☐ **Transamerica Premier Life Insurance Company**
Home Office: Cedar Rapids, IA

☐ **Transamerica Life Insurance Company**
Home Office: Cedar Rapids, IA

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

Addendum to Application for Life Insurance Coverage

Check appropriate company - referred to hereafter as "The Company".

Ohio Law requires that this addendum be completed and approved by the Company prior to (a) the issuance of any Whole Life or Universal Life insurance policy with a death benefit that exceeds $50,000 and not owned by a qualified retirement plan, including conversions to such policies from existing term policies; (b) changes to such policies; and (c) reinstatements of such policies. This document serves as an addendum to the life insurance application(s) used in those circumstances.

Please answer the following questions by checking either yes or no, and provide details for any yes answers.

1. ☐ Yes ☐ No Has anyone offered or provided to anyone any inducement - such as cash or other compensation - in relation to the application for, conversion of, or changes to this life insurance policy (existing or applied for)? If yes, please explain: _____

2. ☐ Yes ☐ No Is there any plan to sell or transfer any interest in the existing or applied for life insurance policy? If yes, please explain: _____

3. ☐ Yes ☐ No If an entity will own the existing or applied for policy, is there a plan to sell or transfer any beneficial interest in the entity? If yes, please explain: _____

4. ☐ Yes ☐ No Will premiums for the existing or applied for life insurance policy be borrowed or financed? If yes, please explain (including details of loan guarantee, if any): _____

5. ☐ Yes ☐ No If you answered yes to question 4, can the loan be repaid by the transfer of this policy to the lender or any other person affiliated with the lender? If yes, please explain: _____

6. ☐ Yes ☐ No If you answered yes to question 4, will the amount of any loan or loans, or the borrower's payment obligation, on termination of the financing exceed the amount needed to pay life insurance policy premiums on the existing or applied for policy, plus, loan interest, and loan fees? If yes, please explain: _____

I understand that any arrangement for borrowing funds for the payment of policy premiums is a matter between the lender and the borrower. The Company is not a party to any such arrangement and will not become a party to any such arrangement.

I also understand that neither The Company nor any person acting on its behalf has furnished legal or tax advice upon which I/we may rely. The financing of life insurance premiums involves important tax and other considerations. The Company strongly recommends that you seek advice from your own qualified advisors.

It is represented that the statements and answers given in this Addendum to the application are true, complete and correctly recorded. It is agreed that this Addendum shall be a part of the application to The Company for insurance on the life of the Proposed Insured, and shall be the basis for any policy issued on this application. I understand that the statements and answers given in this Addendum are material to The Company's decision regarding this application, and that The Company would not issue, reinstate, or change the policy as applied for if the statements and answers given on the subject matters covered in this Addendum are not true, complete and correctly reported.

Signed at _____
City, State

_____
(Proposed) Insured(s) Name(s) - Please print

_____ _____
(Proposed) Insured(s) Signature(s) Date

_____ _____
Witness Date

Signed at _____
City, State

_____
(Proposed) Owner(s) Name(s) - Please print
(If different from Insured(s))

_____ _____
(Proposed) Owner(s) Signature(s) Date
(If different from Insured(s))

_____ _____
Witness Date

Financial Foundation IUL Application Checklist

Important Reminders	**DO:**
	☐ Complete the entire application (front and back).
	☐ Print application in blue or black ink.
	☐ Have applicant initial all changes.
	☐ Obtain all required signatures.
	☐ Complete and sign the Agent's Report.
	☐ Include certification if a trust or corporation is Owner and/or beneficiary of the policy.
	☐ Include a signed Illustration.
	☐ If you want Chronic and/or Critical illness riders;
	  ☐ In Section 10, check the 'other' box and write in 'Chronic and Critical Illness riders requested'.
	  ☐ In Agent Comments section below, write in 'Chronic and Critical riders requested'.
	  ☐ Living Benefits MUST be elected on the application. They may not be added once the policy has been placed inforce.
	☐ Include all signed disclosures.
	
	DON'T:
	☐ Use pencil or whiteout.
	☐ Accept or send money for total coverage on the proposed primary Insured over $2,000,000.00.
	☐ Accept cash with application if the proposed primary Insured is age 76 and over.
	☐ Submit an agent check as the initial premium.
	☐ Submit starter checks or checking deposit slips for check-o-matic withdrawals.
	☐ If within the past 12 months the proposed insured has been treated for or experienced heart trouble, stroke or cancer, no payment may be accepted with the application.

PLEASE MAKE SURE ALL APPLICABLE FORMS WITHIN THE PACKET ARE COMPLETED

Leave with Applicant	**THE FOLLOWING PAGES NEED TO BE LEFT WITH THE CONSUMER:** ☐ Privacy Notice ☐ Conditional Receipt (If money taken with application) ☐ Notices page (Notice of Investigative Report, Disclosure of Information, and Insurance Information Practices) ☐ HIPAA Authorization for Release of Health Related Information ☐ Replacement Disclosure - REPLDISC 0210 **(Required in CT, DC and ND)**

Agent Comments

RESET

LIFE APPLICATION – Transamerica Premier Life Insurance Company
Mailing Address: 4333 Edgewood Road NE, Cedar Rapids, IA 52499
Administrative Office: P.O. Box 5068, Clearwater, Florida 33758-5068

INDIVIDUAL LIFE INSURANCE APPLICATION

SECTION 1. PROPOSED PRIMARY INSURED/OWNER

Face Amount $

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Employer | Years

15. Employer's Address and Phone Number

16. Occupation & Duties

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 2. PROPOSED ADDITIONAL INSURED

Face Amount $

If more than one Additional Insured, please use Additional Information Supplement.

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. APPLICANT/OWNER IF OTHER THAN THE PROPOSED PRIMARY INSURED

If owner is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If owner is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Home Phone ( ) | 4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date | 7. Relationship to the proposed primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

SECTION 4. CHILDREN'S BENEFIT RIDER

Face Amount $

Name	Relationship	Date of Birth	Height	Weight
			ft in	lbs
			ft in	lbs
			ft in	lbs

Are all children listed? ☐ Yes ☐ No Are all children living with proposed primary Insured? ☐ Yes ☐ No

If not, explain why: _____

SECTION 5. PRIMARY BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries. If beneficiary is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If beneficiary is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 6. CONTINGENT BENEFICIARY – If percentage shares are not listed below, they will be divided equally among the beneficiaries.

Name	Percent	Relationship	Social Security Number/Tax ID#
Total	**1 0 0**		

SECTION 7. PROPOSED PLAN OF INSURANCE

☐ Transamerica Financial Foundation IUL℠

SECTION 8. DEATH BENEFIT OPTION (if applicable)

☐ Level Benefit ☐ Increasing Benefit

SECTION 9. LIFE INSURANCE COMPLIANCE TEST (if applicable)

☐ Guideline Premium Test ☐ Cash Value Accumulation Test (CVAT)

SECTION 10. ADDITIONAL BENEFITS–PRIMARY INSURED ONLY Not all applicable with all products.

☐ Base Insured Rider..... $ _____
☐ Accidental Death Benefit Rider..... $ _____
☐ Guaranteed Insurability Rider..... $ _____
☐ Disability Waiver of Premium Rider
☐ Disability Waiver of Monthly Deductions Rider
☐ Long Term Care Rider (complete Supplemental Application)
☐ Other _____

SECTION 11. PREMIUMS PAYABLE

Initial Planned Premium..... $ _____ , _____ . _____

☐ Single Premium ☐ Annually ☐ Semiannually ☐ Quarterly ☐ Monthly ☐ Other _____
☐ Electronic (bank draft) _____ Draft Date (1st thru 28th) ☐ Direct Bill

A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.

_____
Secondary Addressee

_____
Street Address (Cannot be a PO Box) City State Zip

SECTION 12. PREMIUM ALLOCATIONS (Only for IUL)

Indicate your premium allocation percentages below. Total must equal 100% and must be whole percents only.

_____.0% Global Index Account
_____.0% S&P 500® Index Account
_____.0% Basic Interest Account
100% Total

S&P® is a registered trademark of Standard & Poor's Financial Services LLC ("S&P") and Dow Jones® is a registered trademark of Dow Jones Trademark Holdings LLC ("Dow Jones"). The foregoing trademarks have been licensed for use by S&P Dow Jones Indices LLC. S&P® and S&P 500® are trademarks of S&P and have been licensed for use by S&P Dow Jones Indices LLC and the Company. The S&P 500® index is a product of S&P Dow Jones Indices LLC and has been licensed for use by the Company. This policy is not sponsored, endorsed, sold or promoted by S&P Dow Jones Indices LLC, Dow Jones, S&P or their respective affiliates and neither S&P Dow Jones Indices LLC, Dow Jones, S&P nor their respective affiliates make any representation regarding the advisability of purchasing this policy.

SECTION 13. OTHER INSURANCE IN FORCE FOR ALL PROPOSED INSUREDS

Does the proposed Insured have existing life insurance, disability policies, critical illness or annuity contracts? ☐ Yes ☐ No

Proposed Insured Name	Company	Product Type	Amount of insurance	Year issued	Replacement?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

IS THIS INTENDED TO BE A 1035 EXCHANGE? ☐ Yes ☐ No
Anticipated Cash Value Transfer $ _____ , _____ . _____

A) Has any proposed Insured ever had life, disability or health insurance declined, rated, modified, issued with an exclusion rider, canceled, or not renewed? If yes, please explain._____ ☐ Yes ☐ No
_____
B) Will the insurance applied for on any proposed Insured discontinue, replace or change any existing life or annuity policy? If yes, complete replacement forms, if appropriate. ☐ Yes ☐ No
C) Is there an application for life, accident or sickness insurance now pending or contemplated on any proposed Insured in this or any other company? If yes, give details in Agent's Report. ☐ Yes ☐ No

SECTION 14. PERSONAL FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

All financial information on non-juvenile business must be that of the proposed primary Insured, not the Owner.

A) Gross Income Current Yr $ _____, _____. _____

B) Gross Income Previous Yr $ _____, _____. _____

C) Source of Funds ☐ Employment ☐ Retirement ☐ Inheritance ☐ 1035 Exchange ☐ Other_____

D) Current Net Worth $ _____, _____. _____

NOTE: Complete a Confidential Financial Questionnaire for coverage over $2,000,000 for ages 18 through 70 and $1,000,000 for ages 71 and up.

SECTION 15. BUSINESS FINANCIAL STATEMENT FOR PROPOSED PRIMARY INSURED

A) Current Estimated Market Value $ _____ , _____ , _____

B) Assets *Liquid* $ _____ , _____ , _____

Nonliquid $ _____ , _____ , _____

C) Liabilities $ _____ , _____ , _____

D) Net Worth $ _____ , _____ , _____

SECTION 16. MEDICAL QUESTIONS – Each question must be individually asked and answered for each proposed Insured.

Give the details to "No" answer for medical question 16A and "Yes" answers to questions 16B-E in Section 17 below:

A) For the last 180 days has the proposed primary Insured been actively at work, on a full time basis, at their usual place of business or employment? ☐ Yes ☐ No

B) To the best of your knowledge, has any proposed Insured within the last 10 years had or been told by a member of the medical profession that he or she had, or has been treated for:

1) Heart murmur, high blood pressure, chest pain, heart attack, stroke, or other disorder of the heart or circulatory system? ☐ Yes ☐ No

2) Asthma, Emphysema, Chronic Bronchitis, Tuberculosis, or any other Respiratory disorder; colitis, ulcer or any other gastrointestinal disorder; jaundice, hepatitis, liver or kidney disorder? ☐ Yes ☐ No

3) Cancer, tumor, polyp, breast, prostate or any other reproductive disorder; or any thyroid or endocrine disorder? ☐ Yes ☐ No

4) Brain, seizure or mental disorder, anxiety, depression, suicide attempt or any paralysis? ☐ Yes ☐ No

5) Diabetes, anemia, or any disorder of the blood; sugar, protein, or blood in the urine? ☐ Yes ☐ No

C) To the best of your knowledge, has any proposed Insured within the last 10 years:

1) Used amphetamines, heroin, cocaine, marijuana, or any other illegal or controlled substance except as prescribed by a physician? ☐ Yes ☐ No

2) Sought or been advised to seek treatment, limit or discontinue use of alcohol? ☐ Yes ☐ No

3) Been on or are now on prescribed medication or prescribed diet? ☐ Yes ☐ No

4) Had or been advised to have any hospitalization, surgery, or any diagnostic test including, but not limited to, electrocardiograms, blood studies, scans, MRI's or other test (excluding HIV or AIDS tests)? ☐ Yes ☐ No

5) Had an examination, treatment or consultation with a doctor or health care provider other than above? ☐ Yes ☐ No

D) Within the last 10 years, has any proposed Insured been told by a member of the medical profession that he or she had a diagnosis of AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for the HTLVIII test? ☐ Yes ☐ No

E) Has any proposed Insured had a parent, brother, or sister who had any occurrence of or death from coronary artery disease, cardiovascular disease, internal cancer or melanoma prior to age 60? ☐ Yes ☐ No

SECTION 17. DETAILS TO ANSWERS FOR MEDICAL QUESTIONS Identify question number; state diagnosis, dates, duration, treatment, results and medications of each illness or injury. List the name, full address, phone number, and dates of each health care provider consulted.

Question #	Proposed Insured's Name	Diagnosis, Dates, Durations, Treatments, Results and Medications	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 18. PERSONAL PHYSICIAN (if none, so state)

Proposed Insured's Name	Date Last Seen, Reason and Results	Name, Address and Phone # of Attending Doctor and Hospital

SECTION 19. RESIDENCY – Each question must be individually asked and answered for each proposed Insured.

A) The proposed Insured is a citizen of ☐ USA ☐ Other Country _____ Type of VISA_____

B) How many years has the proposed Insured resided in the USA?_____

C) Does any proposed Insured travel outside the USA? ☐ Yes ☐ No

If yes, provide details: include name of proposed Insured, destination, number of trips, duration of each trip, purpose of trip, plans for the next year.

SECTION 20. DRIVING AND PUBLIC RECORDS –Each question must be individually asked and answered for each proposed Insured.

A) Has any proposed Insured had their driver's license suspended, restricted, revoked, or been cited for a moving violation in the last 5 years? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

B) Has any proposed Insured in the last ten years been convicted of a misdemeanor (other than a minor traffic violation) or felony? ☐ Yes ☐ No If yes, include name of proposed Insured and give reason:

SECTION 21. SPECIAL ACTIVITIES – Each question must be individually asked and answered for each proposed Insured.

A) Except as a passenger on a regularly scheduled flight, has any proposed Insured flown within the past 2 years, or does any proposed Insured have plans to fly in the future? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

B) In the past 2 years has any proposed Insured participated in organized racing (automobile, motorcycle, or boat), underwater or sky diving, hang gliding, canyoneering, mountain or rock climbing? If yes, complete the Avocation and Aviation Questionnaire. ☐ Yes ☐ No

SECTION 22. OTHER INSURANCE–TO BE COMPLETED BY THE AGENT

A) Will the policy applied for discontinue, replace or change any existing life insurance policy or annuity? ☐ Yes ☐ No

B) If mandated by your state, did you present, read and leave a copy of the Replacement Notice with the Applicant/Owner at time of application? ☐ Yes ☐ No

(In some states the Replacement Notice must be completed and sent in with the application whether or not the Applicant/Owner intends to replace existing coverage.)

C) Did you present and leave the Applicant/Owner approved sales material? ☐ Yes ☐ No

SECTION 23. ILLUSTRATION CERTIFICATION (if applicable) **The box below MUST be checked if a signed illustration of the policy applied for is NOT enclosed with this application.**

☐ The Applicant/Owner and the Licensed Agent certify that they have each read and agree with their respective statements below regarding the policy applied for:

Applicant's/Owner's statement: By signing this application, I, the Applicant/Owner acknowledge that I have NOT received an illustration of the policy applied for and understand that an illustration of the policy as issued will be provided no later than the policy delivery date. **Licensed Agent's statement:** By signing this application, I, the Licensed Agent certify that I have NOT provided an illustration of the policy as applied for. However, I will provide an illustration conforming to the policy as issued upon or prior to delivery of the policy.

SECTION 24. AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

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 undersigned applicant is the premium payor and Owner of the policy applied for.

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 Transamerica Premier Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Premier Life Insurance Company, or its reinsurers, to make a brief report of my personal 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.

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.

I acknowledge receipt of the (1) Notice to Persons Applying for Insurance Regarding Investigative Report, (2) MIB Pre-Notification, and (3) Notice of Insurance Information Practices.

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.

I also understand that I will not receive any insurance coverage for any money paid with this application unless a policy is issued except in accordance with the terms of the Conditional Receipt.

TAXPAYER IDENTIFICATION CERTIFICATION

Under current federal tax laws, the Company is required to obtain your Taxpayer Identification Number (e.g., a social security or employer identification number, or "TIN") and certification that you are not subject to backup withholding. Please review the following certification and sign accordingly.

Under penalties of perjury, I certify that (1) the TIN listed in this application is my correct TIN; (2) I have not been notified that I am subject to backup withholding or I am not subject to backup withholding because I am an exempt recipient; and (3) I am a U.S. Person (U.S. citizen/legal resident). If not a U.S. Person, I have completed the appropriate Form W-8BEN. The IRS does not require your consent to any provision of this form other than this certification.

Fraud Warning: 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.

Signed at _____ _____ on _ _ _ _ _ _ _ _
(city) (state) (date)

_____ _____
Signature of proposed primary Insured/Owner (Child age 16 and over must sign) | Print Agent Name

_____ _____
Signature of parent or legal guardian for Insured(s) 15 and under | Agent #

_____
Signature of proposed Additional Insured

_____ _____
Signature of Applicant/Owner if other than the proposed primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name) | Signature of Agent/Licensed Rep.

_____
Signature of Split Agent/Licensed Rep.

This page intentionally left blank

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Premier Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Tobacco Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed it, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a notice and/or a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,000,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance for a class of risk with extra ratings regardless of age.

There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a proposed primary Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed primary Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Premier Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

X _____ _____ , 20 _____

Signature of Proposed Owner | Date

_____ _____

If Proposed Owner is a Trust, the Trustee must sign as Owner. Give full name and date of Trust.

If Proposed Owner is a Corporation, an authorized officer, other than the proposed primary Insured must sign as Owner. Give corporate title and full name of corporation.

Submit this completed and signed original with the application and payment.

Original

This page intentionally left blank

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____ , with _____ as the proposed primary Insured.

This Receipt cannot become valid unless all blanks are completed above, your check, draft or authorized withdrawal is made payable to Transamerica Premier Life Insurance Company (the Company), this Receipt is signed by a duly authorized insurance producer or other Company authorized representative, and you signify that you understand the conditions and limitations of this Receipt and have had them explained to you by signing the Acknowledgment below.

This Receipt does not provide any conditional insurance until after all of the conditions and requirements specified are met, and is strictly limited in scope and amount as set forth below.

CONDITIONAL COVERAGE: Conditional insurance on the proposed primary Insured, under the terms of the contract applied for, may become effective as of the date of completing all parts of the application (including medical questions), the date of the last medical examination, tests, and other screenings required by the Company, if any, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

CONDITIONS TO CONDITIONAL COVERAGE UNDER THIS RECEIPT: Such conditional insurance will take effect as of the Effective Date, but only so long as all of the following conditions are met:

1. The payment made with the application must not be less than the full initial premium for the mode of payment chosen in the application, must be received at our Administrative Office within the lifetime of the proposed primary Insured to whom the conditional coverage would apply and, if in the form of check or draft, must be honored for payment;
2. All parts of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (all parts) must be true and complete; and
4. The Company is satisfied that, as of the Effective Date the proposed primary Insured to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Tobacco Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed it, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a notice and/or a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on the proposed primary Insured to be covered shall be limited to the lesser of the amount(s) applied for, or:

1. $400,000 of life insurance if the proposed primary Insured is age 0-15 and is insurable at a standard or better class of risk, or
2. $1,000,000 of life insurance if the proposed primary Insured is age 16-65 and is insurable at a standard or better class of risk, or
3. $400,000 of life insurance if the proposed primary Insured is age 66-75 and is insurable at a standard or better class of risk, or
4. $100,000 of life insurance for a class of risk with extra ratings regardless of age.

There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. Conditional coverage only applies to the proposed primary Insured. There is no conditional coverage on any other persons proposed for coverage in the application.

IF CONDITIONS ARE NOT MET OR DEATH OCCURS FROM SUICIDE, THERE IS NO COVERAGE UNDER THIS RECEIPT. If one or more of this Receipt's conditions have not been met exactly, or if a proposed primary Insured dies by suicide or intentional self-inflicted injury, while sane or insane, the Company will not be liable under this Receipt except to return any payment made with the application. If the proposed primary Insured should die before completing all medical examinations, tests, screenings, and questionnaires required by the Company or would not be insurable under the Company's rules, then the Company will not be liable under this Receipt except to return any payment made with the application.

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in the application have been met.

Dated at _____ on _____ ,20____ X _____

City, State | Date | Insurance Producer or other Company Authorized Rep

---

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Premier Life Insurance Company. The insurance producer has fully explained to me all the terms, conditions, and limitations of the Conditional Receipt, and I understand them.

I also understand neither the insurance producer, any person who has signed this Receipt, nor the medical/paramedical examiner is authorized to accept risks or determine insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

Leave this page with the proposed Owner if money is submitted with application

Proposed Owner

This page intentionally left blank

NOTICES

DETACH AND LEAVE THIS PAGE WITH APPLICANT

NOTICE TO PERSONS APPLYING FOR INSURANCE REGARDING INVESTIGATIVE REPORT

To proposed Insured: In connection with this application, an investigative consumer report may be prepared about you. Such reports are part of the process of evaluating risks for life and health insurance. Typically, this report will contain information about your character, general reputation, personal characteristics and mode of living. The information in the report may be obtained by talking with you or members of your family, business associates, financial sources, neighbors, and others you know. You may ask to be interviewed in connection with the preparation of any such report. Also, we may have the report updated if you apply for more coverage.

Upon your written request, we will let you know whether a report was prepared and we will give you the name, address, and telephone number of the agency preparing the report. By contacting that agency and providing proper identification, you may obtain a copy of the report.

MIB PRE-NOTIFICATION

Proposed Insured and other persons proposed to be insured, if any. 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, 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.

NOTICE OF INSURANCE INFORMATION PRACTICES

To proposed Insured: Personal information may be collected from persons other than the individual(s) proposed for coverage. Such information as well as other personal or privileged information subsequently collected by us or our agent may in certain circumstances be disclosed to third parties without authorization. Upon request, you have the right to access your personal information and ask for corrections. You may obtain a complete description of our Information Practices by writing to Transamerica Premier Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

PLEASE PROVIDE A COPY OF THIS NOTICE TO THE PROPOSED INSURED IF NOT A HOUSEHOLD MEMBER.

This page intentionally left blank

Additional Information Supplement

SECTION 1. PROPOSED CONTINGENT OWNER **If owner is a corporation, partnership or institutional body, please complete the Entity Certification of Authority form. If owner is a trust, please complete the Trustee Certification Trust form. Attach a copy of the first page and the signature page of the Trust.**

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Home Phone ( ) | 4. Social Security Number / Tax ID #

5. Sex ☐ Male ☐ Female | 6. Date of Birth/Trust Date | 7. Relationship to proposed primary Insured

8. Are you a citizen of ☐ USA ☐ Other Country _____ Type of VISA _____

SECTION 2. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 3. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name | First Name | M.I.

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

State | Zip Code | 3. Years at Address | 4. Home Phone ( ) | 5. Driver's License Number | State

6. Sex ☐ Male ☐ Female | 7. Date of Birth | 8. Age | 9. Place of Birth – State/Country | 10. Social Security Number

11. Height ft in | 12. Weight lbs | 13. Marital Status | 14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties | # Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 4. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 5. PROPOSED ADDITIONAL INSURED **Face Amount $**

We will allow the AIR death benefit recipient to be a choice of: ☐ Owner ☐ Primary Insured ☐ Same beneficiary as the base policy

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Years at Address	4. Home Phone ( )	5. Driver's License Number	State

6. Sex ☐ Male ☐ Female	7. Date of Birth	8. Age	9. Place of Birth – State/Country	10. Social Security Number

11. Height ft in	12. Weight lbs	13. Marital Status	14. Relationship to proposed primary Insured

15. Employer's Name, Address and Phone Number

16. Occupation & Duties	# Years

17. Have you used **TOBACCO** or any other product containing **NICOTINE** in the last 5 years? ☐ Yes ☐ No Date last used _____

18. Rate Class Quoted: ☐ Preferred Elite ☐ Preferred Plus ☐ Preferred ☐ Non-Tobacco ☐ Preferred Tobacco ☐ Tobacco ☐ Juvenile

SECTION 6. DECLARATIONS

I (We) represent that all statements and answers made in this supplement are full, complete and true to the best of my (our) knowledge and belief. It is agreed that this statement shall be made part of the application, and is subject to all terms and conditions contained in the application.

Signed at _____ _____ on MM - DD - YYYY
(city) (state) (date)

sec. 1 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

sec. 3 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

sec. 2 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

sec. 4 _____
Signature of proposed Additional Insured
(Child age 16 and over must sign)

_____
Signature of Parent or Legal Guardian for Insured(s) 15 and under

_____
Signature of Applicant/Owner, if other than the proposed primary Insured (If business insurance, show title of officer and name of firm. If trust, show trustee's name)

_____
Witness (Agent/Licensed Rep.)

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL: _____

PRODUCER 1: _____ | _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 2: _____ | _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

PRODUCER 3: _____ | _____ SHARE %: _____
LAST FIRST

OFFICE ID #: _____ PRODUCER ID #: _____ PRODUCER PROFILE #: _____
(UP TO 6 DIGITS) (UP TO 10 DIGITS) (UP TO 3 DIGITS)

Indicate City/County Code as required in AL, GA, KY, LA, & SC _____

What is the purpose for insurance? _____

Are you related to the Proposed Insured? ☐ Yes ☐ No Relationship _____

How long have you known the Proposed Insured? _____

Proposed Insured is: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

☐ Yes ☐ No To the best of your knowledge, does the applicant have any existing life insurance or annuities?

☐ Yes ☐ No To the best of your knowledge, could replacement be involved?

X _____
Signature of Producer

This page intentionally left blank

PAYOR'S CHECK-O-MATIC PREMIUM PAYMENT PLAN (Automatic Bank Draft)

Authorization to Insurance Company

The Premium Payor hereby authorizes Transamerica Premier Life Insurance Company to debit his/her account or accounts by means of check or draft drawn or other order made whether by electronic or paper means at the below named financial institution for premiums that may become due under the policy as a result of this application. This authorization is to remain in effect until written notice of revocation is received at the Administrative Office of the Company or until the Check-O-Matic Premium Payment Plan is terminated in a manner provided below. I (We) expressly agree to all conditions applicable to the Check-O-Matic Premium Payment Plan including those appearing below.

Authorization to Financial Institution

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks, drafts and other orders whether by electronic or paper means, with such debits made to my account and drawn or directed by Transamerica Premier Life Insurance Company to its own order, provided there are sufficient collected funds in said account to pay the same upon presentation. Until you receive written cancellation of this authorization by me (or either of us), you are fully protected when you honor any of those orders. You may, however, discontinue this arrangement by giving 30 days written notice to me (or either of us) and the insurance company. Your treatment of and your rights regarding those orders, shall be the same as if I signed or initiated them. If any of those orders are not honored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability if insurance is forfeited as a result. Notice of charge for debit is hereby waived.

Initial Payment (Must Check One Box)

☐ CHECK: Check this box if you are attaching a check for the initial modal premium. The check will be deposited upon receipt of the application by the Company.

☐ AUTOMATIC WITHDRAWAL: Check this box to have the initial modal premium withdrawn from the account listed below. By checking this box, I/we agree that I/we want an amount sufficient to pay the initial premium due for the insurance policy withdrawn from the account. This initial premium amount may not equal the amount reflected below. I/we further understand that no insurance will be provided except under the terms of a conditional receipt which may be given at the time the application is taken, and then only if and when all conditions and requirements of the conditional receipt have been satisfied.

Initial premium will be withdrawn upon receipt of the application by the Company and not on the day of the future recurring monthly payment stated below.

Account Information

TAPE VOIDED CHECK HERE

If not attaching void check or if withdrawing from Savings Account, complete the following information

Bank Name, Office or Branch

Payor Name(s)

Check one: ☐ Checking ☐ Savings

Transit Routing Number

Account Number

Complete the Following Information for Future Recurring Payments

Premium to Withdraw	☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
$ _____	☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

Signature

Payor Signature(s) – as on financial institution's records. A copy is as valid as the original.

X _____ **Date:** _____

Conditions Applicable to Check-O-Matic Premium Payment Plan

No check, draft or any other orders, either by electronic or paper means, shall constitute payment until the Company actually receives payment thereof within the period provided in the policy.

The Check-O-Matic Premium Payment Plan may be terminated by either party by giving written notice to the other.

The Check-O-Matic Premium Payment Plan does not in any manner amend or alter the terms and provisions of any policy, contract or agreement except as may be specifically stated in a policy endorsement or properly executed contract amendment.

For changes or questions call: Toll-free 1-800-851-9777

Or Write: Transamerica Premier Life Insurance Company, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

RESET

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

1. Last Name	First Name	2. 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

❑ 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

RESET

TRANSAMERICA®

Supplemental Application
Death Benefit Option Election Form

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

This Supplemental Application replaces and supercedes SECTION 8. DEATH BENEFIT OPTION, on the application. Please elect one of the following death benefit options below:

- ☐ Level Benefit
- ☐ Increasing Benefit
- ☐ Graded Death Benefit

I acknowledge and agree that this Supplemental Application together with the original application and any amendments thereto shall be the basis for any insurance issued. This Supplemental Application shall form a part of the original application and of the policy issued thereunder, if any, and they shall be binding on any person who shall have or claim any interest under such policy.

Print Name of Owner

Signature of Owner

Signature of Agent

Date

RESET

Transamerica Financial Foundation IUL®

Offered by Transamerica Premier Life Insurance Company, Cedar Rapids, IA ("the Company")

Statement of Understanding and Acknowledgment

Applicant's Name: _____

I am applying for an Index Universal Life Insurance Policy to be issued by the Company. In connection with my application I understand that:

THE POLICY

This policy is intended for people whose primary purpose in buying life insurance is for the death benefit.

Since a portion of the interest credited to the Index Account(s) is calculated in part by reference to outside indexes, there is the potential for greater volatility in the amount of Excess Index Interest credited than of interest credited to the Basic Interest Account. This policy works best for those individuals who can tolerate fluctuations in interest crediting and is not recommended for policyowners who do not intend to allocate a significant portion of their net premiums to the Index Account(s).

This policy is not an investment in the stock markets or the indexes and does not participate in any stock or investments.

PREMIUMS

I must pay premiums on a regular basis to keep the policy in effect. The policy may lapse if I do not have sufficient Cash Surrender Value (Policy Value less the Surrender Charge and less any Loan Balance) in the policy to pay the next Monthly Deduction and Index Account Monthly Charge and have not paid enough premiums to meet the Minimum No Lapse Premium requirement. In that event, I would be required to pay additional premiums to keep the policy in force.

ACCOUNT OPTIONS

The policy I am applying for allows me to allocate my net premium payments to more than one Account Option: the Basic Interest Account and the Index Accounts. Interest will be credited differently to the different Account Options.

INTEREST

Net premiums allocated to the Basic Interest Account will earn interest at the Current Interest Rate declared by the Company. This rate is guaranteed never to be less than 2% per year. Net Premiums received after a Monthly Policy Date that are to be allocated to the Basic Interest Account will earn interest at the Current Interest Rate until the next Monthly Policy Date, when they will be placed into the next Basic Interest Account Segment.

Net Premiums allocated to the Index Accounts will earn interest at a guaranteed minimum annual interest rate of 0.75%. Net Premiums received after a Monthly Policy Date that are to be allocated to an Index Account will earn interest at the guaranteed rate until the next Monthly Policy Date, when they will be placed into the next Index Account Segment. Additional interest ("Excess Index Interest") may be credited at of the end of each one-year Segment Period.

EXCESS INDEX INTEREST

Excess Index Interest on the Index Accounts is determined using a formula based on changes in the index(es), excluding dividend income, and cannot exceed the Cap established by the Company. The Company may determine a different Cap for each Segment and can increase or decrease the Cap at its discretion at the Segment Anniversary. Current Caps will be shown in Policy Statements and may be obtained from the Company's Administrative Office.

Excess Index Interest, if any, is credited to a segment at the end of each one year Segment Period. Any Policy Values, Death Benefit or Cash Surrender Value determined during a Segment Period will be based only on guaranteed minimum interest that has already been credited during the Segment Period. A Policy Statement reflecting Policy Values and the interest credited for a policy year will be provided annually.

EXCESS INDEX INTEREST (CONTINUED)

Monthly Deductions, Index Account Monthly Charges, and certain policyowner transactions, such as transfers, loans and withdrawals, occurring during a Segment Period will reduce the value used in determining Excess Index Interest. This will result in the reduction of any Excess Index Interest that might otherwise have been credited at the end of the Segment Period. Upon surrender of the policy, no Excess Index Interest will be credited for partial years on any Index Account Segment.

TRANSFERS

Transfers from an Index Account Segment will only be processed at the end of the Segment Period. For purposes of dollar cost averaging, transfers to an Index Account are processed on the monthly policy date following receipt of the request. Transfers from the Basic Interest Account will only be processed on the monthly date following receipt of the request.

LOANS AND WITHDRAWALS

Loans and withdrawals may be taken from the Basic Interest Account and the Index Accounts(s). Loans and withdrawals are Subject to certain fees and charges and to the conditions and limitations specified in the policy.

SURRENDERS

If the policy is surrendered, the Cash Surrender Value of the policy will be equal to the Policy Value less any applicable surrender charges and any Loan Balance. Surrender charges apply for the first fifteen policy years and for fifteen years from the date of any Face Amount increase. The surrender charge will vary based on the Face Amount and duration of the Policy and the issue age, gender and class of risk of the insured on the policy date and at the time of any increase in the Face Amount.

CONSUMER BROCHURE

I have received a copy of the Consumer Brochure containing information regarding the policy. I understand that I have a certain period of time after receipt of the policy issued to me to review and return it for a refund of premium as described in the policy.

I have read and understand the above disclosures of certain limitations and restrictions regarding the policy and the Index Account(s).

The guaranteed minimum interest rates for the Basic Interest Account and Index Accounts are shown on the previous page. Non-guaranteed rates and other elements appearing on illustrations or other related materials are hypothetical and actual results may be less favorable than those shown on such documents. I understand I may select the assumed rates and elements used in illustrations or other related materials.

Date: _____ Applicant Name (print): _____

Signature of Applicant: _____

INDEX UNIVERSAL LIFE INSURANCE IS NOT A SECURITY and index universal life insurance policies are not an investment in the stock market or in the indexes. Index Account Interest is based, in part, on index performance.

Past performance of an index is not an indication of future index performance. There is no guarantee that any Excess Index Interest will be credited above the guaranteed minimum interest rate for the Index Account(s). Additionally, there is no guarantee that the company will declare an interest rate greater than the guaranteed minimum interest rate for the Basic Interest Account.

Index Universal Life Insurance offered by:
Transamerica Premier Life Insurance Company, Cedar Rapids, IA • Home Office: Cedar Rapids, IA

RESET

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:

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

Signature of Primary Proposed Insured/Patient or Personal Representative	Date
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

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

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

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

Policy or contract number (if known): _____

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

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:

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

RESET

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:

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

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:

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

RESET

☐ **Transamerica Life Insurance Company**
☐ **Transamerica Premier Life Insurance Company**
4333 Edgewood Road NE, Cedar Rapids, IA 52499

Notice and Consent for HIV-Related Testing OHIO

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood or other bodily fluid sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

Human Immunodeficiency Virus (HIV)

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to HIV are found in the blood and other bodily fluids of people who have been exposed to the virus. You do not have to have AIDS to have antibodies against HIV. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-testing Consideration

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure Of Test Results

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company designated on your application for insurance. The insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal (negative), you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the insurer who participate in medical underwriting decisions of the insurer. Abnormal test results may also be disclosed to affiliates of the insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva), or urine abnormality may be made known to MIB, Inc. (MIB). MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with MIB that you had a positive HIV antibody test; however, there will be a record at MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, MIB, upon request, will supply the information on you in its file to that member.

Notice and Consent for HIV-Related Testing OHIO

Test Results

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at a greater risk of developing AIDS or AIDS-related conditions if you do not take appropriate medications. If you are infected with HIV, you are infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Other Sources Of Information

For more information about HIV or AIDS you may ask a doctor, a nurse, a counselor, or call the Ohio AIDS Hotline at 1-800-332-AIDS (2437), or the National AIDS Hotline at 1-800-872-2437. The hotline is a free call.

Consent

I have read and I understand this *HIV Notice and Consent form*. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety (90) days from the date of my signature below. Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

Notification of Positive Test Result

In the event of a positive test result:

☐ Send the result to me at:

_____
Street

_____
City, State, Zip Code

☐ I authorize the Insurer to send the result to the following physician or health care provider:

_____
Name

_____
Address

_____
Phone Number

☐ I authorize the Insurer to send the result to another person:

_____
Name

_____
Address

Authorization

Proposed Insured (*Please Print*)	Date of Birth
Signature of Proposed Insured	Date Signed
Signature of Person Obtaining Consent	Date Signed

RESET

TRANSAMERICA PREMIER LIFE INSURANCE COMPANY

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

Supplemental Application for Index Universal Life Policy

Supplement to Application Dated: _____

Premium Amount: $ _____

Indicate your premium allocation percentages below. Total must equal 100%.

_____.0%	Global Index Account
_____.0%	Index Account
_____.0%	Basic Interest Account
100%	**Total**

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 that this Supplemental Application together with the original application and any amendments thereto shall be the basis for any insurance issued. This Supplemental Application shall form a part of the original application and of the policy issued thereunder, if any, and they shall be binding on any person who shall have or claim any interest under such policy.

Dated at_____ this _____day of _____, _____

_____ _____

Signature Of Owner if other than Proposed Insured

Signature Of Proposed Insured

TRANSAMERICA PREMIER LIFE INSURANCE COMPANY

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

Supplemental Application for Index Universal Life Policy

Supplement to Application Dated: _____

Premium Amount: $ _____

Indicate your premium allocation percentages below. Total must equal 100%.

_____.0%	Global Index Account
_____.0%	Index Account
_____.0%	Basic Interest Account
_____**100%**	**Total**

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 that this Supplemental Application together with the original application and any amendments thereto shall be the basis for any insurance issued. This Supplemental Application shall form a part of the original application and of the policy issued thereunder, if any, and they shall be binding on any person who shall have or claim any interest under such policy.

Dated at_____ this _____day of _____, _____

_____ _____

Signature Of Owner if other than Proposed Insured Signature Of Proposed Insured

RESET

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

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

Illustration Certification Form

☐ I certify that I displayed a **computer screen illustration** for _____ (APPLICANT) that complies with state requirements and for which no hard copy was furnished. The illustration was based on the following personal and policy information:

1. Gender ..... Male ☐ Female ☐
2. Age ..... _____
3. Underwriting Class ..... _____
4. Generic Name (check one) ..... ☐ Universal Life: ☐ Flexible Premium Adjustable Life ☐ Single Premium ☐ Term

   Policy Name ..... _____
5. Type of Rider(s) ..... _____
6. Initial Death Benefit ..... _____
7. Nonguaranteed Interest Rate ..... _____
8. Guaranteed Interest Rate ..... _____
9. Policy Years Illustrated ..... _____
10. Premium Amount Illustrated ..... _____
11. Assumed number of years premiums are paid ..... _____

_____ (DATE) _____ (AGENT)

I acknowledge that I viewed a computer screen illustration based on the information as stated above. No hard copy of the illustration was furnished. I understand that an illustration conforming to the policy as issued will be provided to me no later than at the time the policy is delivered.

_____ (DATE) _____ (APPLICANT)

☐ I certify that **no illustration was used** by me or any other authorized agent of _____ Insurance Company **in the sale** of 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) _____ (AGENT)

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)

☐ I certify that the **illustration shown at the point of sale is other than the policy as applied for** by _____ (APPLICANT). An illustration conforming to the requirements of _____ (STATE) state regulations on illustrations shall be delivered to this applicant no later than the policy delivery date.

_____ (DATE) _____ (AGENT)

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)