TRANSAMERICA LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("Insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

TransElite Universal Life Application

☐ First Application ☐ Add Dependents – Contract # _____ ☐ Increase Coverage – Contract # _____

Group Name | Group Number | Location

Applicant Information
required for all coverage

Name *(Last, First, M.I.)*	☐ Male ☐ Female	Social Security No.	Date of birth	Cell or home phone
Home address		City	State	Zip code
Email address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No		Tobacco user in the last year? ☐ No ☐ Yes *Answer if rates are tobacco distinct.*	
Date of hire	Weekly hours worked	Annual salary	Occupation	Applicant ID / Work phone/ext.

Protection against unintended lapse: I understand I have the right to designate at least one person other than myself to receive notice of lapse or termination of this coverage for nonpayment of premium. I understand notice will not be given until thirty days after premium is due and unpaid.
☐ I elect NOT to designate any person to receive such notice.

Secondary Addressee Name	Home Address	City	State	Zip code

Dependent Information
if applying for dependent coverage

Name *(Last, First, M.I.)*	Gender	Relationship to applicant	Date of birth	Social Security No.	Tobacco user in the last year? *Answer for Spouse or Domestic Partner*
	☐ M ☐ F				☐ No ☐ Yes
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				

Beneficiary

Name *(Last, First, M.I.)*	Address	Relationship	Phone #	Social Security No.
Primary				
Contingent				

Applicant will be the beneficiary for any dependent coverage

Benefit Selections

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Universal Life

☐ TransElite Universal Life Option: ☐ A (level) ☐ B (increasing)	Universal Life Face Amount	Automatic Increase Option Rider	Premium
☐ Applicant	$	☐ Yes ☐ No	$
☐ Spouse or Domestic Partner	$	☐ Yes ☐ No	$
☐ Children	$		$
*Attach Child Term Rider to ☐ Applicant ☐ Spouse or Domestic Partner			$

Term Rider* Face Amount	Premium
$	$
$	$
$	$
	$

Dependents can be covered under UL or Term Rider, but not both

Total Premium $

Life Insurance Owner (if different than Applicant)	Address	Relationship	Social Security No.

Eligibility Questions

1. *Employer Groups:* Are you actively at work on a full-time basis and able to perform the duties of your occupation? *Member Groups:* Are you a member in good standing and able to perform the normal activities of someone of like age? If "no", you and your dependents are not eligible for coverage.	☐ No ☐ Yes
2. If applying for dependent coverage, is any proposed insured currently disabled? If "yes", list names _____, who are not eligible for coverage.	☐ No ☐ Yes

If you answer "no" to question #1, no coverage will be issued. Anyone named as being ineligible on question 2 will be automatically excluded from coverage.*

Evidence of Insurability Questions Part 1: Please answer the following questions to the best of your knowledge and belief.	
3. In the past six months, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any accident or sickness, except for normal pregnancy? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes
4. In the past five years, has any proposed insured had an actual diagnosis or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*

Evidence of Insurability Questions Part 2: Please answer the following questions to the best of your knowledge and belief.	
5. Indicate Height and Weight: Applicant	/
Spouse or Domestic Partner	/
6. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession for any heart (including heart attack), circulatory, vascular (including stroke), blood, brain, digestive, kidney, liver, lung, musculoskeletal, respiratory, rheumatoid, neurological, pancreas, reproductive, or other major organ disorders, cancer or malignancy in any form (except non-melanoma skin cancer), diabetes, Optic Neuritis, blood transfusion, chronic fatigue syndrome, fibromyalgia, high blood pressure requiring more than two medications to control, or been treated or counseled in the past two years for alcohol or drug abuse? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

For further consideration for anyone who fails to qualify for coverage above, provide details of all "yes" answers to questions 2, 3, 4, & 6.
Anyone found to be acceptable will be added to your coverage via an endorsement.

Question #	Name	Please list: Illness, Injury, Condition, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Life Replacement

Do you currently have any other existing life insurance policies or annuity contracts? ☐ No ☐ Yes If "yes", complete a life replacement form for your state and return with this application.

Universal Life and Whole Life Illustration Acknowledgement

I certify that a life insurance illustration showing non-guaranteed values was not used during the sale of the insurance coverage I am applying for on this application. I understand that if my application is approved, an illustration conforming to the policy/certificate as issued will be delivered to me no later than when I receive my policy/certificate. I understand that any non-guaranteed elements contained in any illustration are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgment, and will return a copy of the signed illustration to the Insurer.

Life Accelerated Death Benefit Disclosure Acknowledgement

If applying for an Accelerated Death Benefit (ADB) Rider, did you receive the applicable Disclosure, if required in your state?
ADB for Chronic Condition Rider ☐ Yes ☐ No ADB for Critical Condition Rider ☐ Yes ☐ No ADB for Terminal Condition Rider ☐ Yes ☐ No

Applicant Statement and Agreement

I have read or had read to me the completed application. I certify that all statements and answers made on or attached to this application are true to the best of my knowledge and belief. I realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage. I understand that coverage will take effect only if this application is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate to which this application is attached.

Signed in (City/State) _____ Date: _____

Signatures _____ _____
Applicant Adult Dependents (where required)

Licensed Agent/Representative Statement and Agreement

I certify that I have accurately recorded on this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

To the best of your knowledge, does any applicant currently have any other existing life insurance policies or annuity contracts? ☐ No ☐ Yes If yes, be sure the applicant completes a life replacement form for your state and return with this application.

I certify that a life insurance illustration was not used in connection with this application (but a company-provided rate sheet may have been used and no non-guaranteed values were shown to the applicant)

I certify that I have provided any applicable outline of coverage and life accelerated death benefit disclosure forms.

Name _____ Signature _____ Agent # _____ License # _____

Authorization to Release Information

I hereby authorize any licensed physician, medical or dental practitioner, hospital, clinic, pharmacy, pharmacy benefit manager, health maintenance organization, or other medical or medically-related facility, insurance company, MIB, Inc.* ("MIB"), employer, consumer reporting agency, or government body that has any personal information or record of my health, to give personal information to Transamerica Life Insurance Company, or its reinsurers, third party administrators, premium collection agencies, outside legal counsel, or electronic enrollment vendors. Personal information means health records (including mental health records), criminal and driving records, prescription drug records, alcohol or drug use records, insurance claim and application records and financial and employment records. Any personal information provided may be used for purposes of underwriting, claim and contestability review(s), including determining eligibility for insurance.

I hereby authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal/protected health information to MIB*. I know that I, or any person authorized by me, may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for 24 months from the date shown below or during the duration of a claim if longer. I understand that I may revoke this authorization at any time by sending written notice to Transamerica Life Insurance Company.

Signed in (City/State) _____ Date: _____ Signatures _____ _____
Applicant Adult Dependents

*Information regarding your insurability will be treated as confidential. The Insurer, or its reinsurers, may, however, make a brief report thereon to MIB, a non-profit membership organization of life 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. 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, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.