



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

**Supplemental  
 Application for  
 Long Term Care Rider  
 (LTCR)**

This is a supplement to the Application for Life Insurance for the proposed Insured. Please complete if LTC Rider is being elected.

**New Application**       **Reinstatement**      (Check the applicable box.)

**Section 1 Proposed Insured and Owner Information**

	First Name	M.I.	Last Name	Date of Birth (MM/DD/YYYY)
Proposed Insured:	_____	_____	_____	_____
Owner: (if other than the proposed Insured)	_____	_____	_____	_____

**Section 2 Protection Against Unintended Lapse**

I, the Owner, understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. (Check the applicable box.)

I designate the following person to receive notice prior to cancellation of my rider for nonpayment of premium (complete information below):       I elect **NOT** to designate a person to receive this notice. I may change my election at a future date.

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

**Section 3 Health Questions - In this section, "You" means the proposed Insured.**

1. During the last 12 months, have you ever:

a) required assistance or supervision of any kind to perform any every day activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring or toileting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) used a catheter, chair lift, crutches, dialysis, motorized scooter, oxygen equipment, quad or three-pronged cane, respirator, walker or wheelchair?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) been advised to enter or resided in a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), or rehabilitation facility, or attended an adult day care facility, or required home health care?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. During the last 3 years, have you ever used insulin to treat Diabetes, or have you ever been diagnosed or treated for Diabetes WITH COMPLICATIONS (such as Neuropathy, Retinopathy, Nephropathy, Heart Disease, Stroke or Peripheral Vascular Disease)?  Yes  No

3. Have you EVER been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following condition(s):

Alzheimer's disease or Dementia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Amputation due to disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ALS (Lou Gehrig's disease)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis with narcotic pain medication	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Strokes/CVA's/TIA's	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organ Transplant (other than Corneal)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Huntington's Chorea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Muscular Dystrophy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Myasthenia Gravis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Organic Brain Syndrome	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis with fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Parkinson's disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Polymyositis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Scleroderma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Memory loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Unplanned weight loss greater than 15 pounds within the last 2 years	<input type="checkbox"/> Yes	<input type="checkbox"/> No

4. Do you have a parent or sibling diagnosed or treated by a member of the medical profession for Huntington's Chorea or Polycystic Kidney Disease?  Yes  No

**If Questions 1, 2, 3 or 4 were answered yes, the rider is not available for the proposed Insured and this application supplement should not be completed or submitted.**

5. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions:
- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Disorientation                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Used a Straight Cane            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Transient Ischemic Attack (TIA) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of Balance                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of Strength                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tremors                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dizziness                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
6. Do you have a handicap sticker, handicap placard, or handicap license plate? (Give reason below.)  Yes  No
7. In the last 24 months, have you had to limit or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies? (Give reason below.)  Yes  No

**Give details for all yes answers to questions 5, 6, & 7. For every medication there should be a condition and for most conditions there should be a medication or treatment.**

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/Medication Taken	Name of Physician Seen/Physician's Address

8. Within the past 5 years, have you ever received any long term care benefits, disability income benefits or Social Security Disability benefits? If the answer is yes, provide details in Section 5, Remarks.  Yes  No
9. Within the past 5 years, have you ever been declined for long term care insurance including long term care insurance provided by rider to a life insurance or other policy? List company name, date and reason in Section 5, Remarks.  Yes  No

**Section 4 Existing and Pending Coverage - In this section, "You" means the proposed Insured. (Provide details of yes answers below.)**

1. Are you covered by Medicaid?  Yes  No
2. Are you covered under any other long term care insurance policy, contract or rider in force?  Yes  No
3. Has any of your long term care insurance, including coverage by riders, lapsed, been surrendered or otherwise terminated in the past 24 months?  Yes  No
4. Is the coverage applied for intended to replace any long term care, medical or health or disability insurance coverage?  Yes  No
5. Are there any other life insurance policies currently in force on your life which provide similar long term care or accelerated death benefit coverage?  Yes  No
6. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)? If yes, please give details in Section 5, Remarks.  Yes  No
7. Did you have a long term care insurance policy or certificate in force in the last 12 months?  Yes  No  
If yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in Section 5, Remarks.
8. Do you intend to replace any in force medical or health insurance coverage with this policy? If yes, please provide details in Section 5, Remarks and complete the required replacement form.  Yes  No

**If yes to questions 5-8, please provide details.** If more space is needed, please use the Supplemental Information form.

Name and Address of Insurance Company	Policy/Certificate Number	Type and Amount of Benefits	Lapse Date	Currently In Force?		Being Replaced?	
				Yes	No	Yes	No
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 5	Remarks

**I, the proposed Insured, and I, the Owner if different, have read the application and hereby represent** that all statements and answers given in this application supplement are true and complete to the best of my/our knowledge and belief. **I/we agree** that: (1) the statements and answers in this application supplement, and the Application shall be the basis for any contract issued, and that no information about the applicant will be considered to have been given to the company unless it is stated in the application; (2) the coverage I/we are applying for provides benefits for the proposed Insured only; and (3) no waiver or modification shall be binding upon Transamerica Premier Life Insurance Company (“the Company”) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

**Caution: If your answers on this application supplement and/or on the Application for the life insurance policy to which the LTC Rider will be attached are incorrect or untrue, Transamerica Premier Life Insurance Company may have the right to deny benefits or rescind coverage.**

**I understand** that benefits under the Long Term Care Rider are provided through an accelerated death benefit option, and that if I exercise the accelerated death benefit option, any beneficiary I designate will receive a reduced death benefit.

**I certify** that I have received the Outline of Coverage, HIPAA Privacy Notice, the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the “Guide to Health Insurance for People with Medicare.”

**Fraud Warning: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.**

**X** \_\_\_\_\_  
Signature of proposed Insured

\_\_\_\_\_  
Date (MM/DD/YYYY)

**X** \_\_\_\_\_  
Signature of Owner (if other than proposed Insured)

\_\_\_\_\_  
Date (MM/DD/YYYY)

**X** \_\_\_\_\_  
Signature of Licensed Agent/Insurance Producer

\_\_\_\_\_  
Date (MM/DD/YYYY)

**AGENT/INSURANCE PRODUCER'S REPORT**

<b>Insurance Producer's Report</b>				
1. Did you personally interview the proposed Insured, ask all the questions and witness the signatures?				<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did you see or hear or were you advised of any physical impairment of the proposed Insured with regard to walking, speaking, any form of tremor or any signs of confusion or disorientation?				<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did you review the current long term care, medical or health or disability insurance coverage of the proposed Insured and find that the coverage applied for is appropriate for the applicant's needs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
4. To the best of your knowledge, is the insurance applied for intended to replace any other long term care, medical or health or disability insurance coverage in force with this or any other company?				<input type="checkbox"/> Yes <input type="checkbox"/> No
5. To the best of your knowledge, is the information provided in this application true and complete?				<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the proposed Insured live alone?				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>LIST ANY OTHER HEALTH INSURANCE COVERAGE YOU HAVE SOLD ON THE PROPOSED INSURED</b>				
(1) List policies or other coverage sold that are still in force; and				
(2) List policies or other coverage sold within the last five (5) years that are no longer in force.				
Insurance Company	Policy/Certificate Number	Type and Amount of Benefits	In Force	Lapse Date
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Licensed Agent/Insurance Producer: \_\_\_\_\_  
Last First

Licensed Agent/Insurance Producer ID #: \_\_\_\_\_  
(Up to 10 Digits)

\_\_\_\_\_  
Signature of Licensed Agent/Insurance Producer Date (MM/DD/YYYY)



Transamerica Premier Life Insurance Company  
Company Home Office: Cedar Rapids, IA 52499  
Administrative Office:  
4333 Edgewood Rd NE  
Cedar Rapids, IA 52499  
(800) 322-7164  
(Hereafter called the Company, we, our or us)

**LONG TERM CARE INSURANCE  
OUTLINE OF COVERAGE  
Rider Form ICC12 LTCR03**

**Notice to buyer:** The captioned Long Term Care rider may not cover all of the costs associated with long-term care incurred during the period of coverage. You are advised to review all rider terms, conditions and limitations carefully.

**Caution:** The issuance of the Long Term Care rider is based on our issuance of the policy to which the rider is attached; and on your responses to the questions on your application for the policy and the application supplement for the rider. Copies of the application for the policy and the application supplement are attached to the policy. If your answers to any of the questions on the application or application supplement are incorrect or untrue, the company has the right (in addition to any rescission rights described in the policy) to deny benefits or rescind the rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

1. The Long Term Care rider is attached to an individual life insurance policy.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the rider. You should compare this outline of coverage to outlines of coverage for other long term care riders or policies available to you. This is not an insurance contract, but only a summary of coverage. Only the underlying life insurance policy and rider contain governing contractual provisions. This means that the life insurance policy and rider set forth in detail the rights and obligations of you, the Insured (if other than yourself) and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDER CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES.** The rider is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. If a change to the rider is required in order to conform to changes in the requirements of the Internal Revenue Code, we will send you an amendment describing the change and you will be given a choice of accepting or rejecting the amendment. If you reject such an amendment, you must give us written notice, and your refusal may result in the rider no longer being tax-qualified or other adverse tax consequences. As with any tax matter, you should consult your tax advisor to evaluate any tax impact of rejecting any such amendment.
4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED.**  
(a) **Renewability** – THE RIDER IS GUARANTEED RENEWABLE. This means we may not, on our own, cancel or reduce the coverage it provides. Subject to the rider's termination provision, this rider will remain in force for as long as the policy remains in force and the required charges for this rider are paid. rider charges are subject to change, but we will not increase the rates above the maximum rates shown in the Policy Data. (b) **Waiver of Rider Charges** – While benefits under the rider are being paid, the Long Term Care rider charges will be waived. However, charges for the underlying policy and/or any other riders providing additional benefits will continue to be assessed.
5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGES.** Rider charges are subject to change. They are based on the policy's amount at risk (as determined for purposes of the Monthly Cost of Insurance) and our table of Long Term Care rider rates then in effect. The table in effect at any time will generally contain rates that increase with the age of the Insured. We may change the table from time to time, but we cannot increase the rates beyond the maximum rates shown in the policy. We can only change the rider rate table if we

change it for everyone under this rider form who is in the same risk class. A risk class includes persons with the same benefits, issue age, and underwriting risk class at issue and whose Long Term Care riders have been in effect for the same length of time. We will give you at least 60 days advance written notice at your last address shown in our records before we change your rider rate table.

6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED.** You have 30 days from the day you receive the rider to review it and return it to us if you decide not to keep it. You do not have to tell us why you are returning the rider. Within 30 days of when it is received, simply return it to us at our Administrative Office or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any rider charge deducted from the Policy Value, within 30 days after our receipt of the returned rider. The rider will be void as if it had never been issued. If you wish to cancel the rider without canceling the policy, you must return the policy and the rider to us so that we can send you back the policy without the rider.
7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. That booklet is called the "Guide to Health Insurance for People with Medicare." Neither Transamerica Premier Life Insurance Company nor its agents/insurance producers represent Medicare, the federal government or any state government.
8. **LONG TERM CARE COVERAGE.** Contracts of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital such as: (a) a Long Term Care Facility; (2) an Adult Day Care Center; (3) a Hospice Care Facility; or (4) the home.

The rider provides coverage in the form of a fixed indemnity benefit for long term care expenses, subject to the rider limitations and elimination period requirements.

#### 9. **BENEFITS PROVIDED BY THE RIDER.**

Subject to the conditions, limitations and exclusions in the rider, the amount of the benefit payable for any Calendar Month is an amount equal to the lesser of A or B where:

- A is 2% of Long Term Care Specified Amount, at commencement of benefits; and
- B is the per diem amount allowed by the Health Insurance Portability and Accountability Act times the number of days in the Calendar Month.

You may request a monthly benefit amount less than the above maximum. Choosing a lesser amount could extend the period during which benefits may be payable. You may change your election 30 days before the beginning of any calendar year.

If the Insured satisfies the Elimination Period and meets the Eligibility for the Payment of Benefits requirements for only part of a Calendar Month, we will prorate the Long Term Care Benefit payment at the beginning of a period of care or at the end. Prorate means we will divide the monthly Long Term Care Benefit by the actual number of days in the month, then multiply that number times the number of days during the month for which you are eligible to receive benefit payments.

Long Term Care rider benefits are an acceleration of the policy's death benefit and will reduce any proceeds payable at surrender of the policy or upon the Insured's death.

**ELIGIBILITY FOR THE PAYMENT OF BENEFITS.** Long Term Care benefits may be payable under the rider if the Insured is a Chronically Ill Individual and (1) has satisfied the 90-day Elimination Period; (2) has received Qualified Long Term Care Services covered under the rider and such services are specified in a Plan of Care; and (3) a current Plan of Care and written Proof of Loss have been approved by us.

**Elimination Period.** The rider has an Elimination Period of 90 days. This means that we will not pay benefits under the rider for any period before the Insured has incurred expenses, on each of 90 separate days during which the rider is in effect, for Qualified Long Term Care Services that would otherwise be covered under the rider. These days of care or services need not be continuous. The

Elimination Period has to be satisfied only once while the rider is in effect. You must provide us with Proof of Loss in order to satisfy the Elimination Period.

We will give the Insured credit toward the Elimination Period for days of confinement, care or services covered under the rider, even if they are paid or payable by Medicare.

Care or services received during confinement in a hospital or rehabilitation hospital/facility cannot be used to satisfy the Elimination Period, even if they are paid or payable by Medicare.

**Chronically Ill Individual** means an individual who has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, at least two out of the six Activities of Daily Living (ADLs) for an expected period of at least 90 days due to a loss of functional capacity; or requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

**Severe Cognitive Impairment (including the term “Severely Cognitively Impaired”)** means a severe loss or deterioration in intellectual capacity that is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured’s:

1. short-term or long-term memory;
2. orientation as to people, places or time;
3. deductive or abstract reasoning; and
4. judgment as it relates to safety awareness.

The evaluation must include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

**Activities of Daily Living (ADLs)** means the following activities: Bathing, Continence, Dressing, Eating, Toileting and Transferring.

**10. GENERAL EXCLUSIONS AND LIMITATIONS. THIS RIDER MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.** Qualified Long Term Care Services do not include care, confinement or services:

1. resulting from alcoholism, or drug addiction or chemical dependency unless as a result of medication used as prescribed by a Physician;
2. resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
3. due to participation in a felony, riot or insurrection;
4. for which no charge is normally made in the absence of insurance;
5. received outside the 50 United States and the District of Columbia, or Canada; and
6. performed by a member of your Immediate Family or the Insured’s Immediate Family. A member of your Immediate Family or the Insured’s Immediate Family can provide covered care or services if he or she is a regular employee of an organization that is engaged in providing the Qualified Long Term Care Services. The organization he or she works for must receive the payment for the care or service. Your Immediate Family or the Insured’s Immediate Family member must receive no compensation other than the normal compensation for employees in his or her job category.

Non-Duplication of Benefits. Qualified Long Term Care Services do not include care, confinement or services:

1. provided in a government facility (unless otherwise required by law);
2. paid or payable under Medicare. This includes any amounts that would be covered under Medicare, except that they are subject to a Medicare deductible or coinsurance of some kind. This does not apply when expenses are reimbursable under Medicare solely as a secondary payer;
3. provided under any governmental programs (except Medicaid); or
4. paid or payable under any state or federal workers’ compensation, employer’s liability or occupational disease law, or any motor vehicle no-fault law;

unless the costs incurred and paid exceed the amount covered by one of these entities, policies or programs.

A government facility includes a facility administered, covered or reimbursed by the Veteran's Administration.

We will not pay benefits under the rider if Qualifying Long Term Care Services received by the Insured are not included in the Insured's Plan of Care.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of Long Term Care services will likely increase over time, you should consider whether and how the benefits of the rider should be used. The rider does not include inflation protection coverage. Increases and decreases to the policy's death benefit resulting from the exercise of your rights under that policy, including your right to make policy loans and withdrawals, will cause a change in the maximum Monthly Long Term Care Rider Benefit Amount as well as the policy's death benefit.
12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The rider provides coverage for mental and nervous conditions as long as the Insured is certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in the rider. Covered illnesses include, but are not limited to, Alzheimer's Disease, Parkinson's Disease, senile dementia and related degenerative and dementia-based illnesses.
13. **LONG TERM CARE RIDER CHARGE.** The Guaranteed Maximum Monthly Charge Rates per \$1000 of amount at risk are shown in the Policy Data.
14. **ADDITIONAL FEATURES.** Interaction of policy provisions and the rider:

**Medical Information.** Issuance of the rider requires that we are provided with and evaluate medical information about the Insured. This is generally known as medical underwriting.

**Policy Face Amount Changes.** While this rider is In Force you may not request an increase in the policy's Face Amount. Transactions that increase or reduce the Face Amount of the policy will also result in a dollar-for-dollar change in the Long Term Care Specified Amount.

**Loans and Withdrawals.** Loans and withdrawals will not be permitted while benefits are being paid under the rider.

**Long Term Care Rider's Effect on Surrender Values under any endorsement providing an enhanced surrender value.** If the policy is surrendered during the option periods provided in such an endorsement, any enhanced surrender value will be reduced by the amount of the Long Term Care rider benefits paid.

**Terminal Illness Accelerated Death Benefit Endorsement Effect on the Rider.** If your policy includes an endorsement providing an accelerated death benefit in the event of a terminal illness ("Terminal Illness ADB Endorsement") the Insured may qualify for benefits under both the Terminal Illness ADB Endorsement and the Long Term Care rider. If the Insured qualifies for benefits under both the Terminal Illness ADB Endorsement and the Long Term Care rider and if a claim is made under both the Terminal Illness ADB Endorsement and the Long Term Care rider, a benefit will be paid under the Terminal Illness ADB Endorsement first. A payment under the Terminal Illness ADB Endorsement will reduce the policy face amount and the Long Term Care Specified Amount will be reduced by the same amount. Once payment under the Terminal Illness ADB Endorsement is made, any payments under the Long Term Care rider will be made based on the newly reduced Long Term Care Specified Amount.

We will not pay benefits under both the Terminal Illness ADB Endorsement and the Long Term Care rider simultaneously. If a claim is made under the Terminal Illness ADB Endorsement while benefits are being paid under the Long Term Care rider, we will stop paying benefits under the Long Term Care rider when we pay benefits under the Terminal Illness ADB Endorsement. The maximum accelerated death benefit used to calculate the amount of the Terminal Illness Accelerated Death Benefit will be reduced by any Long Term Care rider benefits paid out. Once payment under the Terminal Illness ADB Endorsement is made, and the Insured qualifies for benefits under the Long Term Care rider, any payments under the Long Term Care rider will be made based on the newly reduced Long Term Care Specified Amount.



**End of Eligibility.** If rider benefit payments cease because the Insured no longer qualifies for benefits under this rider, the following will apply:

1. If the policy's No Lapse Ending Date has not passed, the test to determine whether the No Lapse Guarantee is in effect will not require a Minimum No Lapse Premium for those months while we were paying benefits under this rider.
  2. Any negative Policy Value will be reset to zero.
  3. Policy transactions that were restricted while we were paying benefits under this rider will become unrestricted.
15. **CONTACT THE STATE AGENCY LISTED IN A *SHOPPER'S GUIDE TO LONG TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE RIDER.**



Home Office: Cedar Rapids, IA
Administrative Office:
4333 Edgewood Road NE
Cedar Rapids IA 52499
(800) 851-9777

NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy to be issued by Transamerica Premier Life Insurance Company.

You should review this new policy carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long-term care insurance policy is a wise decision.

STATEMENT TO THE APPLICANT BY AGENT/INSURANCE PRODUCER, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

- 1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy.
2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods.
3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent/insurance producer regarding the proposed replacement of your present coverage.
4. If, after due consideration, you still wish to terminate your present coverage and replace it with this new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history.

Signature of Agent/Insurance Producer, Broker or Other Representative

Type or print Name & Address of Agent/Insurance Producer, Broker or Other Representative

Applicant's Signature

The "Notice to Applicant" was delivered to me on the above date

# HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices (“Notice”) covers an Affiliated Covered Entity (“ACE”). When this Notice refers to the Transamerica ACE or “we”, “our” or “us”, it is referring to the health care components of the following affiliated entities; Transamerica Financial Life Insurance Company, Transamerica Life Insurance Company, and Transamerica Premier Life Insurance. Each of the companies listed above is a hybrid covered entity under the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively, “HIPAA”). The combined companies listed are designated as a single covered entity for purposes of compliance with HIPAA and certain covered health care components of such companies. The single covered entity shall be known as the Transamerica Affiliated Covered Entity or the “Transamerica ACE.” This designation may be amended from time-to-time to add new covered entities that are under common control and ownership to the Transamerica ACE.

The Transamerica ACE is required under HIPAA to protect the privacy of your protected health information (“PHI”), provide you with notice of our legal duties and privacy practices with respect to PHI and abide by the terms of the Notice currently in effect for the Transamerica ACE. This Notice describes how the Transamerica ACE may use and disclose your PHI and your rights to access and amend your PHI.

**This notice is effective September 23, 2013 and provided to you in connection with your health plan from the Transamerica ACE. In some cases, this may include product riders purchased with a product that is not considered a health plan subject to HIPAA. Health plans include, but are not limited to: Dental, Long Term Care, Medicare Supplement, Prescription Drug Coverage, Supplemental Medical Expense, Medical Expense, and TRICARE.**

## **Our Commitment to Your Privacy**

We are committed to maintaining the privacy of your PHI. This notice will tell you about the ways in which we may use and disclose your PHI for payment, health care operations, and other circumstances as either required or permitted by law. Permitted uses and disclosures may include use and disclosure between the affiliates within the Transamerica ACE. **Except as outlined below, we will not use or disclose your PHI without your written authorization, which you may revoke as described in the “Your Privacy Rights” section below.** For example, use or disclosure of your PHI for marketing, or any disclosure that would constitute a sale of your PHI, would require your authorization.

We are required by law to: safeguard your PHI; give you this Notice of our duties and privacy practices; notify you in the event of a breach of your unsecured PHI; and abide by the terms of the

Notice of Privacy Practices currently in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this Notice, and to make the new notice effective for all PHI maintained by us. In the event of a material change, a revised notice will be sent to all of our policyholders.

## **USES AND DISCLOSURES OF YOUR PHI**

- 1. Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors, hospitals, long term care facilities, and other health care providers involved in your care.
- 2. Payment.** We may use and disclose your PHI as necessary for benefit verification and claims processing purposes. For instance, we may use information regarding health care services you receive from service providers such as physicians, hospitals, pharmacies, nursing homes, assisted living facilities, and home health care agencies to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf. Examples of our payment related purposes also include our collection of premiums, coordinating reinsurance, and care coordination activities.
- 3. Health Care Operations.** We will use and disclose your PHI as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance, auditing, rating, customer service, fraud prevention and reporting, research purposes, specialized government functions, payment of agent commissions, and other functions related to your health plan. With the exception of long-term care insurance underwriting, we are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. If our long-term care insurance underwriting uses genetic information it will only be used in a manner allowed by law.
- 4. Family and Friends Involved in Your Care.** We may disclose your PHI to certain family, friends, and others who are involved in your care or in the payment for your care in order to not hinder that person’s involvement. If you are unavailable, incapacitated, or facing an emergency medical situation, or if we have determined, based on our professional judgment and review of the circumstances, that you would not object and that a limited disclosure may be in your best interest, we may share limited PHI without your approval. If you have designated a person to help

prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited PHI to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.

5. **Business Associates.** Certain services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, claims investigation and adjudication, underwriting support services, care coordination services, etc. We may disclose your PHI to one or more of these outside persons or organizations that assist us with our health care operations. We obligate business associates to appropriately safeguard the privacy of your PHI.
6. **Collection of Information.** To properly underwrite, rate, and administer your health plan, we may collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization, we may also collect or verify information by contacting information sources such as: insurance support organizations (like Medical Information Bureau, Inc.); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.
7. **Agents.** Your agent is our business associate. For customer service purposes, your agent may be notified of certain coverage-related matters and information necessary to assist in servicing your coverage. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when there is a change in premium paying status, when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent may be notified on their commission statement that your policy remains in force for as long as you continue to pay your premium.
8. **Plan Sponsors.** We may also use or disclose PHI to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.
9. **Health-Related Benefits and Services.** We or our business associates may contact you regarding health-related benefits and services that may be of interest to you.
10. **Mergers and Acquisitions.** Your PHI may also be disclosed as a part of a potential sale, merger or acquisition involving our business.

## USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

Your PHI may be used or disclosed as applicable without your authorization in the following circumstances:

- for any purpose when required by law;
- for public health and/or law enforcement activities consistent with law if we suspect child abuse, elder abuse, or neglect or believe you to be a victim of abuse, neglect, domestic violence, or other crimes;
- as required by law for governmental oversight agency conducting audits, investigations (such as investigations in to consumer complaints), or civil or criminal proceedings;
- if required by a court or an administrative ordered subpoena or discovery request;
- as required by law for certain law enforcement purposes; about deceased persons to coroners, health examiners, and funeral directors consistent with law;
- if necessary for organ and tissue donation or transplant;
- for certain government-approved research purposes;
- upon reasonable belief to avert a serious threat to health or safety;
- for specialized government functions (such as military personnel and inmates in correctional facilities);
- for national security or intelligence activities;
- to workers' compensation agencies if necessary to make a benefit determination;
- to Non-affiliated organizations or persons, such as other insurance institutions, agents, insurance support organizations (such as Medical Information Bureau, Inc.), or law enforcement and governmental authority as necessary to prevent or investigate criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage;
- to our parent company and affiliates in conjunction with health care operation purposes.

### Your Privacy Rights

Your rights are explained below. *Any written requests to exercise those rights should be directed to the address provided at the end of this notice.*

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, we are not required to agree to the restriction and we retain the right to terminate a restriction if we believe such termination is appropriate. In the event of a termination by us, you will be notified. You also have the right to terminate a restriction, in writing. You may obtain a Request for Restriction form by contacting us at the phone number listed at the end of this notice.
2. **Confidential Communications.** You may request that we send communications of health information to you by alternative means or to alternative locations, if all or part of that information could endanger you. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests. You may obtain a Request for Confidential

Communication form by contacting us at the phone number listed at the end of this notice.

3. **Access.** You have a right to access much of the PHI that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies, postage, labor and supplies and, in certain cases, may deny your request. You may obtain a Request for Access form by contacting us at the phone number listed at the end of this notice.
4. **Amendment.** You have the right to request that PHI we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain a Request for Amendment form by contacting us at the phone number listed at the end of this notice.
5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your PHI within the six (6) calendar years immediately preceding such a request. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting us at the phone number listed at the end of this notice.
6. **Revocation of Authorization.** If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance on such authorization, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.
7. **Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

**NOTE:** The rights granted to you do not extend to information about you relating to or in anticipation of a claim or civil or criminal proceeding.

### Complaints

If you believe your privacy rights have been violated, you can file a complaint with us by sending your written complaint to our Consumer Affairs Department at the address given below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C.

within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

### Contacting Us

To file a complaint or to make a request as described in the section entitled "Your Privacy Rights," please send your written request to the company at: 4333 Edgewood Road NE, Cedar Rapids, IA 52499. Requests should be directed to our Customer Service Department and Complaints should be sent to the attention of our Consumer Affairs Department. Please be sure to include the following information:

- Your full name
- Address
- Date of Birth
- Last four digits of your Social Security Number
- Policy number
- The nature of your request or complaint

**FOR FURTHER INFORMATION** regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy practices, please write to us at the address shown above or call 1-866-512-7495.

**THIS NOTICE IS REQUIRED BY FEDERAL LAW. WE MAKE IT AVAILABLE TO THE GENERAL PUBLIC, APPLICANTS AND POLICYHOLDERS. YOUR RECEIPT OF THIS NOTICE IS NOT EVIDENCE OF COVERAGE.**

**Transamerica Financial Life Insurance Company**

Home Office: Harrison, New York

**Transamerica Life Insurance Company**

**Transamerica Premier Life Insurance Company**

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

**Disclosure  
Military Sales Practice**

In accordance with applicable law, the following information is provided with respect to the life insurance policy for which you have applied (the "Policy") with the Companies noted above (the "Companies").

- As a member of the United States Armed Forces, you are advised that subsidized life insurance is available to you from the Federal Government under the Servicemembers' Group Life Insurance (SGLI) program, under subchapter III of chapter 19 of title 38, United States Code. Insurance coverage available under the SGLI program is available in \$50,000 increments up to the maximum coverage amount of \$400,000. Effective July 1, 2014, the current basic SGLI premium rate is 7 cents per \$1,000 of insurance. The premium includes an additional \$1.00 per month for Traumatic Injury Protection coverage.
- This Policy is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended, or encouraged the sale of the Policy being offered.
- No person has received any referral fee or incentive compensation in connection with the offer or sale of the Policy, unless such person is a licensed agent/producer of the Companies.
- The policy being offered to you may have the ability to accumulate cash value which could be used pay contract charges or fees in certain circumstances. The terms and circumstances under which this contract may accumulate cash value, and where any cash value could be used to pay contract charges or fees are detailed in your contract and product illustration;
- This Policy contains a "free look" period of no less than 10 days. (The "free look" period may be more depending on your state of residence.) You may choose to return the Policy during the "free look" period. If returned to the Company at the address shown on the cover of the Policy, your Policy becomes void, and we will refund your premiums paid (according to the terms stated in the Policy).

With respect to a sale or solicitation on Federal land or facilities located outside of the United States, if you need the assistance of the governmental agency that regulates insurance; or if you have a complaint you have been unable to resolve with your insurer, you may contact the state insurance commission for the State having primary jurisdiction: [http://www.naic.org/state\\_web\\_map.htm](http://www.naic.org/state_web_map.htm)

I acknowledge that I have read and understand the information about the Policy's "free look" provision and I have received a copy of an illustration and/or the application.

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant/Owner if other than the Proposed Insured

\_\_\_\_\_  
Date

*If the policy was solicited on a military installation, DD Form 2885 was left with the client, and other required forms were reviewed, completed and copies were left with the client.*

\_\_\_\_\_  
Producer Signature

\_\_\_\_\_  
Date

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



## Terminal Illness, Chronic Illness and Critical Illness Accelerated Death Benefit Riders Disclosure

Transamerica Life Insurance Company

Transamerica Premier Life Insurance Company

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

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This disclosure form provides a brief description of accelerated death benefit riders that may be available under your policy. For details of the riders available and your rights and obligations under the policy, please read your policy carefully. Accelerated benefits are payments made to you during the lifetime of the Insured in lieu of payment of the full death benefit of the policy.

*Terminally Ill* means the Insured has a medical condition, resulting from bodily injury or disease, or both, which is expected to result in the death of the Insured within 12 months of diagnosis.

*Chronically Ill* means the Insured:

- (a) Is unable to perform, without Substantial Assistance from another person for a period of at least 90 days, at least two out of six Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or
- (b) Requires Substantial Supervision by another person, for a period of at least 90 consecutive days, to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

*Critically Ill* means the Insured has been diagnosed by a Physician with one or more of the following health conditions or underwent one or more of the following medical procedures:

- (a) Heart Attack
- (b) Stroke
- (c) Cancer
- (d) End Stage Renal Failure
- (e) Major Organ Transplant
- (f) Blindness
- (g) Paralysis
- (h) AIDS
- (i) Aplastic Anemia
- (j) First Coronary Angioplasty
- (k) First Coronary Artery Bypass
- (l) Motor Neuron Disease
- (m) Central Nervous Disease

**Conditions Under which Accelerated Benefits May be Elected:** If the Insured becomes Terminally Ill, Critically Ill or Chronically Ill while the policy and rider are in effect, you may elect to receive an Accelerated Death Benefit payment subject to the provisions of the policy and rider and the following conditions:

1. You must provide us with the required certification applicable to the requested form of Accelerated Death Benefit; and
2. The policy and the rider must be in effect at the time of your Accelerated Death Benefit request; and
3. The Face Amount of the policy at the time the Accelerated Death Benefit request is received must be at least \$25,000; and
4. We must receive the written consent of all irrevocable Beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

**Amount of Accelerated Death Benefit:** The Accelerated Death Benefit payment we make to you will be less than the amount of the Available Death Benefit which you request to accelerate, but never less than the Election Percentage multiplied by the difference between the Policy Value, if any, and any Loan Balance. For each form of Accelerated Death Benefit, the Accelerated Death Benefit payment for the amount of the death benefit which you request to accelerate will be calculated as A minus B minus C minus D minus E where A, B, C, D and E are determined as follows:

- A. The actuarial present value of the amount of the Available Death Benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your rider.
- B. Any amount necessary to provide insurance to the date of the Accelerated Death Benefit payment if we make the payment during a grace period or after the policy has lapsed.
- C. The Loan Balance, if any, at the time the Accelerated Death Benefit is paid, multiplied by the Election Percentage.
- D. The actuarial present value of future premiums, including premiums for any Base Insured Rider or Joint Insured Term Rider, but excluding other rider premiums, multiplied by the Election Percentage. The actuarial present value of future premiums is the amount as determined by us that would, prior to the acceleration, otherwise be payable to keep the policy In Force during the period of the Insured's remaining lifetime as determined by our physician's assessment, at time of the acceleration. This amount is determined by us using the applicable rated age, mortality tables, and interest rate described under 1), 2), and 3) of the Present Value of Accelerated Death Benefit provision. For the Terminal Illness Accelerated Death Benefit, the future premiums are assumed to be zero.
- E. An administrative charge for each Accelerated Death Benefit request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2016 is \$350, but will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index for All Urban Consumers (CPI) since January 1, 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used. In no event will the administrative charge for each Accelerated Death Benefit request exceed \$1,000.

If we approve your request for a Chronic Illness Accelerated Death Benefit or Critical Illness Accelerated Death Benefit, the amount that may be payable will be based in part on the Insured's remaining life expectancy as determined by us at the time of the acceleration. Generally, the longer the Insured's remaining life expectancy, the lower the payment amount will be. The shorter the Insured's remaining life expectancy, the higher the payment amount will be.

**Maximum Accelerated Death Benefit:** The maximum death benefit you may accelerate over the lifetime of the Insured is equal to the lesser of:

- 1. 90% of the Available Death Benefit of this policy for Critical Illness and Chronic Illness; 100% of the Available Death Benefit of this policy for Terminal Illness; or
- 2. A maximum Accelerated Death Benefit amount declared by us. This amount will never be less than \$500,000.

The maximum death benefit you may accelerate in any 12 month period because the Insured is Chronically Ill is the lesser of (1) 24% of the Available Death Benefit of the policy at the time of the initial acceleration, and (2) the annual equivalent of the per diem limitation set forth in Title 26, Section 7702B (d) of the Internal Revenue Code, as adjusted for inflation.

**Effect of the Accelerated Death Benefit Payment on the Policy:** The policy's benefits and values, as those amounts exist on the date the Accelerated Death Benefit is paid, will be reduced by the Election Percentage. The premium and/or charges and monthly deductions, as applicable, for the policy and any affected riders will also be adjusted after an Accelerated Death Benefit is paid.

**Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Payment of an Accelerated Death Benefit may affect eligibility for Medicaid or other government benefits and entitlements. Accelerated Death Benefits do not and are not intended to qualify as long-term care insurance.**

**We intend that payments we make under the Accelerated Death Benefit options will receive favorable tax treatment; however, there are circumstances when receipt of an Accelerated Death Benefit payment may be taxable. Please consult your personal tax advisor to determine the tax status of any benefits paid under these options.**

By signing below, you agree that you have read the above and received a copy of this disclosure form.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Owner's (Applicant's) Signature

\_\_\_\_\_  
Agent's Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**



**REPLACEMENT ADVERTISING  
AGENT STATEMENT**

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

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

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**AGENT SIGNATURE**

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

**IMPORTANT NOTICE:  
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES**

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

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

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

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

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

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

1. **Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract?**  YES  NO
2. **Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract?**  YES  NO

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

INSURER NAME	CONTRACT OR POLICY #	INSURED	REPLACED (R) OR FINANCING (F)
1.			<input type="checkbox"/> Replaced
2.			<input type="checkbox"/> Replaced
3.			<input type="checkbox"/> Replaced

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

The existing policy or contract is being replaced because \_\_\_\_\_.

I certify that the responses herein are, to the best of my knowledge, accurate:

\_\_\_\_\_  
Applicant's Signature and Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Producer's Signature and Printed Name

\_\_\_\_\_  
Date

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

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

**PREMIUMS:**

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

**POLICY VALUES:**

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

**INSURABILITY:**

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

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

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

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

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

**OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:**

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

**30 DAY RIGHT TO CANCEL**

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

**REPLACEMENT ADVERTISING  
AGENT STATEMENT**

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

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

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**AGENT SIGNATURE**

# Transamerica Premier Life Insurance Company TPLIC SR. New Business Cover Sheet

Fax to: 866.834.0437

Date: \_\_\_\_\_ Number of pages including this cover sheet: \_\_\_\_\_

Agent Name \_\_\_\_\_

Agent # \_\_\_\_\_ Office ID \_\_\_\_\_

Agent Phone # \_\_\_\_\_ Agent Fax # \_\_\_\_\_

Send Correspondence to \_\_\_\_\_

Send Policy to \_\_\_\_\_

Proposed Insured's Name \_\_\_\_\_

Is this an Internal Replacement?  Yes - Policy number \_\_\_\_\_

No

Is this a companion policy?  Yes - Companion name \_\_\_\_\_

No

**Tip!** To speed processing...

- Submit initial application and forms ONLY ONCE, either via fax or mail
- Retain your original copy of this fax, as we reserve the right to request a re-fax of the original if we are unable to read the fax. Do NOT mail original application and forms unless requested.
- Print legibly, in English, and use black ink
- Do NOT use white-out
- Make sure all necessary supplemental forms are included

## Forms Checklist

Primary Insured    Additional Insured

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Application  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIPAA Authorization Form   |
| <input type="checkbox"/> | <input type="checkbox"/> | Terminal Illness Form, <b>if applicable</b>  |
| <input type="checkbox"/> | <input type="checkbox"/> | Initial Premium or Pre-authorization Form  |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV Consent Form, <b>if applicable</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | Replacement Form, <b>if applicable</b><br>Form must be dated same as, or earlier than the application                          |
| <input type="checkbox"/> | <input type="checkbox"/> | Illustration, <b>if applicable</b><br>Illustration or Illustration Certification is required in NAIC states for Universal Life |
| <input type="checkbox"/> | <input type="checkbox"/> | Transfer or 1035 Exchange Form<br>Mail original 1035 form, if applicable, within 5 working days of the fax                     |
| <input type="checkbox"/> | <input type="checkbox"/> | Health Questionnaire (list type), <b>if applicable</b>   |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical Requirements, <b>if applicable</b><br>Order all necessary Medical Requirements, indicate orders on Agent's Report      |
| <input type="checkbox"/> | <input type="checkbox"/> | Other (please explain) _____   |

Special Instructions: \_\_\_\_\_

- Transamerica Life Insurance Company
- Transamerica Premier Life Insurance Company

Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499-0001

**Terminal Illness Accelerated Death Benefit Disclosure Form**

The owner may apply for the single sum accelerated benefit when the insured has been diagnosed with a terminal illness. A terminal illness is a condition resulting from injury or illness which, as determined by a physician, has reduced life expectancy to not more than 12 months from the date of the physician’s statement. The company requires proof of a terminal condition, including an attending physician’s statement and any other proof that we may require. We reserve the right to seek a second medical opinion or have you examined at our expense by a physician we choose.

This benefit cannot be exercised:

1. if the policy is not in force;
2. is only in force as extended term insurance;
3. if the policy is within two years of endowment; or
4. if any eligible rider is within two years of expiration.

The single sum benefit may only be requested once. If there is an irrevocable beneficiary or assignee, they must consent in writing to payment of this benefit.

The policy’s specified amount, policy value, surrender charge and indebtedness, if any, will be reduced by the election percentage. We will provide you with revised policy specification pages.

**RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE AND YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR.**

By signing below, you agree that you have read the above and received a copy of this disclosure form.

\_\_\_\_\_   
 Date

\_\_\_\_\_   
 Owner’s (Applicant’s) Signature

\_\_\_\_\_   
 Agent’s Signature

**IMPORTANT: The signed original must be submitted with the application for life insurance. The copy is to be left with the applicant.**

**Transamerica Life Insurance Company**

**Transamerica Premier Life Insurance Company**

Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499-0001

## **TERMINAL ILLNESS, CRITICAL ILLNESS, and CHRONIC ILLNESS ACCELERATED DEATH BENEFIT DISCLOSURE FORM**

Accelerated Benefits are payments made to the Owner during the lifetime of the Insured. Such benefits will be paid in lieu of payment of the full Death Benefit of the Policy or Additional Insured Rider upon death of the Insured. The conditions under which accelerated benefits may be elected vary by Rider as described below.

**NOTE: Your Policy may not be eligible for coverage under all the Accelerated Death Benefit Riders described below. Please check your Policy and the Riders for details on each Accelerated Death Benefit Rider that is included with your Policy and the Insured's coverage under each Rider.**

### **TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER**

Benefits may be elected under this Rider if the Insured has a Terminal Condition. Terminal Condition means a condition resulting from injury or illness that with reasonable medical certainty, as determined by a Physician, will result in death within 12 months from the date of the Physician's Statement.

### **CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER**

Benefits may be elected under this Rider if the Insured is Chronically Ill. Chronically Ill means that the Insured has been certified, within the last 12 months, by a Licensed Health Care Practitioner as:

1. Being unable to perform, without substantial assistance from another person, at least two Activities of Daily Living for a period of at least 90 consecutive days; or
2. Requiring substantial supervision for a period of at least 90 consecutive days by another person to protect oneself from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living are bathing, continence, dressing, eating, toileting, and transferring.

No Application for Election of Accelerated Benefits will be accepted under the Chronic Illness Accelerated Benefits Rider during the first two years that it is in effect.

The maximum Death Benefit accelerated in any year is the lesser of 24% of the life insurance coverage on the initial Election Date or \$240,000. This amount will be prorated over other periods of time, such as 2% each month, 6% every 3 months, or 12% every 6 months. The maximum Death Benefit accelerated over the lifetime of the Insured is the lesser of 90% of the Initial Face Amount or \$500,000.

### **CRITICAL ILLNESS ACCELERATED DEATH BENEFIT RIDER**

Benefits may be elected under this Rider if the Insured has experienced a covered Qualifying Event. The Qualifying Events covered under this Rider are:

1. **Heart attack (myocardial infarction)** - The death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart attack does not include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous Heart Attack. The diagnosis of heart attack must be based on the presence of all of the following:
  - a. Chest pain;
  - b. Associated new EKG changes which support the diagnosis; and
  - c. Elevation of cardiac (heart) enzymes above standard laboratory levels.
2. **Stroke** - A cerebrovascular accident or infarction (death) of brain tissue caused by hemorrhage, embolism, or thrombosis lasting more than 24 hours and producing measurable neurological deficit which persists for at least 30 consecutive days following the occurrence of the Stroke. Stroke does not include transient ischemic attacks.
3. **Diagnosis of Cancer.** Cancer means a disease manifested by the presence of one or more malignant tumors and characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Cancer does not include:
  - a. Any skin cancer, except invasive malignant melanoma into the dermis or deeper;
  - b. Pre-malignant lesions, benign tumors, or polyps; and
  - c. Carcinoma in-situ.

4. **Diagnosis of End Stage Renal Failure.** End Stage Renal Failure means an irreversible and total failure of both kidneys which requires the undergoing of renal transplantation or regular renal dialysis.
5. **Major Organ Transplant** - The receipt by transplant of any of the following organs or tissues: heart, lungs, liver, kidney, pancreas, or bone marrow.
6. **Diagnosis of ALS (Amyotrophic Lateral Sclerosis)** by a qualified Physician.

No Accelerated Benefit will be paid under the Critical Illness Accelerated Benefit Rider for any Qualifying Event that occurs on or before the 30<sup>th</sup> day following the Effective Date of the Rider unless such Qualifying Event directly resulted from accidental injury.

No Accelerated Benefit will be paid under the Critical Illness Accelerated Death Benefit Rider for any Qualifying Event that directly or indirectly results from self-inflicted injury or attempted suicide.

The Owner may elect to accelerate all or a portion of the Insured's Death Benefit in force under the Policy on the Election Date. **We reserve the right to set a maximum amount that we will pay under any of the Accelerated Benefits Riders on the life of any Insured person. If we do so, the lifetime maximum will be no more than \$500,000. If the Insured becomes eligible for benefits under the Chronic Illness Accelerated Death Benefit Rider, the Death Benefit that may be accelerated in any year will also be subject to a maximum amount.**

Accelerated Benefits are paid as a lump sum, provided, however, that payments under the Chronic Illness Accelerated Death Benefit Rider may be prorated as described above. The following factors may be used by us in the determination of the amount:

1. The Death Benefit accelerated;
2. The Cash Surrender Value of the Policy or Rider;
3. Future Premiums payable under the Policy or Rider;
4. Our assessment of the future expected lifetime of the Insured;
5. Any administrative fee assessed; and
6. The Accelerated Benefits Interest Rate in effect.

The benefit will first be used to pay a pro-rata share of any outstanding debt to us. The benefit will never exceed 90% of the Death Benefit accelerated for the Critical Illness or Chronic Illness Accelerated Death Benefit Riders, 100% for the Terminal Illness Accelerated Death Benefit Rider. It will never be less than the Cash Surrender Value, if any, corresponding to the portion of the Death Benefit accelerated.

The Insured's Death Benefit in force will be reduced each time an Accelerated Benefit is paid. The reduction will equal the portion of the Death Benefit that is accelerated on the Election Date. The Face Amount or Coverage Amount, and if applicable, the Cash Value, Cash Surrender Value, Accumulated Value, Surrender Charge, and outstanding debt under the Policy will be reduced in the same proportion as the reduction in the Insured's Death Benefit. The new premiums and charges for the remaining portion will be as if the contract had been originally issued at the reduced amount.

As an example of the impact that election of Accelerated Benefits has on Policy values, consider the following situation:

Prior to Election		Upon Partial Election of 50% of Death Benefit		Upon Full Election	
Death Benefit	= \$200,000	Remaining Death Benefit	= \$100,000	Death Benefit	= \$0
Cash Value or Cash Surrender Value	= 80,000	Remaining Cash Value or Cash Surrender Value	= 40,000	Cash Value or Cash Surrender Value	= 0
Outstanding Debt	= 50,000	Remaining Outstanding Debt	= 25,000	Outstanding Debt	= 0
Annual Premium	= 4,000	Remaining Annual Premium	= 2,000	Annual Premium	= 0

Dollar values showing specific impact that acceleration will have on your Policy values will be provided when you apply for Accelerated Benefits.

**Payment of Accelerated Benefits will reduce the Death Benefit otherwise payable under the Policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under these Riders.**

\_\_\_\_\_

Date

\_\_\_\_\_

Owner's (Applicant's) Signature

\_\_\_\_\_

Agent's Signature