Reset Form

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

LIFE APPLICATION

Part A1 – Producer

Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile
Name	Producer ID	Split %	Profile

Part A2 – Plan & Rider Information

Plan	Face Amount	Total Premium
	$	$

Rate Class applied for:

❑ Preferred Non-Tobacco ❑ Preferred Tobacco ❑ Preferred Juvenile
❑ Standard Non-Tobacco ❑ Standard Tobacco ❑ Standard Juvenile
❑ 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)

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

Gender	Height	Weight	SSN

Driver's License Number State	Phone Number for Interview	Best time to call	Occupation
	( )	a.m. p.m.	

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? _____ 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.
( )			

SSN	Relationship to Insured

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

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: _____

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 Premier 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: _____ City/State: _____

Account #: | | | | | | | | | | | | | | | | | | |

Routing #: | | | | | | | | | |

No debit card numbers please

Recurring Draft Date (1st-28th):_____ 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)_____ Date:_____

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	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: _____

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 currently:
   a. Hospitalized or bedridden; or been advised, planning or scheduled to have inpatient surgery? ❑ Yes ❑ No
   b. On parole or probation? ❑ Yes ❑ No
2) 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. Had a stroke (CVA), transient ischemic attack (TIA), heart attack, cardiovascular surgery including bypass, angioplasty, stent implant or pacemaker implant; or had, been diagnosed with, been treated for or advised to receive treatment for congestive heart failure? ❑ Yes ❑ No
   c. 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
   d. Used oxygen to assist in breathing (including oxygen use for Sleep Apnea)? ❑ Yes ❑ No
   e. Used illegal drugs (other than marijuana); or been diagnosed with, been treated for or advised to receive treatment for alcoholism, alcohol use/abuse or drug use/abuse (including prescription drugs)? ❑ Yes ❑ No
   f. 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 that has not been completed? ❑ Yes ❑ No
   g. Resided in a nursing home, assisted or long term care facility; or received hospice or home health care? ❑ Yes ❑ No
   h. Been diagnosed with Crohn's disease, Multiple Sclerosis or Parkinson's disease? ❑ Yes ❑ No
   i. Had, been diagnosed with, been treated for or advised to receive treatment for Hepatitis C, Tuberculosis (TB) or Lupus? ❑ Yes ❑ No
   j. Been incarcerated; or been convicted of a felony or misdemeanor; or been convicted of 2 or more DUI's/DWI's or 3 or more moving violations? ❑ Yes ❑ No
3) Has the proposed insured **ever**:
   a. Had, been diagnosed with, been treated for or been advised to receive treatment for Alzheimer's, dementia, memory loss, any cognitive disorder, organic brain disease, mental incapacity, Lou Gehrig's (ALS), Downs Syndrome, Huntington's, Spina Bifida not surgically corrected, Sickle Cell anemia, Cystic Fibrosis or Cerebral Palsy? ❑ Yes ❑ No
   b. 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
   c. 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
   d. Been in a diabetic coma or had or been advised to have an amputation due to disease or disorder? ❑ Yes ❑ No
   e. Received or been advised to receive an implanted defibrillator or an organ transplant (other than corneal)? ❑ Yes ❑ No

Part C3 - For All Questions Answered "Yes" In This Section Give Details On The Supplemental Information To The Application.

1) Does the proposed Insured take any prescription medication? ❑ Yes ❑ No
2) Within the last **10 years**, has the proposed Insured had or received medical treatment for any of the following conditions:
   Any disease or disorder of the blood, heart or circulatory system such as heart attack, stroke or transient ischemic attack (TIA) ❑ Yes ❑ No
   Respiratory Disease ❑ Yes ❑ No
   Kidney/Liver/Digestive Disorder ❑ Yes ❑ No
   Epilepsy/Seizures ❑ Yes ❑ No
   Mental/Nervous Disorder ❑ Yes ❑ No
   Cancer/Leukemia ❑ Yes ❑ No
   High Blood Pressure ❑ Yes ❑ No
   If yes, last reading: _____/_____ Medication: _____
   Diabetes ❑ Yes ❑ No
   If yes, age at onset: _____ Medication: _____ Avg. blood sugar reading: _____
3) Within the last **5 years**, has the proposed Insured:
   a) Had one or more DUI(s), been charged with, or convicted of a felony OR been on probation/parole? ❑ Yes ❑ No
   b) Illegally used any drug or controlled substance or been treated/counseled for drug or alcohol abuse? ❑ Yes ❑ No

Part C4 – 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: _____

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

Signed Date _____ Signed at City _____ State _____

_____
Proposed Insured Signature
(Insured age 15 and over must sign)

_____
Signature of Parent or Legal Guardian
(if Proposed Insured is Under 18 years of age)

_____
Owner Signature (If Owner other than Insured)

_____
Producer Signature

If the EFT premium payment method is chosen, please tape a voided check in this box.

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 PREMIER 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 Premier 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 Premier 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.

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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:________________________ Social Security Number: ________________

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________________ Signed at City____________________ State ________________

____
Proposed Insured Signature
(Insured age 15 and over must sign)

____
Signature of Parent or Legal Guardian
(if Proposed Insured is Under 18 years of age)

____
Owner Signature (If Owner other than Insured)

____
Producer Signature

Last Name and Last 4 Digits of SSN: _____

Agent's Report

Existing insurance? ❑ Yes ❑ No

Is the policy applied for in this application intended to replace any insurance or annuity now in force? ❑ 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