Reset Form

TRANSAMERICA®
FINANCIAL LIFE INSURANCE COMPANY

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

Life Insurance Application For One Life Part 1

APA 40NY-107

Proposed Insured: _____ _____
First Middle Last Mr./Mrs./Ms./Dr.

Birthdate: _____ Age _____ Birth Place: _____ Male ☐ Female ☐
Mo. Day Yr.

Soc. Sec. No.: _____ Employer: _____

Occupation: _____ Annual Income $ _____ ( ) _____
Duties Work Phone

Residence: _____ ( ) _____
No. & Street City State Zip Home Phone

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

Relationship to Proposed Insured: _____

Address: _____ _____
No. & Street City State Zip Soc. Sec. or Tax No.

Beneficiary's Name and Relationship to Proposed Insured: _____

_____

Address: _____ _____
No. & Street City State Zip Date of Trust, if Applicable

1. Plan Applied For: _____ Kind Code: _____
   Preferred Plus ☐ Preferred ☐ Standard Plus ☐ Standard ☐ Other ☐ _____
2. Non-Nicotine Qualification ☐ Nicotine Qualification ☐
3. Amount Applied For $ _____
4. Rating Class of Risk Applied For: ☐ Standard ☐ Extra Rating of _____
5. Additional Benefits by Rider: ☐ Waiver of Premium/Waiver Provision ☐ Accident Indemnity $ _____ ☐ Other _____ $ _____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly/PAC
7. Complete for Flexible Premium Plans:
   Required Premium Per Year (RAP) $ _____
   (only on plans where applicable)
   Planned Periodic Premium $ _____ Per: ☐ A ☐ S ☐ Q ☐ M/PAC
   + Initial Lump Sum $ _____
   = Total Initial Premium $ _____
8. If the Automatic Premium Loan provision is available, it is to be effective: ☐ Yes ☐ No
9. Death Benefit Option election only on plans where applicable: ☐ Option 1 ☐ Option 2 ☐ Option 3
10. Total insurance in force with all companies: Business: $ _____ Personal: $ _____
    Accidental Death Insurance now in force: $ _____ Waiver of Premium/Waiver Provision Coverage: $ _____
11. If the Proposed Insured is under age 18, Are all brothers and sisters insured equally? ☐ Yes ☐ No (If "No", give details.)
    Total life insurance in force and applied for with all companies on the Owner: $ _____
    If the Owner is other than a parent or guardian, the amount of life insurance in force and applied for with all companies on each parent/guardian: Father $ _____ Mother $ _____ Guardian(s) $ _____
12. Mail Additional Premium Notices To: _____
    Address: _____
    No. & Street City State Zip

Yes	No	**"You" means any person proposed to be insured.**
☐	☐	13. May insurance, including annuities, in any company be discontinued or changed if the insurance applied for is issued? If "Yes", give company names and amounts. _____
☐	☐	14. Is any application for life insurance pending with any other company? If "Yes", give company name, amount applied for and total amount to be placed. _____
☐	☐	15. Do you plan to travel outside the U.S., Canada, W. Europe, Hong Kong or Australia/New Zealand, for business or pleasure, within the next 24 months? If "Yes", complete Foreign Travel Questionnaire.
☐	☐	16. In the past two years, have you participated in aeronautics, powered racing or competitive vehicles, skin or scuba diving, mountain climbing, rodeos or competitive skiing? If "Yes", complete Sports and Avocation Questionnaire.
		17. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		18. Driver's License #: _____ State: _____
☐	☐	Within the past five years, has your driver's license been suspended, revoked, or have you been cited for a moviing violation? If "Yes", give dates and reason. _____

Yes	No	"You" means any person proposed to be insured.
☐	☐	19. Do you intend to fly other than as a passenger or have you flown other than as a passenger during the past two years? If "Yes", complete Aviation Questionnaire.
☐	☐	20. Within the past ten years, have you been convicted of a misdemeanor (other than a minor traffic violation) or felony? If "Yes", give dates and reason. _____
☐	☐	21. Are you a member of the armed forces including reserves? Intend to become a member?

Remarks: Give details for any questions answered "YES". If additional space is needed, attach an additonal sheet of paper.

_____

_____

_____

_____

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 to the best of my/our knowledge and belief. It is agreed that this Application will be attached to and made part of the policy to the Company. **I/we agree:** (1) This Application shall consist of Part 1, Part 2, and any required application supplement(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 to the best of my/our belief 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 Financial 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 any omissions or misstatements in this Application could cause an otherwise valid claim to be denied under any insurance issued from this Application.

If I am applying for an indeterminate premium plan, I understand that: (a) the premium for such plan is guaranteed for the initial guarantee period, and, after such period, the current annual premium is not guaranteed and may change; and (b) the premium will never exceed the specified maximum.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Financial 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 Medical Information Bureau, Inc., 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 Medical Information Bureau, Inc., 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 authorize Transamerica Financial Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.

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.

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 TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.

Amount paid with this Application $ _____ ☐ Check or M.O. # _____ ☐ Credit Card * _____

*Complete Credit Card Order Confirmation Form

Signed at _____ on _____, _____

City-State Date

X _____ X _____

Signature of Proposed Insured (or parent or guardian if Proposed Insured is a minor) Witness to Signature of Proposed Insured

Signed at _____ on _____, _____

City-State Date

X _____ X _____

Signature of Owner (if other than Proposed Insured) 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.

_____

Signature of Licensed Resident Agent as required, below.

X _____

(NOT PART OF APPLICATION)

REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ OFFICE ID#: _____ AGENCY PROCESSOR: _____

PRODUCER 1: _____ | _____ SHARE %: _____
LAST FIRST

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

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

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

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

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

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

What is the purpose for insurance? _____

How long have you known the Proposed Insured? _____

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

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

☐ 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

☐ **MONTHLY** (This will be elected if no box is checked)
☐ **QUARTERLY**
☐ **SEMI-ANNUAL**
☐ **ANNUAL**

☐ **PREMIUM**
☐ **LOAN REPAY**
☐ **SAVINGS**
☐ **CHECKING**

☐ **NEW AUTHORIZATION**
☐ **BANK CHANGE**
☐ **ADD TO EXISTING POLICY**
☐ **OTHER** _____

PICK A DATE TO DRAFT (1-28) _____

NAME OF FINANCIAL INSTITUTION: _____
PHONE #: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
ACCOUNT NUMBER: _____
NAME(S) ON BANK ACCOUNT: _____
ROUTING#: _____

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

I request and authorize Transamerica Financial 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.

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

TAPE VOIDED CHECK HERE

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Financial Life Insurance Company ("the Company") may make a brief report to the Medical Information Bureau (MIB), a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance, or to which a claim is submitted, MIB will supply such company with the information it may have in its files. The Company may also release information in its file to reinsurers and to other life insurance companies to which you may apply for life or health insurance, or to which a claim is submitted.

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 seek 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, Suite 400, Braintree, MA 02184-8732, telephone (866) 692-6901 (TTY (866) 346-3642 for hearing impaired).

Notice to Persons Applying for Insurance: Federal law requires us to advise you that in connection with this application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. Such reports are usually part of the process of evaluating risks for life and health insurance. Inquiry may be made into your character, general reputation, personal characteristics and mode of living. It is possible that a representative of a firm employed to make such reports may call upon you in person. You have the right to request disclosure of the nature and scope of the investigation by your written request made within a reasonable time after receipt of this notice.

Notice of Insurance Information Practice: The information collected about you by us may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law. You have the right of access and correction with respect to the information collected except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact your agent or write the Company at its Administrative Office, 4333 Edgewood Road NE, Cedar Rapids, IA 52449.

INSTRUCTIONS FOR CONDITIONAL RECEIPT

DO NOT ACCEPT MONEY OR COMPLETE THE CONDITIONAL RECEIPT IF:

1. any Proposed Insured has been treated for or experienced, within the last 12 months, any disorder of the heart, stroke, or other vascular disease, cancer, or HIV infection, or
2. any Proposed Insured is under the age of 16 or over the age of 75, or
3. the amount(s) applied for under the attached application and any other application pending with Transamerica Financial Life Insurance Company ("the Company") and other Transamerica affiliates plus insurance in force with the Company and other Transamerica affiliates exceeds $3,000,000.

IF THE PROPOSED INSURED IS NOT DISQUALIFIED BY ANY OF THE FACTORS LISTED IN 1 - 3 ABOVE, YOU MAY COLLECT MONEY UP TO THE AMOUNT OF THE DOLLAR LIMIT OF CONDITIONAL COVERAGE FOR THE APPROPRIATE AGE AS SPECIFIED IN THE CONDITIONAL RECEIPT.

Make all checks payable to Transamerica Financial Life Insurance Company. Do not make checks payable to the agent or leave the payee blank, otherwise this Receipt cannot become effective. The amount of payment taken with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application (2 months' premium for Monthly Pre-Authorized Withdrawal Plan) and for the amount of insurance which may become effective prior to delivery of the contract.

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____ , the sum of $ _____ for the life insurance application dated _____, with _____ as the Proposed Insured(s).

This Receipt cannot become valid unless all blanks are completed above, your check is made payable to Transamerica Financial Life Insurance Company, this Receipt is signed by an insurance producer duly licensed by the Company and the state in which the application is contracted or other authorized Company 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(s) and honored on first presentation to the bank;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires initially required by the Company under the published rules of the Company for the Proposed Insured's (s') age or the amount of insurance applied for are completed and received at our Administrative Office. (**Note:** No more than two medical examinations will be required for any one person);
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete;
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 under the Company's rules for insurance on the plan, in the amount, and at the rating class of risk applied for in Part 1 of the application.

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 as a standard class of risk, $400,000 of life insurance if the Proposed Insured is age 66 - 75 and is insurable as a standard class of risk, or $100,000 for all other rating classes of risk regardless of age. There is no conditional coverage for riders or any additional benefits, if any, for which you have applied. No death benefit is payable for a second-to-die or survivorship contract unless both Proposed Insureds die while coverage is in effect.

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.

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 during the lifetime of the Proposed Insured(s) and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at _____ on _____ , 20____ X _____
City, State | Date | Insurance Producer or other Authorized Company Rep

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Financial Life Insurance Company. The agent 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 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 _____ _____ , 20____
Signature of proposed Owner | Date

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.

X _____

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 agent, date and amount of this Conditional Receipt.

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

Original

CONDITIONAL RECEIPT
PLEASE READ THIS CAREFULLY

Received from _____, the sum of $ _____ for the life insurance application dated _____, with _____ as the Proposed Insured(s).

This Receipt cannot become valid unless all blanks are completed above, your check is made payable to Transamerica Financial Life Insurance Company, this Receipt is signed by an insurance producer duly licensed by the Company and the state in which the application is contracted or other authorized Company 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(s) and honored on first presentation to the bank;
2. Part 1 and Part 2 of the application, and all medical examinations, tests, screenings and questionnaires initially required by the Company under the published rules of the Company for the Proposed Insured's(s') age or the amount of insurance applied for are completed and received at our Administrative Office. (**Note:** No more than two medical examinations will be required for any one person);
3. As of the Effective Date, all statements and answers given in the application (both Parts) must be true and complete;
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 under the Company's rules for insurance on the plan, in the amount, and at the rating class of risk applied for in Part 1 of the application.

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.

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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.

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 during the lifetime of the Proposed Insured(s) and all other conditions of coverage set forth in Part 1 of the application have been met.

Dated at _____ on _____, 20____ X _____
City, State | Date | Insurance Producer or other Authorized Company Rep

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ACKNOWLEDGMENT OF TERMS, CONDITIONS, AND LIMITATIONS OF CONDITIONAL RECEIPT

I have read the foregoing Conditional Receipt issued by Transamerica Financial Life Insurance Company. The agent 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 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 _____ _____, 20____
Signature of proposed Owner | Date

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.

X _____

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 agent, date and amount of this Conditional Receipt.

Leave this copy with the proposed Owner if money is submitted with application.

Proposed Owner Copy

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

☐ **MONTHLY** (This will be elected if no box is checked)
☐ **QUARTERLY**
☐ **SEMI-ANNUAL**
☐ **ANNUAL**

☐ **PREMIUM**
☐ **LOAN REPAY**
☐ **SAVINGS**
☐ **CHECKING**

☐ **NEW AUTHORIZATION**
☐ **BANK CHANGE**
☐ **ADD TO EXISTING POLICY**
☐ **OTHER** _____

PICK A DATE TO DRAFT (1-28) _____

NAME OF FINANCIAL INSTITUTION: _____
PHONE #: _____
ADDRESS: _____
CITY, STATE, ZIP: _____
ACCOUNT NUMBER: _____
NAME(S) ON BANK ACCOUNT: _____
ROUTING#: _____

AUTHORIZATION FOR PARTICIPATION IN THE PAC PROGRAM

I request and authorize Transamerica Financial 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.

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

TAPE VOIDED CHECK HERE

RESET

TRANSAMERICA
FINANCIAL LIFE INSURANCE COMPANY

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

Notice and Consent for HIV-Related Testing New York

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her newborn infant. It may take a few weeks to many years for symptoms to appear but they usually include fever, diarrhea, tiredness and enlarged lymph glands.

The HIV Antibody Test

To evaluate your insurability, the insurer named above (the "Insurer") has requested that you provide a sample of your blood, oral fluid and/or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done. A series of tests will be performed by a licensed laboratory through a medically accepted procedure.

The HIV antibody test is extremely accurate. However, like any medical test, this one is not 100% accurate. In rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative), especially when the infection occurred within the previous 3-6 months.

Meaning of Test Results

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. You may wish to consider further independent testing. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

A negative test result means no antibodies to the HIV virus were found. Because of varying incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Absence of HIV antibodies does not mean that you cannot get the virus in the future.

Counseling

Many public health organizations have recommended that before taking an HIV-related test, a person should seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. Public health authorities urge that everyone become educated about how to protect themselves from HIV infection. If you have questions or concerns, you may wish to consult your own physician or health care provider or call the New York State AIDS Hotline, 1-800-541-2437. A list of counseling services is provided for your information. Other counseling services may also be available to you.

Notice and Consent for HIV-Related Testing New York

Confidentiality of Test Results

All test results will be treated confidentially. The laboratory that conducts the test will report the result to the Insurer which may in turn disclose results to its employees, affiliates, reinsurers, contractors or attorneys who need the results for underwriting, claims or another necessary business purpose in connection with your insurance transaction. The Insurer may disclose your test results as permitted or required by law or as authorized in writing by you. Test results will not be shared with your insurance agent or broker. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to HIV, or for the preparation of statistical reports that do not disclose the identity of any particular person. The release for disclosures discussed in this paragraph will be effective for 2 1/2 years from the date shown below.

Notification of Test Result

If your test results are negative, no routine notification will be sent to you. If your test results are other than negative, you are entitled to that information. Because a trained person should deliver that information so that you can understand clearly what the test result means, you are asked to list your private physician so that the Insurer can have him or her tell you the test result and explain the meaning. If you prefer, the results can be sent to you or another person designated by you.

In the event of a test result that is other than negative, I authorize disclosure to the following physician or other person or entity:

_____
Name

_____
Street

_____
City, State, Zip Code

If you prefer the results to be sent directly to you, initial here: _____

Consent

I have read and I understand this *Notice and Consent for HIV-Related Testing*. I voluntarily consent to the withdrawal of blood, oral fluid and/or urine from me, the testing of my blood, oral fluid and/or urine for HIV antibodies, and disclosure of the test results as described.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____
Name of Proposed Insured *(Please Print)*

_____
Date of Birth

_____
Signature of Proposed Insured

_____
Date Signed

Counseling Resources List

As required by New York law, the following list of counseling resources is being provided to you. It was compiled from publicly available information, which is subject to change without notice to Transamerica Financial Life Insurance Company (TFLIC). Therefore, TFLIC makes no representations or warranties that this information is accurate as of the date you received this list. Also, TFLIC makes no representations or warranties about the quality or nature of any services these resources may provide.

This is a not a complete list of all resources that may be available to you. We suggest you contact your own physician or health care provider, your county health department, or your local chapter of the American Red Cross, for further information.

For referral or assistance, you may call:

The New York State AIDS Hotline toll-free number
1-800-541-2437

After hours hotline
1-800-872-2777 (Mon. thru Fri. 4 p.m. to 8 p.m.)
(and Sat. & Sun. 10 a.m. to 6 p.m.)

or contact your nearest local AIDS program:

New York City Area:

New York City AIDS Hotline
1(800) 825-5448

Bronx
(718) 901-6564

Brooklyn
(718) 735-0580

Harlem
Central (212) 690-1760
East (212) 360-5962

Queens
1(800) 462-6785

Staten Island
(718) 483-4531

Other Areas:

Albany
1(800) 962-5065

Buffalo
1(800) 962-5064

Nassau
1(800) 462-6785

New Rochelle
1(800) 828-0064

Rochester
1(800) 962-5063

Suffolk
1(800) 462-6786

Reset Form

TRANSAMERICA
FINANCIAL LIFE INSURANCE COMPANY

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

Application Part 2
Non-Medical Health History

MPN 1NY-807

Complete a separate Part 2 for each person applying for coverage. **File #** _____

1. **PROPOSED INSURED'S NAME:** *(First, M.I., Last)*	**DATE OF BIRTH**	**SOCIAL SECURITY NO.**
		— —

2. **NAME AND ADDRESS OF YOUR PERSONAL PHYSICIAN:**

3. **DATE AND REASON LAST CONSULTED:**

4. **CURRENT MEDICATION OR TREATMENT:**

5. **HEIGHT:**	**WEIGHT:**	Has your weight changed more than 15 pounds in the past year? ☐ Yes ☐ No If "Yes", reason:

For all "Yes" answers, provide full details on Page 2.

6. **WITHIN THE PAST FIVE YEARS HAVE YOU:**

a. Consulted, been examined or been treated by any physician or practitioner? ☐ Yes ☐ No
b. Had an X-ray, electrocardiogram or any laboratory test or other diagnostic study other than an AIDS-related test? ☐ Yes ☐ No
c. Had observation or treatment at a clinic, hospital or other medical facility? ☐ Yes ☐ No
d. Had or been advised to have a surgical procedure? ☐ Yes ☐ No
e. Had dizziness, shortness of breath, pain or pressure in the chest, or persistent fever? ☐ Yes ☐ No
f. Had any injury requiring treatment? ☐ Yes ☐ No
g. Used nicotine in any form? *(Indicate type, frequency and date last used on Page 2)* ☐ Yes ☐ No

7. **HAVE YOU EVER HAD, BEEN TOLD BY A MEMBER OF THE MEDICAL PROFESSION THAT YOU HAVE, OR BEEN DIAGNOSED WITH OR TREATED FOR:**

a. Seizure, fainting, stroke, loss of consciousness, tremor, paralysis, or any disease or abnormality of the brain or nervous system? ☐ Yes ☐ No
b. High blood pressure, heart attack, murmur, palpitation, or anemia or any disease or abnormality of the heart, blood vessels or blood? ☐ Yes ☐ No
c. Asthma, pneumonia, emphysema, tuberculosis, or any disease or abnormality of the lungs, bronchial tubes, or respiratory system? ☐ Yes ☐ No
d. Ulcer, colitis, hepatitis, cirrhosis, or any disease or abnormality of the esophagus, stomach, intestines, rectum, gallbladder or liver? ☐ Yes ☐ No
e. Sugar, protein, or blood in urine, sexually transmitted disease, stone or any disease or abnormality of the kidney, bladder, prostate, breasts or reproductive system? ☐ Yes ☐ No
f. Diabetes or any disease or abnormality of the thyroid, adrenal or other glands? ☐ Yes ☐ No
g. Arthritis, gout, back trouble, any disease or abnormality of the joints, muscles or bones? ☐ Yes ☐ No
h. Any disease or abnormality of the eyes, ears, nose, throat or skin? ☐ Yes ☐ No
i. Cancer, tumor, polyp, or cyst? ☐ Yes ☐ No
j. Any physical deformity or amputation? ☐ Yes ☐ No
k. Anxiety, depression, or any psychiatric or emotional condition or disorder? ☐ Yes ☐ No
l. An immune deficiency disorder, Acquired Immune Deficiency Syndrome (AIDS), or Human Immunodeficiency Virus (HIV) infection? ☐ Yes ☐ No

Application Part 2
Non-Medical Health History
MPN 1NY-807

8. **WITHIN THE PAST TEN YEARS, HAVE YOU USED:**

a. Amphetamines, barbiturates, sedatives or morphine or any other narcotic drug except as prescribed by a physician? . . . . . ☐ Yes ☐ No

b. Cocaine/crack, methamphetamine, Ecstasy (MDMA), heroin, marijuana, PCP, LSD, or any other hallucinogenic drug? . . . . . ☐ Yes ☐ No

9. a. Have your parents, brothers, sisters or grandparents ever had cancer, diabetes, heart disease, mental illness or attempted suicide? . . . . . ☐ Yes ☐ No

b. Have you ever been treated or counseled for the use of alcohol or drugs or joined an organization for alcohol or drug dependence or abuse? . . . . . ☐ Yes ☐ No

c. Has any application for insurance on your life ever been declined, withdrawn, postponed, rated, or modified in any way? . . . . . ☐ Yes ☐ No

d. Are you now pregnant? . . . . . ☐ Yes ☐ No

Question Number	Give complete details of all "Yes" answers to questions 6-9, including all dates, diagnoses, duration, outcome, treatments and medications prescribed and the names and addresses of all hospitals and attending physicians. If additional space is required, attach sheet of paper - signed, dated and witnessed.

10. **FAMILY HISTORY:** 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				
Mother				
Brothers #				
Sisters #				

It is represented that the statements and answers given above are true, complete, and correctly recorded to the best of my knowledge and belief. It is agreed that this Application Part 2 will be attached to and made part of the application to the Company. 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 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) _____ on this _____ day of _____ , 20 _____

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

X _____
Signature of Witness/Agent/Registered Representative

X _____
Signature of Proposed Insured *(of parent or legal guardian if Proposed Insured is a minor)*

RESET

TRANSAMERICA® FINANCIAL LIFE INSURANCE COMPANY

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

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

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

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

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

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

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

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

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

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

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

Policy or contract number (if known): _____

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

TRANSAMERICA®
FINANCIAL LIFE INSURANCE COMPANY

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

New York Identification

PRIMARY INSURED

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City
State / Zip Code	3. Home Phone ( )	4. Social Security Number

OWNER

1. Last Name	First Name	M.I.
2. Address (Cannot be a P.O. Box)	Apt#	City
State / Zip Code	3. Home Phone ( )	4. Social Security Number

PRIMARY BENEFICIARY

Name / Address	Percent	Relationship	Phone #	Social Security# / Tax ID#
Total	**1 0 0**			

CONTINGENT BENEFICIARY

Name / Address	Percent	Relationship	Phone #	Social Security# / Tax ID#
Total	**1 0 0**			

AGENT

❑ I attest that, on behalf of the Company, I requested the information above; however, the applicant refused to provide this information.

Policyowner name

Producer or Agent Signature

Producer or Agent Number

Reset Form

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Definition of Replacement

Insurance Department of the State of New York

Definition of Replacement

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

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

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

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and your agent or broker is required to provide you with a completed Disclosure Statement and the IMPORTANT Notice Regarding Replacement or Change of Life Insurance Policies or Annuity Contracts.

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

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

_____ _____

Signature of Agent or Broker Date