TRANSAMERICA® LIFE INSURANCE COMPANY

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

GA #_____

Individual Life Insurance Application For One Life Part 1

Proposed Insured: John (First) D. (Middle) Smith (Last) Mr. (Suffix) Mr./Mrs./Ms./Dr.

Birthdate: 05 (Mo.) / 05 (Day) / 1955 (Yr.) Age 59 Birth Place: Dallas, TX Male ☒ Female ☐

Soc. Sec. No.: 987-65-4321 U.S. Citizen ☒ Yes ☐ No If no, complete Residency & Travel Questionnaire

Employer: Accounting Firm, Inc. (800) 555-5555 (Area Code & Work Phone)

Occupation: Accounting

Annual Income $ 70,000 Net Worth $ 200,000

Residence: 123 Easy St. (No. & Street (Cannot be a P.O. Box)), Dallas (City), TX (State), 75001 (Zip), USA (Country), (555) 555-5555 (Area Code & Home Phone)

Owner's Name: _____ Birthdate: _____
(If other than Proposed Insured) Mo. Day Yr.

If Trust, provide name and date of Trust: _____

Relationship to Proposed Insured: _____

Address: _____ _____
No. & Street (Cannot be a P.O. Box) City State Zip Country Soc. Sec. or Tax No.

U.S. Citizen ☐ Yes ☐ No If no, VISA Type/Immigration Status: _____ E-mail: _____
(Not for Policy/Billing Notices)

Beneficiary's Name and Relationship to Proposed Insured: Mary Smith - wife

Address: Same
No. & Street (Cannot be a P.O. Box) City State Zip Country Date of Trust, if Applicable

1. Plan Applied For: Trendsetter LB - 20 Kind Code: 6710 TB 51 C T X
2. Risk Classification: Preferred Plus/Select ☐ Preferred ☒ Standard Plus ☐ Standard ☐
   Extra Rating of ☐ _____ Other ☐ _____ (↑ found on illustration)
3. Nicotine Classification: Nicotine ☐ Non-Nicotine ☒
4. Amount Applied For $ 250,000
5. Additional Benefits by Rider: ☐ Waiver of Premium/Waiver Provision ☐ Accident Indemnity $_____ ☐ Other _____ $_____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☒ Monthly ☐ Other _____
   ☒ PAC ☐ Direct Bill
7. Complete for Flexible Premium Plans:
   Required Premium Per Year (RAP) $_____
   Planned Periodic Premium $_____
   + Initial Lump Sum $_____
   = Total Initial Premium $_____
8. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ☐ Yes ☐ No (APL will be in effect unless no is checked.)
9. Do you have any existing life insurance or annuities? If none, check this box ☒. If yes, please list the policies below.
   a. Do you intend to discontinue, replace or change insurance with any company if the life insurance applied for is issued? Please indicate yes or no in the chart.

Type of Coverage (Personal / Business / Employer Provided / Group)	Company/Policy Number	Face Amount	Replacement?
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No
		$	☐ Yes ☐ No

   b. Total Accidental Death insurance inforce with all companies: $ _____

10. Is any application for life insurance pending with any other company? ☐ Yes ☒ No
If yes, give company name, amount applied for and total amount to be placed. _____

11. Are there any life insurance policies on the life of the Proposed Insured that you do not own, including but not limited to any that you have sold or settled? ☐Yes ☒ No If yes, give insurance company name, owner's name, and amount of insurance of each policy.

_____

12. Mail Additional Premium Notices To: _____

Address: _____
No. & Street City State Zip Country

Yes	No	**"You" means any person proposed to be insured.**
☐	☒	13. Have you ever participated in, or within the next two years do you intend to participate in, hang-gliding, sky diving, parachuting, ultralight flying, vehicle racing, scuba diving, mountain or rock climbing, rodeos, competitive skiing or snowboarding, extreme sports or other hazardous activities? If yes, complete Sports and Hazardous Activities Questionnaire.
☐	☒	14. Do you plan to travel in the next 12 months for business or pleasure to a destination outside the U.S., Canada, Western Europe, Hong Kong, Australia or New Zealand? If yes, complete Residency & Travel Questionnaire.
		15. Have you used nicotine at any time? Date Last Used
☐	☒	Cigarettes _____
☐	☒	Cigar/Pipe/Chewing Tobacco _____
☐	☒	Other _____
		16. Driver's License #: TX 91725o 312 State: TX
		In the past five years, have you been convicted of or pleaded guilty to:
☐	☒	a. Moving violations? If yes, give dates and type. _____
☐	☒	b. Driving under the influence of alcohol and/or other drugs? If yes, give dates. _____
☐	☒	c. Reckless driving? If yes, give dates. _____
☐	☒	17. Except as a passenger on a regularly scheduled flight, has the Proposed Insured flown within the past 2 years, or does the Proposed Insured have plans to fly in the future other than as a passenger? If yes, complete Aviation Questionnaire.
☐	☒	18. Have you ever been convicted of a felony, misdemeanor or infraction other than a traffic violation? If yes, provide full details including state and date of offense.
☐	☒	19. Are you a member of the armed forces including reserves? Intend to become a member? Any deployment orders outside U.S.? If yes, give full details.
☐	☒	20. Is the Proposed Insured currently in bankruptcy or has the Proposed Insured been the subject of any voluntary or involuntary bankruptcy proceeding pending within the last 12 months? If yes, please provide full details including Chapter 7, 11, or 13, date filed, and date of discharge and dismissal, if any.

Remarks: Give details for any questions answered yes

_____

_____

_____

_____

_____

_____

I, the Proposed Insured, and I, the Owner if different, hereby represent that the statements and answers given in this application are true, complete and correctly recorded. **I/we agree:** (1) this application shall consist of Part 1, Part 2, and any required application supplement(s)/amendment(s), and shall be the basis for any contract issued on this application; (2) except as otherwise provided in the conditional receipt, if issued, with the same Proposed Insured as on this application, any contract issued on this application shall not take effect until after all of the following conditions have been met: (a) the full first premium is paid, (b) the Owner has personally received the contract during the lifetime of and while the Proposed Insured is in good health, and (c) all of the statements and answers given in this application must be true and complete as of the date of Owner's personal receipt of the contract and that the contract will not take effect if the facts have changed; (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company (the Company) unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

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

NOTICE TO CONSUMER

The death benefit on many business related life insurance policies will be taxable to you under Section 101(j) of the Internal Revenue Code to the extent it exceeds the premiums and other considerations paid by you for the policy unless the written Notice and Consent is obtained **prior to policy issue** and certain other requirements of such section are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners.

You are advised to consult with your qualified tax advisor prior to purchasing this policy.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

I, the Proposed Insured, hereby authorize any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, the MIB Group, Inc. and its members or affiliates, consumer reporting agency, or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition (for example: coronary disease; cancer; Human Immunodeficiency Virus (HIV) related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me or my minor children and any other non-medical information of me or my minor children to give to the Company or its legal representative, any and all such information.

I understand the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing contract. Any information obtained will not be released by the Company to any person or organization **except** to reinsuring companies, the MIB Group, Inc. and its members or affiliates, or other persons or organizations performing business or legal services in connection with my application, claim or as may be otherwise lawfully required or as I may authorize.

I know that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be as valid as the original. I agree this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether I am living or not.

I acknowledge receipt of the Notice of Disclosure of Information. **I understand** that if an investigative consumer report is ordered in connection with this application, I may elect to be interviewed in connection with the preparation of the report and, upon request, I will be provided with a copy of the report. I elect to be interviewed if an investigative consumer report is prepared. ☒ Yes ☐ No

PLEASE MAKE CHECKS PAYABLE TO THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.

Amount paid with this Application $ 122.40 ☐ Check # _____ ☐ Credit Card (Complete Credit Card Order Confirmation Form)

Signed at Dallas, TX on 05/14, 2014
City-State Date

X John D Smith
Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor)

X
Witness to Signature of Proposed Insured

Signed at _____ on _____
City-State Date

X _____
Signature of Owner (if other than Proposed Insured)

X _____
Witness to Signature of Owner

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

_____

_____

_____

X
Signature of Licensed Producer

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: 5/14/14

AGENCY NAME: _____ OFFICE ID#: _____

CASE MANAGER: _____ E-MAIL: _____

PRODUCER 1: Smith (LAST) | Brad (FIRST) SHARE %: 100

OFFICE ID #: _____ (UP TO 6 DIGITS) PRODUCER ID #: 97101111 (UP TO 10 DIGITS) PRODUCER PROFILE #: _____ (UP TO 3 DIGITS)

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

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

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

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

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

What is the purpose for insurance? Mortgage Protection

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

How long have you known the Proposed Insured? Never

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

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

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

X _____
Signature of Producer

PRE-AUTHORIZED CHECK/WITHDRAWAL PLAN ("PAC")

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 Part 1 of the application have been met.

POLICY NO.	INSURED	AMOUNT

- [X] MONTHLY (This will be elected if no box is checked)
- [ ] QUARTERLY
- [ ] SEMI-ANNUAL
- [ ] ANNUAL

PICK A DATE TO DRAFT (1-28) _____

- [X] PREMIUM
- [ ] LOAN REPAY
- [ ] SAVINGS
- [X] CHECKING

- [X] NEW AUTHORIZATION
- [ ] BANK CHANGE
- [ ] ADD TO EXISTING POLICY
- [ ] OTHER _____

NAME OF FINANCIAL INSTITUTION: Chase Bank
PHONE #: (972) 555-4444
ADDRESS: 321 Bank St.
CITY, STATE, ZIP: Dallas, TX 75001
ACCOUNT NUMBER: 0042003512
NAME(S) ON BANK ACCOUNT: John D. Smith
ROUTING#: 081900451

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

I request and authorize Transamerica Life Insurance Company (the Company) to make withdrawals, by draft or electronic transfer, from my account with the Financial Institution named above for premiums in the amounts specified above, or as specified by the policy (including any amendments, endorsements or riders), or as agreed to by me, and for such other payments as I may authorize the Company to make. I request that the withdrawal be on or before the days when payment(s) fall due, except that if a withdrawal is to pay for premiums on more than one policy, it is to be drawn on the earliest due date. I request that this authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I understand that this authorization in no way affects the terms of the policy, other than the mode of payment, and I understand that if the premiums are not paid within the grace period allowed by a policy, as in the event any such withdrawal being dishonored, or for any reason, then the policy shall terminate subject to any nonforfeiture provisions in the policy.

AUTHORIZATION TO HONOR PAC WITHDRAWALS

As a convenience to me, I hereby request the financial institution named above to accept and honor the draft or transfer withdrawals from my account. I agree that your rights in respect to each draft or transfer shall be the same as if it were a check drawn on you and signed personally by me and that you shall be fully protected in honoring such draft or transfer. I further agree that if any such withdrawal is dishonored, whether with or without cause and whether intentionally or inadvertently, the Financial Institution shall be under no liability whatsoever if such dishonor results in the forfeiture of insurance.

These authorizations shall remain in effect until revoked in writing, mailed to the other parties at the address of record. The Company and/or Financial Institution shall have a reasonable time to act on the revocation notice. I have retained a copy of these authorizations.

(X) John D Smith — 5/14/14

BANK SIGNATURE(S) OF DEPOSITOR(S) — DATE — SIGNATURE OF POLICYOWNER IF NOT DEPOSITOR

John D. Smith Check

VOID

PAC10609T

1 8 4 *

TG-NF

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from John D. Smith, the sum of $ $128.40 for the life insurance application dated 5/14/14, with John D. Smith as the Proposed Insured.

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

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

CONDITIONAL COVERAGE: Conditional insurance, under the terms of the contract applied for, may become effective as of the date of completing Part 1 of the application, the date of completing Part 2 of the application, or the date requested in the application, whichever is latest (the Effective Date), but only after all the conditions to conditional coverage have been met.

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

1. The payment made with the application must be received at our Administrative Office within the lifetime of the Proposed Insured and honored on first presentation for payment;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires required by the Company are completed and received at our Administrative Office;
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete; and
4. The Company is satisfied that, at the time of completing Part 1 and Part 2 of the application, each person to be covered was insurable at any rating under the Company's rules for insurance on the plan applied for and in the amount and at the Nicotine Classification applied for.

60-DAY LIMIT OF CONDITIONAL COVERAGE: If the Company does not approve and accept the application for insurance within 60 days of the date you signed the Part 1, the application will be deemed to be rejected by the Company, and there will be no conditional insurance coverage. In that case, the Company's liability will be limited to returning any payment you have made. The Company has the right to terminate conditional coverage at any time prior to 60 days by mailing a refund of the payment made.

DOLLAR LIMITS OF CONDITIONAL COVERAGE: The aggregate amount of conditional coverage provided under this Receipt, if any, and any other Conditional Receipt issued by the Company on each person to be covered shall be limited to the lesser of the amount(s) applied for or $1,000,000 of life insurance if the Proposed Insured is age 16 - 65 and is insurable at the standard or better class of risk, $400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable at the standard or better class of risk, or $100,000 for a class of risk with extra ratings regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied.

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

Except as provided in this Conditional Receipt, no coverage under the contract you are applying for will become effective unless and until after a contract is delivered to you and all other conditions of coverage set forth in Part 1 of the application have been met.

ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

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

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

X John D. Smith
Signature of Proposed Owner

5/14, 20 14
Date

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

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

You should retain a copy of this Receipt and Acknowledgment. If you do not hear from the Company regarding the proposed insurance within 60 days, notify the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52499, Attention: Underwriting Dept., giving your full name, date of birth, the name of the insurance producer, date and amount of this Conditional Receipt.

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

TRANSAMERICA
LIFE INSURANCE COMPANY

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

GA # _____

Application Part 2
Non-Medical Health History

File # _____

1. **Proposed Insured:** *(Print Full Name)*	2. **Date of Birth:**	3. **Social Security #**
John D. Smith	Month 05 Day 05 Year 1955	987-65-4839

4. **Name/Address/Phone of primary care physician:**

Name: Dr. David Scott Address: 1000 Medical Ln.

Phone: (972) 555-5555 City/St/Zip: Dallas, TX 75001

Date and reason for last visit: 01/14 - Broken Ankle

5. **Height:** 6'0" **Weight:** 200

Give complete details of all yes answers to questions 6 - 9, including but not limited to all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals, attending physicians, health care providers and clinics. If additional space is required, attach sheet(s) of paper - **signed, dated and witnessed.**

6. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**	Yes	No
a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, multiple sclerosis, epilepsy, or any disease or abnormality of the brain?	☐	☒
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood?	☐	☒
c. Asthma, chronic bronchitis, pneumonia, emphysema, tuberculosis or any disease or abnormality of the lungs, bronchial tubes or respiratory system?	☐	☒
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver?	☐	☒
e. Sugar, protein or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts, ovaries or reproductive system?	☐	☒
f. Diabetes or any disease or abnormality of the thyroid, adrenal, pituitary or other glands?	☐	☒
g. Arthritis, gout, connective tissue disease, back trouble or any disease or abnormality of the joints, muscles or bones?	☐	☒
h. Any disease or abnormality of the eyes, ears, nose, throat or skin?	☐	☒
i. Cancer, tumor, polyp or cyst?	☐	☒
j. Any physical deformity or amputation?	☐	☒
k. Anxiety, depression, suicide attempt or any psychiatric, mental or emotional condition or disorder?	☐	☒
l. Any immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV), or tested positive on an AIDS/HIV-related test?	☐	☒

7.	Yes	No
a. Within the past ten years, have you ever used sedatives, amphetamines, barbiturates, morphine, cocaine/crack, methamphetamine, Ecstacy (MDMA), heroin, marijuana, LSD, PCP, any hallucinogenic drug or narcotic drug except as prescribed by a physician?	☐	☒
b. Have you ever been treated or counseled or been advised to seek treatment or counseling for the use of alcohol, drugs or other substance or joined an organization for alcohol or drug dependence or abuse?	☐	☒

8. **OTHER THAN WHAT YOU HAVE ALREADY DISCLOSED, WITHIN THE PAST FIVE YEARS HAVE YOU:**	Yes	No
a. Consulted, been examined or been treated by any physician or practitioner?	☒	☐
b. Had or been advised to have an X-ray, electrocardiogram, laboratory test or other diagnostic study?	☒	☐
c. Had observation or treatment at a clinic, hospital or other medical facility?	☐	☒
d. Had or been advised to have a surgical procedure?	☐	☒
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever?	☐	☒
f. Had any injury requiring treatment?	☒	☐

Details:

8 A. Routine physical 6/2013

B. Broken ankle - 01/2014

F. Broken ankle

* D T 0 3 8 *

9.	Yes	No
a. Have any of your parents, brothers, sisters, or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide?	☒	☐
b. Has your weight changed by more than 15 pounds in the past year?	☐	☒
c. Has any application for life, health, disability or long term care insurance been declined, withdrawn, postponed, rated, modified, issued with exclusion rider, cancelled or non-renewed?	☐	☒
d. Are you now pregnant?	☐	☒

Father - cancer

10. **OTHER THAN THOSE ALREADY DISCLOSED, ARE YOU CURRENTLY TAKING ANY PRESCRIPTION, VITAMIN, SUPPLEMENT OR OVER-THE-COUNTER MEDICATION?** ☒ Yes ☐ No *If yes, list all and indicate why.*

Simvastatin - High Cholesterol

11. **FAMILY RECORD:** Show age and present health, or if deceased, show age at death and cause of death.

	Age if Living	Present Health	Age at Death	Cause of Death
Father			76	cancer
Mother	81	Good		
Brothers # 1	56	Great		
Sisters # 2	61, 64	Great		

12. **WITHIN THE PAST FIVE YEARS HAVE YOU USED NICOTINE IN ANY FORM?** ☐ Yes ☒ No *If yes, indicate type, frequency and date last used.* _____

13. **FOR THE LAST 180 DAYS, HAVE YOU BEEN ACTIVELY AT WORK ON A FULL TIME BASIS AT YOUR USUAL PLACE OF BUSINESS OR EMPLOYMENT?** ☒ Yes ☐ No *If no, provide complete details.*

14. Do you participate in regular weekly exercise?	☒ Yes	☐ No
15. Do you participate in athletics *(Team or Individual)*?	☐ Yes	☒ No
16. Have you ever used any tobacco products?	☐ Yes	☒ No
17. Do you get regular examinations by your health care provider?	☒ Yes	☐ No
18. Do you get regular annual dental checkups?	☒ Yes	☐ No
19. Do you clean your house or do yard work?	☒ Yes	☐ No
20. Do you have a pet?	☒ Yes	☐ No
21. Are you a member of a social group or volunteer for charity work?	☒ Yes	☐ No

It is represented that the statements and answers given above are true, complete, and correctly recorded. To the extent allowed by law, I waive my rights to prevent disclosure of any knowledge or information about the above questions. This waiver applies to any health care provider, physician, hospital, official or employee, or other person who has attended or examined me, or who has been consulted by me. I authorize such person(s) to make such disclosures. Such person(s) may also testify to their knowledge. This authorization is made on behalf of myself and any person who shall have or claim any interest in any contract of insurance issued on this application.

Signed at (City/State) Dallas, TX on 5/14, 2014

AGENT'S STATEMENT: I certify that I have truly and accurately recorded on this form the information supplied by the Proposed Insured.

(X) John D. Smith
Signature of Proposed Insured

X _____
Signature of Witness/Agent/Registered Representative

John D. Smith
Print name of Proposed Insured

Monumental Life Insurance Company
Stonebridge Life Insurance Company
Transamerica Life Insurance Company
Western Reserve Life Assurance Co. of Ohio
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
John D. Smith	5/5/1955	4321
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

(X) John D. Smith — 5/14/14

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.

HIP1008

Please return this original copy to Company

NF
Rev 0909

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Disclosure Statement Accelerated Death Benefit Option

Insured: John D. Smith

Policy/Application No.: _____

THIS DISCLOSURE STATEMENT CONTAINS A BRIEF DESCRIPTION OF SOME OF THE IMPORTANT FEATURES OF THE ACCELERATED DEATH BENEFIT OPTION. READ YOUR ENTIRE ENDORSEMENT CAREFULLY FOR DETAILS.

DESCRIPTION

Accelerated Death Benefit Option - An option for the Owner to choose to receive a portion of the death benefit while the Insured is still alive, subject to satisfactory evidence that the Insured has 12 months or less to live because of a Terminal Illness. Terminal Illness is a medical condition, resulting from bodily injury (excluding self-inflicted injury) or disease, or both, and:

- which has been diagnosed by a Physician after the policy issue date shown on page 2 of the policy data; and,
- for which the diagnosis is supported by clinical, radiological, laboratory, or other evidence of the medical condition which is satisfactory to us; and,
- which is not curable by any means available to the medical profession; and,
- which a Physician certifies is expected to result in death within 12 months of diagnosis and the certification is within 30 days of the Accelerated Death Benefit request.

The amount available is up to 75% of the current death benefit, up to a maximum of $250,000 per life, with a minimum payment of $10,000. An administrative fee of $250.00 will be assessed. If the maximum Accelerated Death Benefit is not taken in the initial request, a subsequent request may be submitted, subject to the provisions of the option, and another fee will be assessed when any additional Accelerated Death Benefit is paid.

The policy values and policy death benefit will be adjusted to reflect the payment of an Accelerated Death Benefit. They will be reduced by the same proportionate ratio as the amount of the Accelerated Death Benefit paid to the amount of insurance before the Accelerated Death Benefit was paid.

If you receive payment of accelerated benefits from a life insurance policy, you may lose your right to receive certain public funds, such as Medicare, Medicaid, Social Security Income (SSI), and possibly others. Also, receiving accelerated benefits from a life insurance policy may have tax consequences for you. We cannot give you advice about this. You may wish to obtain advice from a tax professional or an attorney before you decide to receive accelerated benefits from a life insurance policy.

Accelerated Death Benefit funds are paid to the Owner. There is no restriction on how the funds are used.

GENERAL REQUIREMENTS

1. The policy must be in force on the date the Accelerated Death Benefit is approved; and,

2. We must receive a written request to exercise this option at the Home Office or our designated Administrative Office within 30 days after the certification of diagnosis of the Terminal Illness, or as soon as reasonably possible. The request should include the name of the Insured, the policy number and, must be signed and dated by the Owner. If the policy has an irrevocable beneficiary, that person(s) must also sign the request. If the policy is assigned, we must receive a completed and signed release of assignment. If the policy was issued in a community property state, we may require your spouse to sign the request; and,

3. We must receive written proof of the Insured's Terminal Illness before we make an Accelerated Death Benefit payment. This proof will consist of a Physician's certification acceptable to us. We may request additional medical information from the Physician submitting the certification or any Physician we consider qualified.

AGREEMENT

I, the Owner:

1. UNDERSTAND AND AGREE THAT THIS OPTION IS LIMITED TO TERMINAL ILLNESS AS DESCRIBED BY THIS DISCLOSURE STATEMENT.

2. UNDERSTAND AND AGREE THAT NO AGENT, BROKER AND/OR OTHER SALES REPRESENTATIVE HAS THE AUTHORITY TO MAKE ANY CHANGE WHATSOEVER TO ANY PART OF THIS OPTION OR DISCLOSURE STATEMENT.

3. UNDERSTAND AND AGREE THAT THIS OPTION WILL NOT PROVIDE ANY BENEFIT FOR ANY TERMINAL ILLNESS WHICH EXISTED BEFORE THE ISSUE DATE.

Signed at Dallas, TX on 5/14, 20 14

Soliciting Agent's Signature(s)

(X) John D. Smith
Insured's Signature

Owner's Signature

GA Code

If Owner is a corporation, the signature and title of an authorized officer other than the Insured is required and the full name of the corporation must be shown.

TRANSAMERICA
LIFE INSURANCE COMPANY

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

Terminal Illness Accelerated Death Benefit Disclosure

You may request an accelerated death benefit when the Insured has been diagnosed with a Terminal Illness. A Terminal Illness is a medical condition, resulting from injury or disease which, as diagnosed by a Physician, has reduced life expectancy to not more than 12 months from the date of the Physician's certification. We must receive written proof of the Insured's Terminal Illness before we make an accelerated death benefit payment. We reserve the right to seek a second medical opinion or have the Insured examined at our expense by a Physician we choose.

We will pay an accelerated death benefit upon due proof that the Insured has a Terminal Illness, subject to the following conditions:

1. The Terminal Illness is first diagnosed on or after the later of the Date of Issue or Policy Date; and
2. The policy and endorsement are in force at the time of the accelerated death benefit request; and
3. The Face Amount of the policy at the time the accelerated death benefit request is received is at least $25,000; and
4. At the time you request to exercise the accelerated death benefit, there must be at least two (2) years remaining before the Expiry Date of the policy;
5. We receive written proof of the Insured's Terminal Illness satisfactory to us, including a Physician's certification; and
6. We receive a consent form signed by all irrevocable beneficiaries and all assignees in a form acceptable to us.

An administrative fee will be deducted from the present value of each accelerated death benefit amount requested. As of the Endorsement Date, the administrative charge is $350. The administrative charge will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index (CPI) since 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used.

The maximum death benefit you may accelerate is equal to the lesser of:

1. 100% of the Face Amount of the policy; or
2. $500,000, including all other accelerated death benefit amounts previously elected or currently under review under all policies, endorsements or riders issued by us on the life of the Insured.

The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the accelerated death benefit is paid will also be reduced. The reduced premium will equal the appropriate premium rate applied to the reduced Face Amount plus any applicable policy fee. We will provide you with information showing the reduced Face Amount resulting from the accelerated death benefit payment.

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

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

5/14/14
Date

⊗ John D. Smith
Owner's (Applicant's) Signature

Agent's Signature

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

TRANSAMERICA
LIFE INSURANCE COMPANY

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Terminal Illness, Chronic Illness and Critical Illness Accelerated Death Benefit Options Disclosure

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

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

Chronically Ill means the Insured:

(a) Is unable to perform without substantial assistance from another person for a period of at least 90 days, at least two out of six Activities of Daily Living (Bathing, Continence, Dressing, Eating, Toileting and Transferring); or

(b) Requires substantial supervision by another person, for a period of at least 90 consecutive days, to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

Critically Ill means the Insured has been diagnosed with one or more of the following health conditions:

(a) Heart Attack

(b) Stroke

(c) Cancer

(d) End Stage Renal Failure

(e) Major Organ Transplant

(f) Amyotrophic Lateral Sclerosis (ALS)

(g) Blindness

(h) Paralysis

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

1. You must provide us with the required certification applicable to the requested form of Accelerated Death Benefit.
2. This policy must be In Force at the time of your Accelerated Death Benefit request; and
3. The Face Amount of this policy at the time the Accelerated Death Benefit request is received must be at least $25,000; and
4. You must have completed any applicable waiting period (30 calendar days for Critical Illness due to sickness; and 2 policy years for Chronic Illness).
5. At the time you request to exercise the Accelerated Death Benefit option, there must be at least two (2) years remaining before the Expiry Date of the policy; and
6. We must receive the consent of all irrevocable beneficiaries (if any) and all assignees (if any) in a form acceptable to us.

If we approve your acceleration request, we will make the payment on the next Monthly Policy Date.

Amount of Benefit: The Accelerated Death Benefit payment we make to you will be less than the amount of the death benefit which you request to accelerate. For each form of Accelerated Death Benefit, the Accelerated Death Benefit payment for the amount of the death benefit which you request to accelerate will be calculated as A - B - C - D where A, B, C, and D are determined as follows:

A. The present value of the amount of the death benefit which you request to accelerate, which will be calculated using specific factors and an annual discount interest rate as described in your policy form.

B. Any due or unpaid premium if we make payment during the grace period.

C. The actuarial present value of future premiums, excluding rider premiums that would otherwise be payable to keep this policy In Force during the period of the Insured's remaining lifetime at time of the acceleration, using the applicable rated age, mortality table, and interest rate. For the Terminal Illness Accelerated Death Benefit, the future premiums are assumed to be zero.

D. An administrative charge for each Accelerated Death Benefit request. The administrative charge for each Accelerated Death Benefit request as of January 1, 2012 is $350, but will be subject to future increases based on cumulative annual cost-of-living increases as measured by the Consumer Price Index for All Urban Consumers (CPI) since January 1, 2012. Cumulative annual cost of living increases will not exceed 5% per calendar year. In the event that the CPI is no longer published, a substantially similar index will be used.

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

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

1. 90% of the Face Amount of this policy for Critical Illness and Chronic Illness; 100% of the Face Amount of this policy for Terminal Illness; or
2. $500,000, including all other Accelerated Death Benefits previously elected or currently under review under all policies, endorsements or riders issued by us or our affiliates on the life of the Insured.

The maximum death benefit you may accelerate in any 12 month period because the Insured is Chronically Ill is 24% of the Face Amount of the policy at the time the option is exercised.

Effect of Benefit on Policy: The policy's Face Amount will be reduced by the amount of the death benefit accelerated. If less than the full Face Amount is accelerated, the premium payable after the Accelerated Death Benefit is paid will also be reduced. The reduced premium will equal the appropriate premium rate applied to the reduced face amount plus any applicable policy fee. We will provide you with information showing the reduced face amount resulting from the accelerated death benefit payment.

Payment of Accelerated Benefits will reduce the death benefit otherwise payable under the policy. Receipt of Accelerated Benefits may be a taxable event. Please consult your personal tax advisor to determine the tax status of any benefits paid under these options.

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

5/14/14
Date

(X) John D Smith
Owner's (Applicant's) Signature

Agent's Signature

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

❑ Monumental Life Insurance Company

❑ Stonebridge Life Insurance Company

☒ Transamerica Life Insurance Company

❑ Western Reserve Life Assurance Co. of Ohio

Terminal Illness Accelerated Death Benefit Disclosure Form

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

This benefit cannot be exercised:

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

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

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

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

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

5/14/14
Date

K John D Smith
Owner's (Applicant's) Signature

Agent's Signature

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