Issue ages 45 - 85

EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with <u>every</u> application)

Agent Information		
Agent ID 97106500	Agent Name (Print) Brad Smith	Agent Phone (423) 943-8621
Agent Email brad.sfg@gmail.com		Agent Fax (615) 312-0784
Case Manager Name	Case Manager Phone ( )	
Case Manager Email Address		
Proposed Insured Information		
Insured's name (Print) John Smith		Last 4 digits of Insured's social security # 5555

Required Disclosures with Application:

☒ HIPAA Authorization Form

Other Disclosures (if applicable):

☒ Accelerated Death Benefit Disclosure Form ☒ Replacement Form(s)

Submitting Applications: ***(Faxing is the preferred method)***

If faxing, fax to **1-866-834-0437** and enter date faxed_____ . **Do Not** mail originals if faxing.

If mailing the application and/or check for initial premium please send with cover sheet to:

4333 Edgewood Road NE, Cedar Rapids, IA 52499

If a case manager is listed, please follow your General Agency's submission process with sending the signed application packet.

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

LIFE APPLICATION

Part A1 – Producer

Name	Producer ID	Split %	Profile
Brad Smith	97106500	100	
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

Part A2 – Plan & Rider Information

Plan	Face Amount	Total Premium
Immediate Solutions	$ 10,000	$ 50.00 /mo

Rate Class applied for:

☒ Preferred Non-Tobacco ❑ Preferred Tobacco
❑ Standard Non-Tobacco ❑ Standard Tobacco
❑ Graded

Accidental Death Benefit Rider? (If yes, Accidental Death Benefit Rider will equal base amount) ❑ Yes ☒ No

Child / Grandchild Rider? $_____ (Add Child / Grandchild information to the Supplemental Information to the Application for Life Insurance) ❑ Yes ❑ No

Part A3 – Proposed Insured

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)
John Smith	123 Main St, Johnson City, TN 37601

D.O.B. (MM/DD/YYYY)	U.S. State or Country of Birth	Are you a citizen of the United States? ☒ Yes ❑ No
03/05/1959	Indiana	If "NO," what Country? _____

Gender	SSN	Phone Number for Interview	Best time to call	If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No
M	555-55-5555	(423) 444-4444	9 a.m. 7 p.m.	If "YES," VISA type and number _____
				If "NO," you are not eligible for coverage.

Part A4 – Owner (If Other Than Proposed Insured)

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

Phone Number	D.O.B. (MM/DD/YYYY)	Gender	Are you a citizen of the United States? ❑ Yes ❑ No
( )			If "NO," what Country? _____

SSN	Relationship to Insured	If "NO," are you a legal U.S. Resident? ❑ Yes ❑ No
		If "YES," VISA type and number _____
		If "NO," you are not eligible for coverage.

Part A5 – Beneficiary (Please use the Supplemental Information form if additional room is needed)

Primary Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured
Mary Smith	02/07/1960	444-44-4444	100%	Spouse
Contingent Name (First, M.I., Last, Suffix)	D.O.B. (MM/DD/YYYY)	SSN	Percentage	Relationship to Insured
Joanne Smith	05/10/1981	888-88-8888	100%	Daughter

Part A6 – Existing Insurance

Does the proposed Insured have any existing life insurance or annuity contracts with the company or any other company? ❑ Yes ☒ No

Is this insurance intended to replace or change any life insurance or annuity contract in force with the company or any other company? ❑ Yes ☒ No

If yes, submit the state required forms and please provide company name and policy number. _____

Is this to be a 1035 exchange? ❑ Yes ☒ No

Last Name and Last 4 Digits of SSN: Smith - 5555

Part B1 – Initial Premium Payment Method

❑ By check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual.
Is the check for initial premium payment on the same account as monthly EFT payments? ❑ Yes ❑ No

❑ By payroll deduction or allotment.

☒ Draft initial premium upon receipt from the account below.

❑ Draft initial premium at future date from the account below. Please indicate the month and day (mm/dd): ____ / ____
Month **Day (1st thru 28th only)**

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

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

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

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

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

☒ Checking ❑ Savings Financial Institution Name: Bank of America City/State: Johnson City, TN

Account #: 1 2 3 4 5 6 7 8
No debit card numbers please

Routing #: 1 2 3 4 5 6 7 8 9

Recurring Draft Date (1st-28th): 5th If no recurring draft date is selected, the draft date will be the same day of the month as the Policy Date.

Payor Signature (if other than proposed Insured or Owner) John Smith Date: 11/28/2017

Part B3 – Recurring Payment Method

EFT

☒ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual

Payroll Deduction

Special Frequency ____

❑ List Bill ❑ Civil Service Allotment ❑ Military Allotment

Requested Effective Date ____

Automatic Premium Loan provision (if available)? ☒ Yes ❑ No

Part B4 – Payor Information

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

Name (First, M.I., Last, Suffix)	Address, City, State, Zip Code (cannot be a P.O. Box)	
SSN	Relationship to Insured: Self	Are you a citizen of the U.S.? ❑ Yes ❑ No If not, what country?

Part B5 – Secondary Addressee

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

Last Name and Last 4 Digits of SSN: Smith - 5555

Part C1

Within the last 12 months has the proposed Insured used tobacco products in any form?	❑ Yes ☑ No
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

Part C2 – If Any Question In This Section Is Answered "Yes", The Proposed Insured Is Not Eligible For Any Coverage.

1) Is the proposed Insured hospitalized, bedridden, residing in a nursing home, assisted or long term care facility, receiving hospice or home health care, or has the proposed Insured been advised or is the proposed Insured planning to have inpatient surgery?	❑ Yes ☑ No
2) Has the proposed Insured **ever**:	
a) Been diagnosed with, been treated for or advised to receive treatment for Alzheimer's, dementia, memory loss, organic brain disease, mental incapacity, Lou Gehrig's disease (ALS), Downs Syndrome, Huntington's disease, sickle cell anemia, cystic fibrosis, cerebral palsy or been diagnosed by a medical professional as having a terminal medical condition that is expected to result in death within the next 18 months?	❑ Yes ☒ No
b) Tested positive for the antibodies to the AIDS (HIV) virus or been medically diagnosed with or received treatment for HIV, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❑ Yes ☒ No
c) Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	❑ Yes ☒ No
d) Received or been advised to receive an organ transplant other than corneal?	❑ Yes ☒ No
3) Within the past **2 years** has the proposed Insured:	
a) Had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	❑ Yes ☒ No
b) Undergone testing by a medical professional for which the results have not been received or been advised to have any surgical operation, diagnostic testing other than for routine screening purposes, treatment, hospitalization or other procedure which has not been done?	❑ Yes ☒ No

Part C3

4) Has the proposed Insured been diagnosed with diabetes (other than gestational diabetes) before the age of 18?	❑ Yes ☒ No
5) Within the past **4 years** has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for cancer (other than basal cell carcinoma)?	❑ Yes ☒ No
6) Within the past **1 year** has the proposed Insured:	
a) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse, (including prescription drugs), or muscular dystrophy?	❑ Yes ☒ No
b) Had more than 12 seizures; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?	❑ Yes ☒ No
c) Had, been diagnosed with, been treated for or advised to receive treatment for aneurysm or angina; or had or been advised to have heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant?	❑ Yes ☒ No
d) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)?	❑ Yes ☒ No
e) Used oxygen to assist in breathing (including Sleep Apnea); received kidney dialysis; or had, been diagnosed with, been treated for or advised to receive treatment for kidney failure due to a disease or disorder?	❑ Yes ☒ No
7) Within the past 2 years has the proposed Insured used a wheelchair or electric scooter? If answering yes to this question and the reason(s) for the wheelchair or scooter use was/is for a reason that is expected to resolve, please provide details on the Supplemental Information to the Application for Life Insurance.	❑ Yes ☒ No

- If all questions in Part C3 are answered "No," proceed to Part C4.
- If one question in Part C3 is answered "Yes," the proposed Insured is potentially eligible for the Graded Death Benefit product, proceed to Part C5.
- If two or more questions in Part C3 are answered "Yes," the proposed Insured is not eligible for any coverage.

Part C4

8) Within the past **2 years** has the proposed Insured:	
a) Had, been diagnosed with, been treated for or advised to receive treatment for angina (chest pain); aneurysm; vascular, circulatory or blood disorder; heart surgery of any kind including bypass surgery, angioplasty, stent implant or pacemaker implant; or irregular heart rhythm such as atrial fibrillation?	❑ Yes ☒ No
b) Had a heart attack, stroke (CVA) or transient ischemic attack (TIA)?	❑ Yes ☒ No
c) Had more than 12 seizures; used insulin; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure, cirrhosis, hepatitis B or C or other liver disease?	❑ Yes ☒ No
d) Used illegal drugs or been diagnosed with, been treated for or been advised to receive treatment for alcoholism, alcohol use/abuse, drug use/abuse (including prescription drugs)?	❑ Yes ☒ No
9) Within the past **4 years** has the proposed Insured had, been diagnosed with, been treated for or advised to receive treatment for kidney disease?	❑ Yes ☒ No
10) Has the proposed Insured **ever** been diagnosed with, been treated for or advised to receive treatment for Parkinson's disease, multiple sclerosis, chronic obstructive pulmonary disease (COPD) including emphysema, chronic asthma, black lung or other chronic respiratory disease?	❑ Yes ☒ No

- If all questions in Part C4 are answered "No," the proposed Insured is potentially eligible for the Preferred product, proceed to Part C5.
- If one question in Part C4 is answered "Yes," the proposed Insured is potentially eligible for the Standard product, proceed to Part C5.
- If two or more questions in Part C4 are answered "Yes," the proposed Insured is potentially eligible for the Graded Death Benefit product.

Part C5 – Nursing Home Option - If The Following Question Is Answered "Yes", The Proposed Insured Is Not Eligible For The Nursing Home Option On The Accelerated Death Benefit Rider.

Does the proposed Insured need any assistance from other persons in performing any activities of daily living such as eating, bathing, toileting, dressing, taking medications, walking or moving in and out of bed or chair or does the proposed Insured have ongoing incontinence or, in the 2 years prior to the application, has a medical professional recommended that the proposed Insured be confined to a Nursing Home?	❑ Yes ☒ No

Last Name and Last 4 Digits of SSN: Smith - 5555

AGREEMENT / AUTHORIZATION

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

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

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

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

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

FRAUD WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or a denial of insurance benefits.

Signed Date 11/28/2017 Signed at City Johnson City State TN

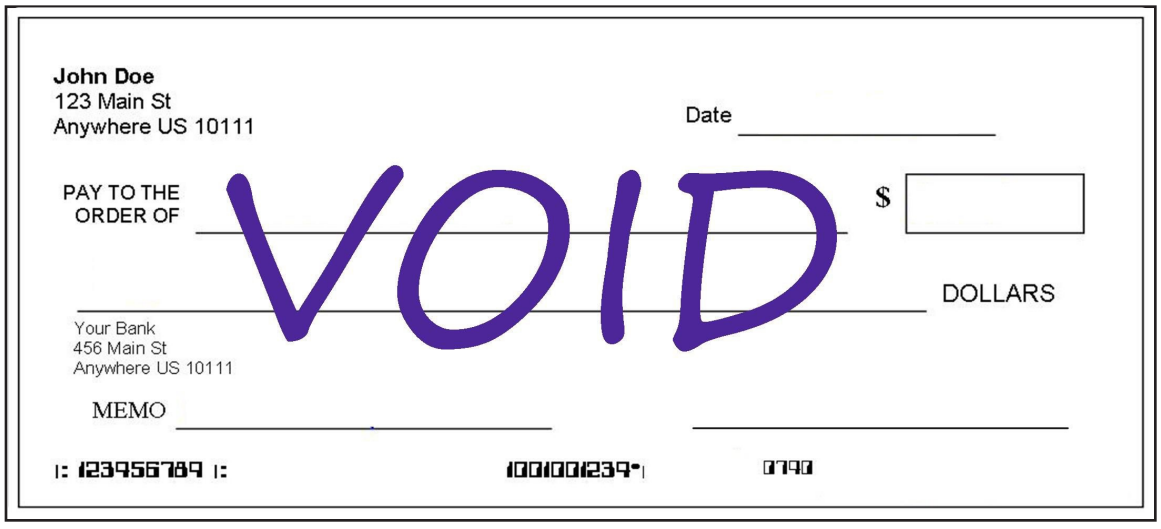
John Smith
Proposed Insured Signature

Owner Signature (If Owner other than Insured)

Brad Smith
Producer Signature

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

Brad Smith
Producer Signature



NOTICE TO PERSONS APPLYING FOR INSURANCE

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

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

TRANSAMERICA LIFE INSURANCE COMPANY
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

MIB DISCLOSURE NOTIFICATION

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

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

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

01/13

CONDITIONAL RECEIPT

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

Conditions of Coverage

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

Effective Date

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

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

Supplemental Information to the Application for Life Insurance

Proposed Primary Insured Name: John Smith Social Security Number: 555-55-5555

Additional Information

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

Additional Information

Child / Grandchild Rider Information

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

Contingent Owner

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

Signed Date 11/28/2017 Signed at City Johnson City State TN

John Smith

Proposed Insured Signature

Owner Signature (If Owner other than Insured)

Brad Smith

Producer Signature

Last Name and Last 4 Digits of SSN: Smith - 5555

Agent's Report

Existing insurance? ❑ Yes ☒ No

I represent that:

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

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

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

Producer Signature

TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: 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 Smith	03/05/1959	5555
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, 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 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
John Smith	11/28/2017
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

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

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

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

Policy or contract number (if known): _____

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

TRANSAMERICA®
LIFE INSURANCE COMPANY

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

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

1. Last Name	First Name	2. SS# Last 4 Digits
Smith	John	5555

OWNER - if other than Primary Insured

1. Last Name	First Name	2. TIN/SS# Last 4 Digits

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name	First Name	M.I.

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

State	Zip Code	3. Home Phone	4. Social Security Number
		( )	

PRIMARY BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#
123 Main St., Johnson City, TN 37601	02/07/1960	100	Spouse	Ph: 423-555-5555 SSN: 444-44-4444 SSN NOT REQUIRED

CONTINGENT BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#
570 Main St., Johnson City, TN 37601	05/10/1981	100	Daughter	Ph: 484-668-8888 SSN: 888-88-8888 SSN NOT REQUIRED

AGENT

☒ I attest that, on behalf of the Company, I requested all information above and the applicant provided the information completed on the form. The applicant was unable/declined to provide any information missing from the form.

Brad Smith
Producer or Agent Signature

11/28/2017
Date

John Smith
Owner Signature

DMF 2014