for.

**AUTHORIZATION:** I authorize any licensed physician, medical practitioner, hospital, clinic, medical or medically related facility, Medical Information Bureau, the Veteran's Administration, or other health care provider, my employer and any consumer reporting agency or insurance company who possess information concerning any care, treatment or advice rendered to me to provide such information to the Company, its representatives or its reinsurers. A photocopy of this Authorization shall be considered as valid as the original, which I or my authorized representative may receive a copy of upon request. The Company, or its reinsurers, may release this information about me to its reinsurers, to the Medical Information Bureau or to another insurance company to which I have applied. This authorization is limited to a period of 30 months commencing on the date of this application. I represent that the foregoing statements are complete and true to the best of my knowledge and belief. I understand that the date coverage becomes effective for any policy applied for on this application will be the date recorded on the Policy Specification page, not the date the application is signed. I understand coverage will be effective when the first premium is paid, provided all persons proposed for insurance are acceptable to the company under its rules and limits as standard risks, on the plan and for the amount applied for and the rate of premium declared. I authorize payroll deduction of the premiums, and acknowledge receipt of the MIB Disclosure Notice and Fair Credit Reporting Act Notice. 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.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_  
city state month year

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Signature of Additional Insured

\_\_\_\_\_  
Signature of Applicant if Other Than Insured  
 Owner  Other

\_\_\_\_\_  
Signature of Parent or Legal Guardian for Insured's 15 and under

Best time to call for a personal history interview \_\_\_\_\_ a.m. \_\_\_\_\_ p.m. Okay to contact at work? Yes  No

**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 \_\_\_\_\_  
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: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 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 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 <input type="checkbox"/> Female <input type="checkbox"/> Male	AGE	BIRTHDAY (Mo-Day-Yr)
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*?<br>*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. | YES                      | NO                       |
|  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you used tobacco in the last 12 months?<br>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?<br>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**

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 **DISTRICT OF COLUMBIA**

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 **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 **OHIO**

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statement is guilty of insurance fraud. .

### 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.

### For applicants in **TENNESSEE**

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.

**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**

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Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is: 50 Braintree Hill, Suite 400, Braintree, Massachusetts 02184-8734; and telephone number is 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.