

Agent Information		
Agent ID	Agent Name (Print)	Agent Phone ()
Agent Email		Agent Fax ()
Case Manager Name	Case Manager Phone ()	
Case Manager Email Address		
Proposed Insured Information		
Insured's name (Print)		Last 4 digits of Insured's social security #
<p>Required Disclosures with Application:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> HIPAA Authorization Form </div> <div> <input type="checkbox"/> Beneficiary/Additional Insured Information Form (DMF Form) </div> </div> <p>Other Disclosures (if applicable):</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Accelerated Death Benefit Disclosure Form </div> <div> <input type="checkbox"/> Replacement Form(s) </div> </div>		
<p>Submitting Applications: (Faxing is the preferred method)</p> <p>If faxing, fax to 1-866-834-0437 and enter date faxed _____. Do Not mail originals if faxing.</p> <p>If mailing the application and/or check for initial premium please send with cover sheet to:</p> <p>4333 Edgewood Road NE, Cedar Rapids, IA 52499</p> <p>If a case manager is listed, please follow your General Agency's submission process with sending the signed application packet.</p>		

Part A1 – Producer					
Name		Producer ID		Split %	Profile
Name		Producer ID		Split %	Profile
Name		Producer ID		Split %	Profile
Part A2 – Plan & Rider Information					
Plan		Face Amount \$		Total Premium \$	
<p>Rate Class applied for:</p> <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Preferred Non-Tobacco <input type="checkbox"/> Standard Non-Tobacco <input type="checkbox"/> Graded </div> <div> <input type="checkbox"/> Preferred Tobacco <input type="checkbox"/> Standard Tobacco </div> </div>					
<p>Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Child / Grandchild Rider? \$ _____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>					
Part A3 – Proposed Insured					
Name (First, M.I., Last, Suffix)			Address, City, State, Zip Code (cannot be a P.O. Box)		
D.O.B. (MM/DD/YYYY)		U.S. State or Country of Birth		Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.	
Gender	SSN	Phone Number for Interview ()	Best time to call a.m. p.m.		
Part A4 – Owner (If Other Than Proposed Insured)					
Name (First, M.I., Last, Suffix)			Address, City, State, Zip Code (cannot be a P.O. Box)		
Phone Number ()		D.O.B. (MM/DD/YYYY)		Are you a citizen of the United States? <input type="checkbox"/> Yes <input type="checkbox"/> No If "NO," what Country? _____ If "NO," are you a legal U.S. Resident? <input type="checkbox"/> Yes <input type="checkbox"/> No If "YES," VISA type and number _____ If "NO," you are not eligible for coverage.	
SSN		Relationship to Insured			
Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)					
Primary Name (First, M.I., Last, Suffix)		D.O.B. (MM/DD/YYYY)		SSN	Percentage Relationship to Insured
Contingent Name (First, M.I., Last, Suffix)		D.O.B. (MM/DD/YYYY)		SSN	Percentage Relationship to Insured
Part A6 – Existing Insurance					
Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, submit the state required forms and please provide company name and policy number. _____					
Is this to be a 1035 exchange? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Part B1 – Initial Premium Payment Method

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

Is the check for initial premium payment on the same account as monthly EFT payments?

☐ Yes ☐ No

☐ By payroll deduction or allotment.

☐ Draft initial premium upon receipt from the account below.

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

Month Day (1st thru 28th only)

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

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

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

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

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

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

Account #:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Routing #:

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

No debit card numbers please

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

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

Part B3 – Recurring Payment Method

EFT

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Payroll Deduction

Special Frequency _____

☐ List Bill ☐ Civil Service Allotment ☐ Military Allotment

Requested Effective Date _____

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

Part B4 – Payor Information

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

Name (First, M.I., Last, Suffix)

Address, City, State, Zip Code (cannot be a P.O. Box)

SSN

Relationship to Insured

Are you a citizen of the U.S.?

☐ Yes ☐ No

If not, what country?

Part B5 – Secondary Addressee

Name (First, M.I., Last, Suffix)

Address, City, State, Zip Code (cannot be a P.O. Box)

Part C1	
Within the last 12 months has the proposed Insured used tobacco products in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If a policy cannot be issued as applied for, would you accept a rated policy if available?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If 'yes,' adjust face amount to premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Part C2 – If Any Question In This Section Is Answered “Yes”, The Proposed Insured Is Not Eligible For Any Coverage.	
1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care, or has the proposed Insured been advised or is the proposed Insured planning to have inpatient surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2) Has the proposed Insured ever :	
a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's, dementia, memory loss, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Received or been advised to receive an organ transplant other than corneal?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Within the past 2 years has the proposed Insured:	
a) Had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Undergone testing by a medical professional for which the results have not been received or been advised to have any surgical operation, diagnostic testing other than for routine screening purposes, treatment, hospitalization or other procedure which has not been done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Part C3	
4) Has the proposed Insured been diagnosed with diabetes (other than gestational diabetes) before the age of 18?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5) Within the past 4 years has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6) Within the past 1 year has the proposed Insured:	
a) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs), or muscular dystrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Had more than 12 seizures; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Had, been diagnosed with, been treated for or advised to receive treatment for aneurysm or angina; or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Used oxygen to assist in breathing (including Sleep Apnea); received kidney dialysis; or had, been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7) Within the past 2 years has the proposed Insured used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance.	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • If all questions in Part C3 are answered “No,” proceed to Part C4. • If one question in Part C3 is answered “Yes,” the proposed Insured is potentially eligible for the Graded Death Benefit product, proceed to Part C5. • If two or more questions in Part C3 are answered “Yes,” the proposed Insured is not eligible for any coverage. 	
Part C4	
8) Within the past 2 years has the proposed Insured:	
a) Had, been diagnosed with, been treated for or advised to receive treatment for angina (chest pain); aneurysm; vascular, circulatory or blood disorder; heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or irregular heart rhythm such as atrial fibrillation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Had more than 12 seizures; used insulin; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9) Within the past 4 years has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
10) Has the proposed Insured ever been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> • If all questions in Part C4 are answered “No,” the proposed Insured is potentially eligible for the Preferred product, proceed to Part C5. • If one question in Part C4 is answered “Yes,” the proposed Insured is potentially eligible for the Standard product, proceed to Part C5. • If two or more questions in Part C4 are answered “Yes,” the proposed Insured is potentially eligible for the Graded Death Benefit product. 	
Part C5 – Nursing Home Option - If The Following Question Is Answered “Yes”, The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.	
Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home?	<input type="checkbox"/> Yes <input type="checkbox"/> No

AGREEMENT / AUTHORIZATION

ACKNOWLEDGMENT OF PROPOSED OWNER AND INSURED(S)—Each of the undersigned hereby certifies and represents as follows: The statements and answers given on this application are true and correct. I acknowledge and agree (A) that this application and any amendments shall be the basis for any insurance issued; (B) that the agent does not have the authority to waive any question on this application, to decide if insurance will be issued, or to modify any term or provision of any insurance which may be issued based on this application, only a writing signed by an officer of the Company can change the terms of this application or the terms of any insurance issued by the Company; (C) except as provided in the Conditional Receipt, if issued with the same proposed Insured(s) as on this application, no policy applied for shall take effect until after all of the following conditions have been met: 1) the minimum initial premium must be received by the Company; 2) the proposed Owner must have personally received and accepted the policy during the lifetime of all proposed Insured(s) and while all proposed Insured(s) are in good health; and 3) on the date of the later of either 1) or 2) above, all of the statements and answers given in this application must be true and complete, and the insurance will not take effect if the facts have changed. Unless otherwise stated the proposed insured is the premium payor and Owner of the policy applied for.

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

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB, Inc. ("MIB") 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. I authorize the Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB. A photographic copy of this authorization shall be as valid as the original.

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

I understand that any omissions or misstatements in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.

FRAUD WARNING: 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 or a denial of insurance benefits.

Signed Date _____ Signed at City _____ State _____

Proposed Insured Signature

Owner Signature (If Owner other than Insured)

Producer Signature

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

Producer Signature

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

NOTICE TO PERSONS APPLYING FOR INSURANCE

As part of the Company's procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through physicians, hospitals, clinics, and other medically-related facilities, who may be contacted using your signed authorization, to obtain details of your past medical treatment.

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

TRANSAMERICA PREMIER LIFE INSURANCE COMPANY

Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Transamerica Premier Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Premier Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

01/13

CONDITIONAL RECEIPT

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

Conditions of Coverage

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

Effective Date

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

Agent Instructions: Please leave this page with the Proposed Insured/Owner

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: _____ Social Security Number: _____

Additional Information

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

Additional Information

Child / Grandchild Rider Information

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

Contingent Owner

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

Signed Date _____ Signed at City _____ State _____

Proposed Insured Signature _____

Owner Signature (If Owner other than Insured) _____

Producer Signature _____

Last Name and Last 4 Digits of SSN: _____

Agent's Report

Existing insurance? ☐ Yes ☐ No

I represent that:

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

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

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

Producer Signature



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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED				
1. Last Name		First Name		2. SS# Last 4 Digits
OWNER - if other than Primary Insured				
1. Last Name		First Name		2. TIN/SS# Last 4 Digits
ADDITIONAL/OTHER PROPOSED INSURED - if applicable				
1. Last Name		First Name		M.I.
2. Address (Cannot be a P.O. Box)			City	
State	Zip Code	3. Home Phone ()	4. Social Security Number	
PRIMARY BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.				
Name / Address		DOB	Percent	Relationship
				Phone # SSN / Tax ID#
CONTINGENT BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.				
Name / Address		DOB	Percent	Relationship
				Phone # SSN / Tax ID#
AGENT				
<input type="checkbox"/> I attest that, on behalf of the Company, I requested all information above and the applicant provided the information completed on the form. The applicant was unable/declined to provide any information missing from the form.				
			Date	
Producer or Agent Signature			Owner Signature	

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

- Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
- Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

Signature of Primary Proposed Insured/Patient or Personal Representative

Date

Signature of Secondary Proposed Insured/Patient or Personal Representative

Date

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

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

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

Policy or contract number (if known): _____

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

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

4333 Edgewood Road NE, Cedar Rapids, IA 52499

**HIPAA Authorization for
Release of Health-
Related Information**

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

- Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
- Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
- Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
- The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

Signature of Primary Proposed Insured/Patient or Personal Representative

Date

Signature of Secondary Proposed Insured/Patient or Personal Representative

Date

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

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

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

Policy or contract number (if known): _____

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

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

**SOCIAL SECURITY BENEFIT
BILLING AUTHORIZATION FORM**

POLICY NUMBER _____

SOCIAL SECURITY BENEFIT PAYMENT PAID ON:

Box A - Required

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

- | | |
|--|--|
| <input type="checkbox"/> Beneficiary receiving Supplemental Security Income (SSI)
1st of the month (Option A) | <input type="checkbox"/> Benefit paid on Second Wednesday (Option C) |
| <input type="checkbox"/> Benefits paid on 3rd of each month, started receiving SS
benefits prior to May 1997 or receiving both SS benefits and
SSI payments (Option B) | <input type="checkbox"/> Benefit paid on Third Wednesday (Option D) |
| | <input type="checkbox"/> Benefit paid on Fourth Wednesday (Option E) |

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

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

Box B - Bank Withdrawal Account

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____
☐ Survivor Account

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

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

Transit Routing Number _____ Account Number _____ Account Holder Signature _____

Box C - Direct Express MasterCard

Insured Name: _____ Birthdate of Insured: _____

Payor Name if different than Insured: _____ Birthdate of Payor: _____
☐ Survivor Account

5332 48 _____
Direct Express MasterCard Account Number

Cardholder Signature _____ Date _____ \$ _____
Premium amount

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

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

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

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

Signature of Authorized Account Holder _____

Date _____

Schedule Of Social Security Benefit Payments 2017



JANUARY 2017						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

FEBRUARY 2017						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28				

MARCH 2017						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	

APRIL 2017						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

MAY 2017						
S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

JUNE 2017						
S	M	T	W	T	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

JULY 2017						
S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

AUGUST 2017						
S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

SEPTEMBER 2017						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

OCTOBER 2017						
S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

NOVEMBER 2017						
S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

DECEMBER 2017						
S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

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

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

If you don't receive your payment on the expected date, please allow three additional mailing days before contacting Social Security.



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