RESET

TRANSAMERICA® FINANCIAL LIFE INSURANCE COMPANY

Transamerica Financial Life Insurance Company
Home Office: 440 Mamaroneck Avenue
Harrison, NY 10528
Administrative Address: 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 Company noted above (the "Company")], 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 Company, its affiliates and reinsurers, and its agents, employees, or other representatives. I further authorize the Company and its 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 Company, 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 Company may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Company will only use and disclose such information as permitted by applicable regulations and as described in its 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 Company 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 Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

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

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

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

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

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

Policy or contract number (if known): _____

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

## Transamerica Financial Life Insurance Company

**Home Office:** 440 Mamaroneck Avenue, Harrison, NY 10528 **Administrative Address:** 4333 Edgewood Road NE Cedar Rapids, IA 52499

*Unless otherwise stated, "You" refers to the Proposed Primary Insured.*

**1**

### Proposed Primary Insured Personal Information

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number
__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Place of Birth (State / Territory, Country)

Gender ☐ **Male** ☐ **Female**

Marital Status ☐ **Single** ☐ **Married (including common law)** ☐ **Registered Domestic Partner**

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Years at Address

Mailing Address **(If different from Physical Address)**

City | U.S. State / Territory | Zip Code

U.S. Driver's License Number | U.S. State / Territory | Expiration Date (mm/dd/yyyy)
__ __ / __ __ / __ __ __ __

Preferred Phone Number ☐ **Mobile**

Alternate Phone Number ☐ **Mobile**

Best Time to Call ☐ **AM** ☐ **PM**

Time Zone

Preferred method of communication ☐ **Mail** ☐ **Phone** ☐ **Email**

Email Address

Occupation

## 2 U.S Citizenship

**If yes**, go to next section.

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

Country of Citizenship

## 3 Other Insurance

**If you are doing an Internal Replacement, please fill out the Full Surrender form.**

Do you have any existing life insurance or annuities? **If yes**, please fill out the table for all existing life/annuity coverage and complete the state required forms, if applicable.

☐ **Yes** ☐ **No**

**If yes**

Is the insurance applied for on your life intended to discontinue, replace or change any existing life or annuity coverage? **If yes**, please note the coverage intended to be replaced in the table and complete the state required forms, if applicable.

**If yes**

☐ **Yes** ☐ **No**

*Type of Coverage: Personal, Business, Employer Provided, Group*

| Type of Coverage | Company | Policy # | Face Amount | Replacement? |
|---|---|---|---|---|
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |

Is this intended to be a 1035 Exchange? **If yes**, please complete the 1035 supplement.

**If yes** →

☐ **Yes** ☐ **No**

Anticipated Cash Value Transfer

$

4

## Owner

**Complete this section only if the owner is not the Proposed Primary Insured.**

Is the owner a Person or a Trust?

☐ **Person** ☐ **Trust - (go to the Trust questions below)**

**If person,** complete through Country of Citizenship.

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number __ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

Email Address

Gender ☐ **Male** ☐ **Female**

**Do you have a Contingent Owner?** If you have a contingent owner, complete the Contingent Owner Supplement.

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory | Zip Code

Country | Years at Address | Preferred Phone Number ☐ **Mobile**

Mailing Address **(If different from Physical Address)**

City | U.S. State / Territory | Zip Code

Owner's relationship to Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Domestic Partner**

☐ **Child** ☐ **GrandParent** ☐ **Other** _____

**If yes**, go to next section. →

Is the owner a U.S. citizen? ☐ **Yes** ☐ **No** →

Green Card Number and Expiration (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

United States citizens and valid Green Card holders are eligible.

Country of Citizenship

**Complete this section only if the owner is a Trust.**

**If owner is a trust**, complete a Trust Certification.

Trust | Original Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Tax ID Number __ __ - __ __ __ __ __ __ __

## 4 Owner

*continued*

Do you have any pending or existing life insurance or annuities? **If yes**, please note the coverage intended to be replaced in the table and complete the state required forms, if applicable.

☐ **Yes** ☐ **No**

**If yes**

*Type of Coverage: Personal, Business, Employer Provided, Group*

| Type of Coverage | Company | Policy # | Face Amount | Intended Replacement? |
|---|---|---|---|---|
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |
| | | | $ | ☐ Yes ☐ No |

## 5 Primary Beneficiaries

**Primary Beneficiary 1 Percentage of Death Benefits**

____ %

Total shares between all primary beneficiaries must equal 100%.

**If beneficiary is a trust**, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable)

Date of Birth or Trust Date (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person)

__ __ __ - __ __ - __ __ __ __

U.S. Tax ID Number (if a Business Entity or Trust)

__ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

**Continued on next page**

5

## Primary Beneficiaries

*continued*

**Total shares between all primary beneficiaries must equal 100%.**

**Primary Beneficiary 2 Percentage of Death Benefits**

___ %

Total shares between all primary beneficiaries must equal 100%.

**If beneficiary is a trust**, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

**Primary Beneficiary 3 Percentage of Death Benefits**

___ %

Total shares between all primary beneficiaries must equal 100%.

**If beneficiary is a trust**, please complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

**If you need space for more primary beneficiaries, complete the Beneficiary Supplement.**

## 6 Contingent Beneficiaries

**Total shares between all contingent beneficiaries must equal 100%.**

**Contingent Beneficiary 1 Percentage of Death Benefits**

___ %

Total shares between all contingent beneficiaries must equal 100%.

**If beneficiary is a trust**, complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

**Contingent Beneficiary 2 Percentage of Death Benefits**

___ %

Total shares between all contingent beneficiaries must equal 100%.

**If beneficiary is a trust**, complete a Trust Certification.

Legal First Name | Middle Name | Legal Last Name | Suffix

Business Entity or Trust (if applicable) | Date of Birth or Trust Date (mm/dd/yyyy) __ __ / __ __ / __ __ __ __

U.S. Social Security Number (if a person) __ __ __ - __ __ - __ __ __ __ | U.S. Tax ID Number (if a Business Entity or Trust) __ __ - __ __ __ __ __ __ __

Mailing Address ☐ Same as Proposed Primary Insured | City

U.S. State / Territory | Zip Code | Phone Number

Relationship to the Proposed Primary Insured

☐ **Spouse** ☐ **Parent** ☐ **Grandparent** ☐ **Child** ☐ **Estate**

☐ **Domestic Partner** ☐ **Trust** ☐ **Other** _____

**If you need space for more contingent beneficiaries, complete the Beneficiary Supplement.**

## 7 Secondary Addressee

Complete this section if you would like to list an additional person to receive copies of notices and letters regarding possible lapses in coverage.

| Legal First Name | Middle Name | Legal Last Name | Suffix |
|---|---|---|---|
| | | | |

Mailing Address

| City | U.S. State / Territory | Zip Code |
|---|---|---|
| | | |

| Email Address | Phone Number |
|---|---|
| | ☐ **Mobile** |

## 8 Product Details

| Product Name | Coverage Amount | |
|---|---|---|
| | **$** | *This is the amount of life insurance coverage you are applying for.* |

Rate Class Applied for:

☐ **Preferred Non-Tobacco** ☐ **Preferred Tobacco** ☐ **Preferred Juvenile**

☐ **Standard Non-Tobacco** ☐ **Standard Tobacco** ☐ **Standard Juvenile**

☐ **Graded**

If a policy cannot be issued as applied for, would you accept a rated policy if available?

☐ **Yes** ☐ **No**

**If yes** →

Adjust face amount to premium?

☐ **Yes** ☐ **No**

Automatic Premium Loan (may not be available on all policies).

☐ **Elect** ☐ **Do Not Elect**

### Additional Benefits (Not available with all products and not available in all States)

| Benefit | Amount |
|---|---|
| ☐ **Accidental Death Benefit Rider** | Coverage amount equal to policy face amount |
| ☐ **Child/Grandchild Rider** | **$** |

Complete the **Child/ Grandchild Rider Supplement Application**

## 9 Premium

If you select an initial premium draft date in the future, it may not be greater than 30 days after the application date. If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.

If the initial draft date is prior to the application date, please complete the Back Date to Save Age Form.

Total Premium

$

Initial Draft Date (MM/DD) *1st thru 28th only*

__ __ / __ __ ☐ **Current Date**

Recurring Payment Frequency

☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

| Payment Option | Initial / Recurring | Form Information |
|---|---|---|
| ☐ **EFT** | ☐ **Initial** ☐ **Recurring** | For EFT, please complete the Electronic Payment Form. |
| ☐ **Social Security Billing Benefits** | ☐ **Initial** ☐ **Recurring** | For Social Security Benefits Billing, please complete the Social Security Benefits Billing Form. |
| ☐ **Check** | ☐ **Initial** ☐ **Recurring** | For monthly, please complete the Electronic Payment form for recurring payments. |
| ☐ **1035 Exchange** | ☐ **Initial** ☐ **Recurring** | For 1035 Exchange, please complete the 1035 Exchange Form. |

## 10 Premium Payor

A person or Trust paying the premium

**Complete this section if the premium payor is different than the owner.**

Legal First Name | Middle Name | Legal Last Name | Suffix

U.S. Social Security Number

__ __ __ - __ __ - __ __ __ __

Date of Birth (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

Trust

U.S. Tax ID Number

__ __ - __ __ __ __ __ __ __

Physical Address (Cannot be a P.O. Box) | Apartment / Unit

City | U.S. State / Territory

Zip Code | Country | Phone Number ☐ **Mobile**

**Continued on next page**

## 10 Premium Payor *continued*

Email Address

Premium Payor's relationship if other than the Proposed Insured

☐ **Spouse** ☐ **Child** ☐ **Domestic Partner** ☐ **Other** _____

☐ **Parent** ☐ **Trust** ☐ **Grandparent**

United States citizens and valid Green Card holders are eligible.

Are you a U.S. citizen?

☐ **Yes** ☐ **No** →

Green Card Number and Expiration

**If yes**, go to next section.

Country of Citizenship

## 11 Primary Care Physician

Physician, Hospital or Health Care Provider Name

Phone Number

Address

Date of last visit (mm/dd/yyyy)

__ __ / __ __ / __ __ __ __

**Check this box** if you do not have a physician.

☐

## 12 Lifestyle

**A.** Within the last 12 months have you used nicotine replacement, smoking or tobacco products in any form including, but not limited to the following: nicotine gum, patch or pills; cigarettes; cigars; pipe; chew; snuff; e-cigarettes; vape; hookah; or have you used marijuana more than 12 times in the last 12 months?

☐ **Yes** ☐ **No**

**B.** Height (feet and inches)

__ ' __ __ "

**C.** Current Weight (pounds)

**D.** Approximate weight a year ago (pounds)

☐ **1-14 lbs. more than current** ☐ **1-14 lbs. less than current** ☐ **Same as current**

☐ **15 lbs. more than current** ☐ **15 lbs. less than current**

**If 15 lbs. more or less,** proceed to the following two questions.

**E.** If your weight gain or loss is greater than 15 lbs in the last year, what is the difference in pounds?

_____ **pounds**

**F.** To the best of your knowledge or belief, explain your weight gain or loss of greater than 15 lbs in the last year. Check all that apply.

☐ **Diet** ☐ **Lifestyle Change** ☐ **Other** _____

☐ **Exercise** ☐ **Illness**

13

## Medical History Part 1

To the best of your knowledge or belief, have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**A. Currently under the age of 18 with** autism, depression, bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

**B. Prior to the age of 45 with** Heart Failure or Congestive Heart Failure?

☐ **Yes** ☐ **No**

---

**C.** To the best of your knowledge or belief, are you **currently** hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care; or been advised or planning to have surgery requiring general anesthesia?

☐ **Yes** ☐ **No**

*Home Health Care is defined as: Medical care provided by a medical professional, friends or family member including, but not limited to arranging medications, taking blood pressure or sugar readings, administering medications, wound care, feeding tube, etc.*

---

**D.** To the best of your knowledge or belief, have you **ever** been diagnosed or treated by a licensed member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV) infection?

☐ **Yes** ☐ **No**

---

**E.** Have you **ever** been the recipient or been given medical advice by a member of the medical profession to be a recipient of stem-cell, tissue, bone marrow, or organ transplant (other than corenal)?

☐ **Yes** ☐ **No**

---

To the best of your knowledge or belief, have you **ever** had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**F.** Alzheimer's, dementia, memory loss, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, cystic fibrosis, pulmonary fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?

☐ **Yes** ☐ **No**

**G.** Diabetic coma?

☐ **Yes** ☐ **No**

**H.** Amputation other than at the time of an accident or trauma?

☐ **Yes** ☐ **No**

**I.** Metastatic cancer, recurrent cancer, multiple cancers or cancer with lymph node involvement?

☐ **Yes** ☐ **No**

13

## Medical History Part 1

*continued*

To the best of your knowledge or belief, during the **last 2 years** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**J.** Cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

During the **last 2 years** have you:

**K.** To the best of your knowledge or belief, have you been diagnosed or treated by a licensed member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) and/or Human Immunodeficiency Virus (HIV) infection?

☐ **Yes** ☐ **No**

**L.** Attempted suicide; been convicted of or awaiting trial for a felony?

☐ **Yes** ☐ **No**

**M.** Been convicted for reckless driving or operating while intoxicated (DWI/OWI/DUI), been convicted of 3 or more moving violations, or having any pending legal matters?

☐ **Yes** ☐ **No**

**If all questions in Part 1 are answered "No," proceed to Part 2.**

**If any question in Part 1 is answered "Yes", you are not eligible for any coverage.**

**14**

## Medical History Part 2

To the best of your knowledge or belief, have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**A. Prior to the age of 20 with** Diabetes (other than gestational diabetes)?

☐ **Yes** ☐ **No**

**B. Prior to the age of 26 with** Crohn's Disease?

☐ **Yes** ☐ **No**

**C. Prior to the age of 45 with** Parkinson's Disease; Coronary Artery Disease, Peripheral Vascular Disease, or Cerebral Vascular Disease; Heart Attack, Transient Ischemic Attack (TIA), or Stroke; Cardiac Surgery, Bypass Surgery, Stent Implant, Angioplasty, Pacemaker or Defibrillator Implant, or Heart Valve Replacement?

☐ **Yes** ☐ **No**

---

To the best of your knowledge or belief, have you **ever** had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**D.** Cirrhosis, heart failure, or congestive heart failure (CHF); or an aneurysm that has not been surgically corrected (still present)?

☐ **Yes** ☐ **No**

**E.** Hepatitis C?

**If yes**, proceed to E1 & E2. →

☐ **Yes** ☐ **No**

**E1.** Has the Hepatitis C been cured?

☐ **Cured** ☐ **Not Cured**

**E2.** If cured, when was the last blood test (RNA PCR Titer) showing the Hepatitis C was cured?

☐ **0-24 months after treatment ended**

☐ **More than 24 months after treatment ended**

*If the answer to E2 is 0-24 months, then the best rate class is Graded. If the answer is more than 24 months, then the best rate class is Standard and the answer counts as a "No" when referring to directions below.*

---

**F.** To the best of your knowledge or belief, during the **last 4 years** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for cancer (other than basal cell carcinoma)?

☐ **Yes** ☐ **No**

---

**G.** To the best of your knowledge or belief, during the **last 2 years** have you used illegal drugs or had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs), muscular dystrophy, or systemic lupus erythematosus (SLE)?

☐ **Yes** ☐ **No**

*If SLE has been in remission and there has been no treatment for more than two years, you may then answer this question "No" in regard to only the SLE.*

14

## Medical History Part 2

*continued*

To the best of your knowledge or belief, during the **last 2 years** have you:

**H.** Required assistance with activities of daily living (ADL's) such as bathing, dressing, eating, toileting, getting in and out of chair or bed, or do you have ongoing neurological incontinence or, has a medical professional recommended that you be confined to a Nursing Home?

☐ **Yes** ☐ **No**

**I.** Used a wheelchair, electric scooter or electric cart?

**If yes**, proceed to I1. →

☐ **Yes** ☐ **No**

**I1.** If yes, provide details regarding use:

☐ **Currently use or use occasionally at facilities such as, but not limited to, the grocery store, department stores, warehouse stores, airports**

☐ **Reason for use is expected to resolve in the next 3 months or the reason for use has resolved**

*If the answer to I1 is "Reason for use...", count I as a "No" when referring to directions below.*

To the best of your knowledge or belief, during the **last 1 year** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**J.** More than 6 seizures; or had, been diagnosed with, been treated for or advised to receive treatment for any liver disease (including but not limited to autoimmune hepatitis) other than cirrhosis or Hepatitis C that should have been noted in a prior question?

☐ **Yes** ☐ **No**

**K.** Heart attack, stroke (CVA) or transient ischemic attack (TIA)?

☐ **Yes** ☐ **No**

**L.** Used oxygen to assist in breathing (including for Sleep Apnea); received kidney dialysis; kidney failure or chronic kidney disease (stage 4 or 5); encephalitis; or have you been unemployed or disabled and had, been diagnosed with, treated for or been given medical advice by a member of the medical profession for chronic pain?

☐ **Yes** ☐ **No**

*Chronic Pain is defined as: Pain lasting more than 6 months or requiring 6 or more fills of narcotic pain prescriptions in any 12 month period.*

**If yes** for angina, proceed to M1. →

**M.** Angina (chest pain); or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or had an aneurysm surgically corrected?

☐ **Yes** ☐ **No**

**M1.** When was the angina (chest pain) first diagnosed?

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

*If the answer to M1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count M as a "No" when referring to directions below.*

**If all questions in Part 2 are answered "No," proceed to Part 3.**

**If one question in Part 2 is answered "Yes," you are potentially eligible for the Graded Death Benefit product.**

**If two or more questions in Part 2 are answered "Yes," you are not eligible for any coverage.**

15

## Medical History Part 3

**A.** To the best of your knowledge or belief, **prior to the age of 45,** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for cancer (other than Basal Cell)?

☐ **Yes** ☐ **No**

---

To the best of your knowledge or belief, have you **ever** had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**B.** Bipolar disorder or schizophrenia?

☐ **Yes** ☐ **No**

**C.** Parkinson's disease, multiple sclerosis, systemic lupus erythematosus (SLE), sarcoidosis, Crohn's disease, ulcerative colitis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?

☐ **Yes** ☐ **No**

*Chronic Asthma is defined as: Using inhalers year round on a daily or weekly basis, or filling prescriptions 6 or more times in any 12 month period.*

---

To the best of your knowledge or belief, during the **last 4 years** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**D.** Kidney disease (stage 1, 2 or 3) or other kidney disorder?

☐ **Yes** ☐ **No**

**E.** Used illegal drugs; alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs)?

☐ **Yes** ☐ **No**

---

During the **last 4 years** have you:

**F.** Been convicted for reckless driving or operating while intoxicated (DWI/OWI/DUI), been convicted of 3 or more moving violations, or having any pending legal matters?

☐ **Yes** ☐ **No**

---

To the best of your knowledge or belief, during the **last 2 years** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**G.** Heart attack, stroke (CVA) or transient ischemic attack (TIA)?

☐ **Yes** ☐ **No**

**H.** Used insulin; had more than 6 seizures; spina bifida cystica, pancreatitis, tuberculosis; hepatitis B or other liver disease?

☐ **Yes** ☐ **No**

---

15

## Medical History Part 3

*continued*

To the best of your knowledge or belief, during the **last 2 years** have you had, been diagnosed with, treated for, tested positive for or been given medical advice by a member of the medical profession for any of the following:

**If yes** for angina, proceed to I1.

**I.** Angina (chest pain); cardiomyopathy; vascular, circulatory or blood disorder (including anemia other than iron deficiency); heart surgery of any kind including bypass surgery, angioplasty, stent implant; irregular heart rhythm such as atrial fibrillation or heart murmur; had an aneurysm surgically corrected; or do you currently have a pacemaker/ defibrillator?

☐ **Yes** ☐ **No**

**I1.** When was the angina (chest pain) first diagnosed?

☐ **0-12 months ago**

☐ **13-24 months ago**

☐ **Greater than 24 months ago**

*If the answer to I1 is 0-12 months, then the best rate class is Graded. If the answer is 13-24 months, then the best rate class is Standard. If the answer is greater than 24 months, count I as a "No" when referring to directions below.*

**If all questions in Part 3 are answered "No," you are potentially eligible for the Preferred product.**

**If one question in Part 3 is answered "Yes," you are potentially eligible for the Standard product.**

**If two or more questions in Part 3 are answered "Yes," you are potentially eligible for the Graded Death Benefit product.**

## 16 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 complete to the best of my knowledge and belief. I acknowledge and agree (A) this application shall consist of the Individual Life Insurance Application, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application, and shall be attached to and made part of such policy; (B) that the Producer 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; (C) except as provided in the Conditional Receipt, if issued with the same 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 Owner must have personally received and accepted the policy during the lifetime of each Insured; and 3) on the date of the later of either 1) or 2) above, unless no statement of good health was provided at the time of policy delivery, all of the statements and answers given in this application must be true and complete to the best of my knowledge and belief. Unless otherwise stated the undersigned Insured 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, wellness/fitness, financial services or insurance company, MIB, Inc. ("MIB"), consumer reporting agency, and data aggregator that has any records or knowledge of me or my health/fitness (excluding psychotherapy notes), finances, credit history, credit standing, credit capacity, life activities or purchase history, to give to the Company, or its reinsurers, any such information. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. A photographic copy of this authorization shall be as valid as the original. I understand a credit report may be requested in connection with this authorization.

I hereby expressly consent to receive calls about my application from the Company or its representatives that involve the use of an automatic telephone dialing system and/or an artificial or prerecorded voice.

This authorization will be valid for 24 months. I understand that I may revoke it at any time by giving written notice to the Company at the above address. Any action taken in reliance on this authorization will be valid if such action has been taken prior to receipt of notice of revocation. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by the Company (or the Company becomes obligated to report such codes to MIB) while this authorization is in-force. I understand the Company may use the information collected via this authorization: (1) to underwrite my insurance application, (2) to support the operations of the Company's business, (including performing actuarial or internal business studies, research and analytics and other analysis), or (3) if a policy is issued, to evaluate eligibility for benefits or to contest a claim under the policy.

The Company shall have 60 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 Owner 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 I have read and received the Notice of Disclosure for (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 material misrepresentations in this application could cause an otherwise valid claim to be denied under any insurance issued from this application.**

**If you are not healthy enough to qualify for a level death benefit policy and a graded death benefit policy is issued, with minimal medical underwriting, the premium rate charged includes an extra mortality risk charge.**

**Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.**

**Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income.**

**There is no separate identifiable premium for any accelerated death benefit. Applications to accelerate the death benefit are subject to an administrative charge of $[350]. The amount of the death benefit accelerated will be discounted to reflect early payment.**

**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 the IRS has notified me I am no longer subject to backup withholding, or I am not subject to backup withholding because I am exempt; 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. You must cross out item (2) if you are currently subject to backup withholding.

## 16 Authorization to Obtain and Disclose Information

*continued*

__ __ / __ __ / __ __ __ __

| **Signature of Proposed Insured** | Date (mm/dd/yyyy) | City | U.S. State / Territory |
|---|---|---|---|

__ __ / __ __ / __ __ __ __

| **Signature of Parent or Legal Guardian** (Of children under age 14 years 6 months) | Date (mm/dd/yyyy) | City | U.S. State / Territory |
|---|---|---|---|

__ __ / __ __ / __ __ __ __

| **Signature of Applicant/Owner** (If other than Proposed Insured) | Date (mm/dd/yyyy) | City | U.S. State / Territory |
|---|---|---|---|

| Title of Trust (If owner is trust) | Trustee First Name | Trustee Last Name |
|---|---|---|

| Print Producer 1 Name | Producer 1 Number | Producer 1 Signature |
|---|---|---|

| Print Producer 2 Name | Producer 2 Number | Producer 2 Signature |
|---|---|---|

## 17 Other Insurance (to be completed by the Producer)

Does the Proposed Insured have existing life insurance policies or annuity contracts with the company or any other company?

☐ **Yes** ☐ **No**

Is the policy applied for intended to discontinue, replace or change any existing life insurance policy or annuity?

☐ **Yes** ☐ **No**

If replacement of existing insurance is intended, have you complied with all state requirements, including any Disclosure and Comparison Statements? If **no**, explain.

☐ **Yes** ☐ **No** | Explain

I certify that I used only company approved sales materials and copies of all sales materials used during the solicitation were provided to the applicant.

**Producer Signature**

# NOTICE OF DISCLOSURE

## Please provide a copy of these notices to the applicant and to any proposed Insureds not living in the household.

### 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. I hereby expressly consent to an investigative consumer report being prepared about me.

**Signature of Proposed Insured** Date (mm/dd/yyyy)

**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.**

**F-AP-WL10NY-0518-IR**

### MIB GROUP, INC. (MIB) PRE-NOTIFICATION

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

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

The 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.

**F-AP-WL10NY-0518-MIB**

### 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 producer 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 Financial Life Insurance Company, Attn: Director of Underwriting, 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499.

**F-AP-WL10NY-0518-IP**

# Please provide a copy of these notices to the applicant and to any proposed Insureds not living in the household.

## CONDITIONAL RECEIPT

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

### Conditions of Coverage

1. On the Effective Date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;
2. An amount equal to the first full premium required must be paid and any check, Authorization for Electronic Funds Transfer (EFT), payroll deduction or allotment given in payment must be honored when first presented; and,
3. Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under its rules, limits and underwriting standards for the plan and for the amount applied for, and at the Company's standard premium rate.

### Effective Date

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

**F-AP-WL10NY-0518-CR**

# Agent's Report

**1**

| | Writing Agent Name | Agent Number | Profile Number | Percent of Agent's Split |
|---|---|---|---|---|
| **Producer 1** → | | | | |
| **Producer 2** → | Split Agent Name | Agent Number | Profile Number | Percent of Agent's Split |
| **Producer 3** → | Split Agent Name | Agent Number | Profile Number | Percent of Agent's Split |
| **Producer 4** → | Split Agent Name | Agent Number | Profile Number | Percent of Agent's Split |

**2**

## Agent Disclosure

How long have you known the Proposed Primary Insured?

Relationship to Proposed Primary Insured

Are you financially responsible for the Proposed Primary Insured?

☐ **Yes** ☐ **No**

Are you or any of your family members named as a beneficiary on this policy application?

☐ **Yes** ☐ **No**

**If yes** →

If, yes what insurable interest do you/your family member have in the life of the insured(s)?

Do you intend to submit multiple applications on any of the proposed insureds?

☐ **Yes** ☐ **No**

Is the Agent or Split Agent also the Owner, Applicant or Payor?

☐ **Yes** ☐ **No**

Is the Proposed Primary Insured or owner related to any affiliated Broker/Dealer office or employee?

☐ **Yes** ☐ **No**

**If yes** →

Name and address of Broker/Dealer

| City | U.S. State / Territory | Zip Code |
|---|---|---|
| | | |

Did you provide the "Notice of Disclosure" to the Proposed Primary Insured?

☐ **Yes** ☐ **No** ☐ **N/A**

**Please indicate how this sale was taken:**

☐ In person ☐ Phone or Video Call (Skype, FaceTime, etc.) ☐ Other _____

Was the identification of the Proposed Primary insured verified during the sale?

☐ **Yes** ☐ **No**

Type of Government issued photo ID

Issuer of Identification Document | Number | Expiration Date

## 3 Correspondence Information

Case Manager Name (if applicable)

Agent/Case Manager Email | Office ID

Agent/Case Manager Phone Number | Agent/Case Manager Fax Number

## 4 Signature

I submit this application assuming full responsibility for delivery of any coverage issued and for immediate transmittal to the Company of the first premium when collected. I certify that I reviewed the photo identification of the person(s) seeking to open this policy and verified that person seeking to open this policy is the same person in the documents reviewed. I understand that misrepresentations in connection with this and other certifications in the Company's application documents may result in disciplinary action, termination, civil action or prosecution for violation of state or federal criminal laws.

**Payment with application not accepted if the primary proposed insured total coverage over $1,000,000.00, age 76 and over, or treated for or experienced heart trouble, stroke or cancer within the past 12 months.**

__ __ / __ __ / __ __ __ __

**Signature of Writing Agent/ Registered Representative** Date (mm/dd/yyyy)

**For sales transactions in New York (TFLIC policies)**

Print Consumer Name: _____ (Prospective Policy Owner)

Producer Representation under New York Regulation 187

In recommending this life insurance sales transaction to the consumer, I have acted in the best interest of the consumer. The recommendation is based on an evaluation of the relevant suitability information of the consumer and reflects the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use under the circumstances then prevailing. Only the interests of the consumer have been considered in making the recommendation. The sales transaction is suitable, and I have a reasonable basis to believe that:

(a) the consumer has been reasonably informed of various features of the policy and potential consequences of the sales transaction, both favorable and unfavorable;
(b) the consumer would benefit from certain features of the policy; and
(c) the particular policy as a whole, the underlying subaccounts to which funds are allocated at the time of the sales transaction, and riders and similar product enhancements, if any, are suitable for this consumer based on the consumer's suitability information.

I have:

(a) weighed multiple factors that are relevant to the best interests of the consumer including, but not limited to, the benefits provided by the policy, the price of the policy, the financial strength of the insurer, and other factors that differentiate products or insurers;
(b) at the time of this recommendation, disclosed to the consumer in a reasonable summary format all relevant suitability considerations and product information, both favorable and unfavorable, that provide the basis for the recommendation; and
(c) documented the basis for the recommendation made.

***The following representation is made if the recommended transaction is a <u>replacement</u> of a policy (as defined in New York Insurance Law):***

This replacement is suitable including taking into consideration whether:

(a) the consumer will incur a surrender charge, increased premium or fees, decreased coverage duration, decreased death benefit or income amount, adverse change in health rating, be subject to the commencement of a new surrender period, lose existing benefits (such as death, living or other contractual benefits), be subject to tax implications if the consumer surrenders or borrows from the policy, or be subject to increased fees, investment advisory fees, premium loads or charges for riders and similar product enhancements;
(b) the consumer would benefit from policy enhancements and improvements, such as a decreased premium or fees, increased coverage duration, increased death benefit or income amount; and
(c) the consumer has had another policy replacement, in particular, a replacement within the preceding 36 months.

_____ Date: _____
Producer's signature

_____
Print producer's name

TRANSAMERICA®

# Payment Authorization Form

## Introduction

**Instructions:**
Use this form to choose the initial premium payment method on your application for insurance or to update how you pay for an existing policy. Take care to fill in each field accurately so letters and numbers cannot be misinterpreted and attach a separate sheet if there is more than one policy number. Note that not all payment options are available on all products.

Return Completed Form To:
Transamerica Life Insurance Company
Transamerica Financial Life Insurance Company
6400 C St. SW
Cedar Rapids, IA 52499

Or fax it to us at:
1-800-235-4782

Questions?

Contact your Financial Professional


Visit us at:
transamerica.com

Call us at:
1-800-pyramid

Policy Number (for existing policies only)

Insured First Name

Insured Last Name

**Draft Date (MM/DD, 1st through 28th only)**

__/__

*If you select an initial premium draft date in the future, it cannot be greater than 30 days after the application date, and you will not have potential coverage until that date under the Conditional Receipt.*

**Total Premium**

$___,___.__

**Recurring Payment Frequency (choose one)**

☐ **Monthly** ☐ **Quarterly** ☐ **Semiannually** ☐ **Annually**

Please select your preferred payment type/s by checking the box for initial and/or recurring payments next to the option you favor. (Ex: I want to make my initial payment by check and recurring payments with my credit card.)

| Payment Type Options | Initial and/or Recurring Payment | Form Information |
|---|---|---|
| **Bank Draft (ACH/ EFT)** | ☐ **Initial** ☐ **Recurring** | Complete the ACH payment section below |
| **Social Security Benefits Billing (SSB)** | ☐ **Initial** ☐ **Recurring** | Complete the SSB Option info on the next page. To pay by SSB Card, tokenize the card # and fill out the Credit Card Payment section; or for direct SSB account draft, fill out the Bank Draft Payment section. |
| **Credit Card** | ☐ **Initial** ☐ **Recurring** | Tokenize your card number, and complete the Credit Card Payment section below |
| **Check** | ☐ **Initial** | No additional form required; mail your check to the address at the top of this form |
| **Direct Bill** | ☐ **Recurring** | No additional form required; this method only available quarterly, semiannually, or annually. Bills are generated 30 days prior to due date. |

**If using Social Security Benefits for either form of payment, please enter payer date of birth and then select one:**

Payer date of birth

__/__/__

☐ Beneficiary receiving Supplemental Security Income (SSI) 1st of the month (Option A)

☐ Benefit Paid on 3rd of each month, started receiving SS benefits prior to May 1997 or receiving both SS benefits and SSI payments (Option B)

☐ Benefit Paid on Second Wednesday (Option C)

☐ Benefit Paid on Third Wednesday (Option D)

☐ Benefit Paid on Fourth Wednesday (Option E)

## Credit Card Payment Information

**Credit Card Type:** ☐ **VISA** ☐ **MasterCard**

PCI Token #

Create your PCI token at: creditcardtoken.transamerica.com *(Reminder: When you enter your credit card information on the Token website, your unique number will start with a "T". Be sure to write the full number, including the T, on the line at left.)*

Cardholder First Name

Cardholder Last Name

Card Exp.Date __/__

Payment Amount $__,__.__

**The cardholder is the (choose one):**

☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Cardholder Address

City

State

Zip

Cardholder Phone Number

Cardholder Signature:

**X** _____

*By signing I acknowledge that I have read and agreed to all of the following consents that pertain to my preferred premium payment method.*

## Bank Draft (ACH/EFT) Payment Information

**Account Type:** ☐ **Checking** ☐ **Savings**

Account Holder First Name

Account Holder Last Name

Trust or Entity (if entity, add the title of officer and name of entity; if trust, add trustee's name)

Financial Institution Name

Financial Institution City

State

Zip

Routing Number

Account Number

**The account holder is the (choose one):**

☐ **Insured** ☐ **Owner** ☐ **Spouse** ☐ **Other:** _____

Account Holder Signature:

**X** _____

*By signing I acknowledge that I have read and agreed to all of the following consents that pertain to my preferred premium payment method.*

## Consents

If a conditional receipt was issued along with this authorization, initial premium will be withdrawn/cashed upon receipt of the application by the Company. Unless a conditional receipt was issued along with this authorization, I/we agree this authorization shall not become effective for payment of the initial premium unless and until after a contract is issued and all other conditions of coverage set forth in the application have been met.

As a convenience to me, I request and authorize the Company named above to make withdrawals, by draft or electronic transfer, from my account with the financial institution named for: (1) premiums becoming due (including premiums which have increased from the initial payment amount under the terms of the policy(ies) or due to changes made to the policy(ies)); (2) other amounts due under the policy(ies) listed above (including any amendments, endorsements, riders, or amounts past due); (3) loan payments if authorized above or later agreed to by me; and/or (4) such other payments as I may authorize the Company to make. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made to the policy(ies). I understand that if a withdrawal is not honored for payment by the financial institution, with or without cause and whether intentionally or inadvertently, and the premiums are not otherwise paid within the grace period allowed by a policy, the policy may terminate.

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

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

**Distributions Will Be Subject to Identity Verification**
To help ensure the security of your funds, if bank account information is provided, the Company may obtain a consumer report from a Consumer Reporting Agency (“CRA”) to help verify the validity and accuracy of the account information provided. If I have provided the company with bank account information, I authorize the Company to obtain a consumer report from the CRA as described above, and acknowledge that I: (1) understand that in order for the CRA to verify my account information, some of my personal information will be shared with the CRA; and (2) consent to such sharing, retention, and use.

# Life Insurance Buyer's Guide

This guide can help you when you shop for life insurance. It discusses how to:

- Find a policy that meets your needs and fits your budget.
- Decide how much insurance you need.
- Make informed decisions when you buy a policy.

**Prepared by the National Association of Insurance Commissioners**

The NAIC is an association of state insurance regulatory officials. This association helps the various Insurance Department to coordinate insurance laws for the benefits of all consumers.

**This guide does not endorse any company or policy.**

**Reprinted by:**
**Transamerica Financial Life Insurance Company**
**Transamerica Life Insurance Company**
**Transamerica Premier Life Insurance Company**

## IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance **may be costly.**
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

## BUYING LIFE INSURANCE

When you buy life insurance, you want coverage that fits your needs.

**First**, decide how much you need – and for how long – and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for your future.

**Next**, learn what kinds of policies will meet your needs and pick the one that best suits you.

**Then**, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

## WHAT ABOUT A POLICY YOU HAVE

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy (you have now) helped pay for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older and your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.

- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may not pay benefits for some cause of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

## HOW MUCH DO YOU NEED

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any Group Insurance where your work or Veteran's Insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

## WHAT IS THE RIGHT KIND OF LIFE INSURANCE

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: **term insurance** and **cash value insurance**. Term Insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine Cash Value Life Insurance with Term Insurance for the period of your greatest need for life insurance to replace income.

**Term Insurance** covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term Insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value. You can renew most Term Insurance policies for one or more terms even if your health has changed. Each time you renew the policy or a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase. You may be able to trade many Term Insurance policies for a Cash Value Policy during a conversion period – even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the Term Insurance.

**Cash Value Life Insurance** is a type of insurance where the premium charges are higher at the beginning than they would be for the same amount of Term Insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and interest on it, the amount you owe will be subtracted from the benefits payable when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without have to pay more premiums.

You can also use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash Value Life Insurance may be one of several types: Whole Life, Universal Life and Variable Life are all types of Cash Value Insurance.

***Whole Life Insurance*** covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of Term Insurance. But they are smaller than the premium you would eventually pay if you were to keep renewing a Term Policy until your later years. Some Whole Life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

***Universal Life Insurance*** is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than your charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

***Variable Life Insurance*** is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. You benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

## LIFE INSURANCE ILLUSTRATIONS

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

## FINDING A GOOD VALUE IN LIFE INSURANCE

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much cash value builds up under the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at **all** ages for **all** kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent of company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are non-guaranteed values calculated? For example, interest rates are important in determining policy return. In some companies, increases reflect the average interest earnings on all of the company's policies regardless of when issued. In others, the return for policies issued in a recent year, or group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

# Your Guide to New York Regulation 60

*Replacement Form Instructions*

**TFLIC Reg. 60 Guide – 0915**

# New York
# Regulation 60 Requirement

**New York Regulation 60 became effective November 10, 1998. The intent of this Regulation is to provide full and clear information to consumers to help them make informed decisions regarding replacement of life insurance and annuities. The Regulation affects all new life insurance sold in New York.**

**This guide is designed to give you a brief overview of Regulation 60 requirements and lead you through Transamerica Financial Life Insurance Company's ("TFLIC") procedures for complying with these requirements. Our goal is to help you navigate through the process and have your business processed as quickly as possible.**

## Form Requirements

There are up to five forms that must be completed and signed by the applicant and/or agent/broker in order to fulfill Regulation 60 requirements:

**Definition of Replacement (Form NY-Reg60-Def-0415)**
This form asks questions to help the applicant determine whether he/she is replacing or otherwise changing the status of an existing life insurance policy or annuity contract. The agent/broker is required to ask the questions on the form and explain any terms the applicant does not understand.

**Authorization Form (NY-Reg60-Auth-0415)**
If a replacement is involved, an Authorization Form must be completed and signed by the applicant. The Authorization Form lists all policies that might be replaced, serves as notification to the replaced/existing insurer of the potential replacement, and provides authorization from the applicant to request information necessary to complete the Disclosure Statement.

**Disclosure Statement (Form NY-Reg60-Stmt-0715 for life insurance replacement).**
The Disclosure Statement was designed to give the applicant a summary comparison of the existing policy with the proposed policy so that he/she may make an informed decision as to whether the replacement is in his/her best interest. It also requires the agent/broker to state the reason(s) for recommending the replacement, why the existing policy cannot meet the applicant's needs, and to list the advantages of continuing the existing policy without changes. Instructions for completing the Disclosure Statement are included in this brochure.

**IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts ("IMPORTANT Notice") (Form No. NY-Reg60-Not-0415).**

The purpose of the IMPORTANT Notice is to provide the applicant with the information about factors to consider when deciding when to proceed with a replacement. The IMPORTANT Notice lists some of the possible disadvantages of a replacement and encourages the applicant to carefully study the Disclosure Statement before making a decision. It also explains the applicant's right to a 60-day free look period and reinstatement of the replaced policy.

**Sales Material Checklist (Form NY-Reg60-SMC-0415)**
The agent/broker should list all sales materials used in the sale. The SMC must be completed with all replacement sales in NY. All product sales brochures and any other sales material used during the sale must be listed. There can be no blanks on this form; if there were no sales material used, please write "none".

## No Replacement

If no replacement is indicated on the Definition of Replacement form, leave a copy of the form with the applicant and forward the original to TFLIC, along with the application and other forms required for new business.

**TIPS**

We will be unable to begin processing the replacement until all the properly completed forms are received.

- As a procedure, each line should be completed and there should be no blanks.
- Strikethroughs or N/As are acceptable when they are applicable to the specific data requested. The New York State Department of Financial Services does not allow multiple strikethroughs on the same spot or throughout a document.
- Limited strikethroughs are allowable (although no more than 2 strikethroughs per document); however, any strikethroughs or corrections should include the full signature of the applicant and current date.

**NOTE: If the application is approved other than applied for: (1) a revised Disclosure Statement and revised illustration, if applicable for the product, will need to be completed and provided to the applicant. This must be signed and dated by the agent and returned to the home office. (2) policy issuance will be delayed until receipt of the correct Disclosure Statement. Disclosure Statements will be prepared prior to issuing the policy and sent to the applicant with the policy. If there is a revised Disclosure Statement, only that revised version will be sent with the policy.**

## TFLIC Home Office Obligation

**TFLIC must send a list of sales material and any proposals used in the sale along with the completed, signed, and dated Disclosure Statement to the replaced insurer(s) within 10 calendar days of the policy delivery date. Actual copies of the sales materials will be provided within 10 days upon such request.**

If you have any questions about Regulation 60 requirements, please contact your Marketing representative or TFLIC New Business.

# Agent/Broker's Guide for Submitting Replacement Cases in New York

TFLIC no longer requires the applicant's signature on the Disclosure Statement. The agent signature is required on the Disclosure Statement and is also a requirement to issue the life insurance policy. The Disclosure Statement must be provided to the applicant no later than upon delivery of the new policy. There are two different methods for submitting NY replacement business. This guide will elaborate on these methods and will provide steps to properly complete replacement forms and applications for business submitted in New York.

**Method 1 – This will be utilized primarily by the TEB/Worksite Marketing channel. <u>The agent/broker may request and obtain the policy values from the existing insurer and complete the Disclosure Statement.</u> At the point of sale,**

THE <u>AGENT</u> MUST:

Step 1: Determine if there is a replacement.

- Complete "Definition of Replacement" (form NY-Reg60-Def-0415)
  - o If all of the answers are "No", submit the Definition of Replacement form along with all other required application paperwork to the home office.
  - o If any of the answers are "Yes", continue to proceed with Step 2 below.

Step 2: Complete the three other Replacement Forms (Important Notice Regarding Replacement (NY-Reg60-Not-0415), Disclosure Authorization (NY-Reg60-Auth-0415), and the Disclosure Statement (NY-Reg60-Stmt-0715).

- The agent/broker must request and obtain the policy values from the existing insurer, and place those values on the Disclosure Statement. With this request, the agent/broker must forward to the existing insurer a copy of the Disclosure Authorization (NY-Reg60-Auth-0415) signed by the applicant and the Disclosure Statement (NY-Reg60-Stmt-0715). The replaced insurer will be asked to complete the required information on the Disclosure Statement.
- The replaced insurer has 20 calendar days from receipt of the Disclosure Statement to provide the agent/broker with the requested information. If the agent/broker does not receive the required information, he/she must complete those sections using "good faith approximations based on the information available". In addition, the documents used to estimate these values must be submitted with the application.
- In order to allow for sufficient mailing time to and from the replaced insurer, the agent/broker must wait 23 calendar days from the date he/ she mailed the request to the replaced insurer before completing the replaced insurer's information on the Disclosure Statement and taking an application.
- The agent must sign the acknowledgement on the Disclosure Statement and date it; this signature signifies that the form is correct to the best of his/her (the agent's) knowledge.
- The agent must leave copies of the Definition of Replacement, Important Notice, the Disclosure Authorization with the applicant prior to submitting all replacement forms with the application to TFLIC.
- The Disclosure Statement will be provided at the time of policy delivery.

Step 3: Submit the appropriate TFLIC Application for life insurance, any illustration used, and all four replacement forms the Definition of Replacement form (NY-Reg60-Def-0415); the Important Notice Regarding Replacement (NY-Reg60-Not-0415), the Disclosure Authorization (NY-Reg60-Auth-0415), and the completed Disclosure Statement (NY-Reg60-Stmt-0715) to the home office (New Business). Also complete and submit the Sales Material Checklist (NY-Reg60-SMC-0415) and submit a copy of a recent statement from the existing insurance company. The agent must submit an illustration with all illustratable products, including IULs.

**Note: As noted on page one, policies approved other than applied for will require a new Disclosure Statement and may delay issuance.**

THEN, THE HOME OFFICE WILL:

Step 4: Review the proposed policy values for the new TFLIC policy on the Disclosure Statement, illustration, and Sales Material Checklist (NY-Reg60-SMC-0415) to ensure accuracy.

Step 5: Continue New Business and Underwriting process and send the request for replacement to the existing insurer, along with a list of the sales material used during the sale, as indicated on the Sales Material Checklist (NY-Reg60-SMC-0415).

Step 6: Upon completion of Underwriting, if the policy is approved as it was applied for, then:

Step 7: Send the policy, including the Disclosure Statement under normal business procedures.

As mentioned on page one, if the application is approved other than applied for: (1) a revised Disclosure Statement and revised illustration, if applicable for the product, will need to be completed and provided to the applicant. This must be signed and dated by the agent and returned to the home office. (2) Policy issuance will be delayed until receipt of the correct Disclosure Statement. If there is a revised Disclosure Statement, it will be sent back to the agent for their signature; this signed revised version must be returned to the home office. The home office will then send only the revised Disclosure Statement to the applicant at policy delivery.

THE AGENT MUST:

Step 8: The agent must meet all normal policy delivery requirements, i.e. PDR, amendment and return all such required documents to the home office.

THE HOME OFFICE MUST:

Step 9: If not already done during steps 4-7, the home office must forward the signed and dated Disclosure Statement, along with a list of sales materials to the existing insurer within 10 days of delivery of the policy, with an offer to provide the actual copies within 10 days upon request.

**Agents and brokers should be aware that special circumstances may require internal review by TFLIC Legal and Compliance.**

**Method 2 – This will be utilized primarily by the Brokerage and TLD/WFG distribution channels. TFLIC will now offer a service to complete the Disclosure Statement on the agent's behalf. If an agent accepts this service that is provided by the TFLIC home office, the home office will be responsible for requesting and obtaining the values from the existing insurer. At the point of sale,**

THE AGENT MUST:

Step 1: Determine if Replacement Required

- Complete the Definition of Replacement form (NY-Reg60-Def-0415)
  - o If all of the answers are "No", submit the Definition of Replacement form along with all other required application paperwork to the home office.
  - o If any of the answers are "Yes", continue to proceed with Step 2 below.

Step 2: Complete the Important Notice Regarding Replacement (NY-Reg60-Not-0415) and Disclosure Authorization (NY-Reg60-Auth-0415). The agent must leave copies of all three replacement forms with the applicant.

Step 3: Submit the appropriate TFLIC application for life insurance, illustration if used, and the three replacement forms - the Definition of Replacement form (NY-Reg60-Def-0415); the Important Notice Regarding Replacement (NY-Reg60-Not-0415), and the Disclosure Authorization (NY-Reg60-Auth-0415) to the home office (New Business), along with the Sales Material Checklist (NY-Reg60-SMC-0415) and a copy of a recent statement from the existing insurance company. The agent must submit an illustration with all illustratable products, including IULs.

THEN, THE HOME OFFICE WILL:

Step 4: Forward to the replaced insurer the Disclosure Authorization (NY-Reg60-Auth-0415), and the Disclosure Statement (NY-Reg60-Stmt-0715). The replaced insurer will be asked to provide the policy values from the existing insurance policy. The home office will review the Disclosure Statement, illustration, and Sales Material Checklist (NY-Reg60-SMC-0415) to ensure accuracy.

Step 5: Wait the required period for the existing policy values to be returned by the existing Insurer

- The replaced insurer has 20 calendar days from receipt of the Disclosure Statement to provide the home office with the requested information. In order to allow for sufficient mailing time to and from the replaced insurer, TFLIC must wait 23 calendar days from the date that the home office mailed the request to the replaced insurer.

Step 6: Complete the Disclosure Statement (NY-Reg60-Stmt-0715), with the values from the existing insurer and also complete the proposed policy values for the new TFLIC policy. In the event that the existing insurer does not provide existing values at or before the 23 day time frame, the home office will complete the section for the existing values on the Disclosure Statement using a "good faith" approximation based on the information available. If a recent statement from the existing insurer is not included with the application, it is possible that there will be a delay with issuing the policy.

THE HOME OFFICE MUST:

Step 7: Complete the New Business and Underwriting process and, if the policy is approved, then the home office will send the completed Disclosure Statement back to the agent for his/her signature (this signature signifies that the form is correct to the best of his/her knowledge).

THE AGENT MUST:

**Step 8: The agent must sign the acknowledgement on the Disclosure Statement, date it, and send it back to the home office as soon as possible (25 days or less). This is considered a requirement to issue the policy.**

THE HOME OFFICE MUST:

Step 9: Send the policy, including the Disclosure Statement under normal business procedures.

THE AGENT MUST:

Step 10: The agent must meet all normal policy delivery requirements, i.e. PDR, amendment and return all such required documents to Home Office.

As mentioned on page one, if the application is approved other than applied for: (1) a revised Disclosure Statement and revised illustration, if applicable for the product, will need to be completed and provided to the applicant. This must be signed and dated by the agent and returned to the home office. (2) Policy issuance will be delayed until receipt of the correct Disclosure Statement. The Home Office will then send only the revised Disclosure Statement to the applicant at policy delivery.

THE HOME OFFICE MUST:

Step 11: If it has not already been done, the home office must forward the signed and dated Disclosure Statement, along with a list of sales materials to the existing insurer within 10 days of delivery of the policy, with an offer to provide the actual copies within 10 days upon request.

**Agents and brokers should be aware that special circumstances may require internal review by TFLIC Legal and Compliance.**

# Regulation 60 Life Disclosure Statement Definitions and Completion Instructions

All questions must be completed. Use N/A (Not Applicable when appropriate).

1. **Name of Applicant –** Print name of person applying for coverage.
2. **Telephone Number –** Home telephone number of applicant
3. **Address –** Full address of applicant
4. **Name of Agent –** Print name of agent writing new coverage
5. **Telephone Number –** Agent's business telephone number
6. **Agent's Address –** Agency business address, with Name of Agency or Company affiliation, if any.
7. **Source used to complete information –** If any information on existing coverage was received from one or more replaced company(ies), mark "X" in "the following company(ies)" box and list the names of the company(ies) which provided the information. If any approximations were used because requested information was not provided by one or more replaced company(ies), mark "X" in the "approximations" box and list the names of the replaced company(ies) which did not provide the information.

## 1. Description of Transaction

8. **As of** - As of date of value of each existing policy.
9. **Company Name –** Name of Insurance companies for existing and proposed policies.
10. **Customer Service Phone Number –** Customer Service telephone numbers for existing and replacing insurance companies
11. **Contract Number –** Policy/contract/certificate number of existing policy(ies) (blank for proposed policy).
12. **Issue Date –** Issue date of existing policy(ies)
13. **Type of Insurance –** Type of insurance (i.e. Term, Whole Life, Universal Life).
14. **Base Policy Face Amount –** Face amount of base policy, excluding riders
15. **Riders –** Indicate type of rider and benefit amount (If applicable) for all riders attached to base policy.
16. **Total Annualized Premium –** Include the premium for the base policy and all riders. Premium should be annualized if applicant is paying a premium mode other than annual.
17. **Current Surrender Charge –** Specify current surrender charge of existing policy(ies) (if applicable)
18. **Guaranteed Interest Rate –** Specify contract guaranteed minimum interest rate (if applicable) for existing and proposed policy(ies).
19. **Current Loan Interest Rate –** Indicate loan interest **percentage rate (if applicable) for existing and proposed policy(ies).**
20. **Current Loan Balance –** Indicate current outstanding loan balance of existing policy(ies) and proposed policy (if applicable).
21. **Contestable Expiry Date –** Indicate if contestable period has expired or contestable expiry date (month, day and year) for current policy(ies) and duration of contestable period for proposed policy.
22. **Suicide Expiry Date –** Indicate if suicide period has expired or suicide expiry date (month, day and year) for current policy(ies) and duration of suicide period for proposed policy.
23. **Lapse or Surrender –** Check if existing policy(ies) is to be lapsed or surrendered.
24. **Amendment or Reissue –** Check if existing policy(ies) is to be amended or reissued.
25. **Loan or Withdrawal –** Check if existing policy(ies) cash value will be borrowed or withdrawn.
26. **Death Benefit Reduction To –** Indicate reduced face amount of existing policy(ies).
27. **Reduced Paid Up For –** Indicate new face amount if policy(ies) is being placed on reduced paid-up non-forfeiture option.
28. **Extended Term To –** Specify expiry date (month, day and year) or duration of Extended Term Period (whichever available) if policy(ies) is being placed on Extended Term Insurance (ETI) nonforfeiture option.
29. **Cash Release at Time of Change (at_____) –** Enter dollar amount of funds released by exercising one of the above changes.
30. **Use of Cash Released –** How will cash released be used (e.g. 1035 Exchange, pay premiums on proposed policy).

## 2. Summary Result Comparison Section

**Proposed With Existing Coverage Changed [Values reflecting planned changes for existing policy(ies)].**

31A, B & C **Annualized Premium –** Indicate total annualized premium on a guaranteed and non-guaranteed basis for current year, five years hence and ten years hence for proposed policy(ies). Premiums should be annualized if applicant is paying a premium mode other than annual.

32A, B & C **Surrender Value –** Indicate the surrender value (net of loan) on a guaranteed and non-guaranteed basis at the end of the first year, five years hence and ten years hence for proposed policy(ies).

33A, B & C **Death Benefit –** Enter death benefit on a guaranteed and non-guaranteed basis at the end of first year, five years hence and ten years hence for proposed policy(ies).

34A, B & C **Dividends –** Enter illustrated dividends, if applicable, at the end of the first year, five years hence and ten years hence for proposed policy(ies). (To be completed if dividends are not included above in Surrender Value and Death Benefit.)

## 3. Existing Coverage Unchanged

31A, B & C Annualized Premium – Indicate existing policy(ies) total combined annualized premium based on existing coverage unchanged on a guaranteed and non-guaranteed basis, current year, five years hence and ten years hence. Premiums should be annualized if applicant is paying a premium mode other than annual.

36A, B & C Surrender Value – Enter existing policy(ies) total combined surrender value on a guaranteed and non- guaranteed basis, at the end of first year, five years hence and ten years hence based on existing coverage unchanged.

37A, B & C Death Benefit – Enter existing policy(ies) total combined death benefit on a guaranteed and non-guaranteed (including paid-up additions) basis, at the end of first year, five years hence and ten years hence based on coverage unchanged.

38A, B & C Dividends – Enter illustrated dividends, if applicable, at the end of the first year, five years hence and ten years hence based on existing coverage unchanged. [To be completed if dividends are not included above in Surrender Value and Death Benefit.]

## 4. Agent Statement Section

39. **Disclosure Question 1 –** Enter the reason(s) for recommending the new life policy (i.e. lower premium).
40. **Disclosure Question 2 –** Enter the reason why the existing insurance policy(ies) or annuity contract(s) cannot meet the applicant's objectives (e.g., too expensive, not enough coverage).
41. **Disclosure Question 3 –** List the advantages of continuing the existing insurance policy or annuity contract (e.g., contestability and suicide clauses have expired).
42. **Remarks –** Enter any pertinent comments bearing on the transaction.
43. **Proposal Used –** Check the appropriate box indicating if a proposal and/or sales material was used to make the sale.
44. **Agent Certification –** Agent signs and dates.

**Transamerica Financial Life Insurance Company**
**Home Office: 440 Mamaroneck Avenue, Harrison, NY 10528**
**Administrative Office: 4333 Edgewood Rd NE, Cedar Rapids, IA 52499-0001**

**TFLIC Reg. 60 Guide - 0915**

TRANSAMERICA®
FINANCIAL LIFE INSURANCE COMPANY

Transamerica Financial Life Insurance Company
Home Office: 440 Mamaroneck Avenue, Harrison, NY 10528
Administrative Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499

**Disclosure Authorization**

# Department of Financial Services of the State of New York

*Disclosure Authorization*

AUTHORIZATION: By signing below, I authorize and request Transamerica Financial Life Insurance Company, of Harrison, New York to obtain account information from my current insurer related to my existing life insurance policy or annuity contract. I further authorize the insurer(s) named below to release all requested information necessary to complete the Disclosure Statement required under New York Regulation 60.

| Name of Replaced Insurer | Insured | Policy Number | Insured's Social Security Number (Optional) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

TRANSAMERICA®
FINANCIAL LIFE INSURANCE COMPANY

Transamerica Financial Life Insurance Company
Home Office: 440 Mamaroneck Avenue, Harrison, NY 10528
Administrative Office: 4333 Edgewood Road NE
Cedar Rapids, IA 52499



# Department of Financial Services of the State of New York

*Definition of Replacement*

In order to determine whether you are replacing or otherwise changing the status of existing life insurance policies or annuity contracts, and in order to receive the valuable information necessary to make a careful comparison if you are contemplating replacement, the agent or broker is required to ask you the following questions and explain any items that you do not understand.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

1. Lapsed, surrendered, partially surrendered, forfeited, assigned to the insurer replacing the life insurance policy or annuity contract, or otherwise terminated? ..... ☐ Yes ☐ No
2. Changed or modified into paid-up insurance; continued as extended term insurance or under another form of nonforfeiture benefit, or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other cash values? ..... ☐ Yes ☐ No
3. Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? ..... ☐ Yes ☐ No
4. Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies? ..... ☐ Yes ☐ No
5. Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies? ..... ☐ Yes ☐ No
6. Continued with a stoppage of premium payments or reduction in the amount of premium paid? ..... ☐ Yes ☐ No

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION NO. 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

To the best of my knowledge, a replacement is involved in this transaction: ❑ Yes ❑ No

_____ _____

Date Signature of Agent or Broker