TRANSAMERICA® FINANCIAL LIFE INSURANCE COMPANY

Transamerica Financial Life Insurance Company *("Insurer")*
Home Office: Harrison, NY
Administrative Office: P.O. Box 869094
Plano, TX 75086-9817

Group 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 30 days, if direct bill, or 60 days, if payroll-deducted, 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

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

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 Civil Union/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

☐ **Universal Life** Option: ☐ A (level) ☐ B (increasing)	Face Amount	Automatic Increase Option Rider	Initial Premium	Planned Premium
☐ Applicant	$	☐ Yes ☐ No	$	$
☐ Spouse or Civil Union/Domestic Partner**	$	☐ Yes ☐ No	$	$
☐ Children*	$		$	$
Optional Riders:	Benefit Amount	A=Applicant S=Spouse C=Child)		
☐ Accidental Death	$	Add to ☐ A ☐ S	$	$
☐ Child Term Rider*	$	Add to ☐ A ☐ S	$	$
☐ Waiver of Monthly Deductions for Total Disability		Add to ☐ A ☐ S ☐ C	$	$
☐ Unemployment Lapse Protection Benefit Rider		Add to ☐ A ☐ S ☐ C	$	$
Benefits received from this rider may be considered taxable income. Please consult your tax advisor.				
☐ Accelerated Death Benefit for Critical Condition		Add to ☐ A ☐ S ☐ C	$	$
☑ Accelerated Death Benefit for Terminal Condition		Add to all policies	$0.00	$0.00
			Total Premium $	**Total Premium $**

* Child can be covered under Universal Life OR Child Term Insurance Rider, but not both. Child Term Rider can be attached to Applicant or Spouse's policy, but not both. If the Child is covered under Universal Life, the Child's maximum face amount is $25,000 or the Applicant face amount, whichever is less.

Eligibility Questions

	Question	Answer
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 ______________________________ and provide details below.	☐ No ☐ Yes

If you answer "no" to question #1, no coverage will be issued.

Evidence of Insurability Questions Part 1: Please answer the following questions to the best of your knowledge and belief.

	Question	Answer
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 ______________________________ and provide details below.	☐ No ☐ Yes
4.	In the past five years, has any proposed insured had an actual diagnosis or treatment by a licensed member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? If "yes", list names ______________________________ and provide details below.	☐ No ☐ Yes

Evidence of Insurability Questions Part 2: Please answer the following questions to the best of your knowledge and belief.

	Question	Answer
5.	Indicate Height and Weight: Applicant	/
	Spouse or Civil Union/Domestic Partner**	/
6.	In the past five years, has any proposed insured been diagnosed or treated by a licensed 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 ______________________________ and provide details below.	☐ No ☐ Yes

Please provide details of all "yes" answers to questions 2, 3, 4, & 6. An additional sheet of paper may be attached if necessary.

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

Is it your intent to discontinue or change insurance, including annuities, in any company if the insurance applied for is issued? ☐ No ☐ Yes (provide details)

Which product(s)	Name of existing insurance company	Policy/certificate #

Applicant Statement and Agreement

I have read or had read to me the completed application. **I represent** 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 may result in loss of coverage under the policy/certificate to which this application is attached.

Warning: Any person who knowingly and with intent to defraud any insurance company or other persons, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact, material thereto, commits a fraudulent act, which is a crime, subject to criminal prosecution and civil penalties.

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 coverage effective date requirements listed in the policy to which this application is attached.

Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income and may be taxable.

The Accelerated Death Benefit for Terminal Condition Rider has no cost until you exercise the option to accelerate benefits. On acceleration, an Interest Discount is charged as well as an administrative fee of $100.

The Accelerated Death Benefit for Critical Condition Rider has a monthly cost of insurance of $_______. There will be an administrative charge of $250 deducted from the Accelerated Death Benefit payment.

This application is made part of the Policy.

Signed in (City/State) ____ Date: ______________

Signatures ____ ____

Applicant Minor Child over age 14 ½

Signatures of Adult Dependents____

Minor Child over age 14 ½ Minor Child over age 14 ½

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.

I certify that this insurance does not replace or change any existing life insurance coverage, except as noted under Life Replacement.

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 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 Transamerica Financial Life Insurance Company, or its reinsurers, any such information. **I hereby authorize** Transamerica Financial Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB.* **I understand** the information obtained by use of this Authorization will be used by Insurer to determine eligibility for insurance. Any information obtained will not be released by Insurer to any person or organization except to reinsuring companies, MIB, 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 authorize. **I know** that I 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 two years from the date shown below. . I understand that I may revoke this authorization at any time by sending written notice to Transamerica Financial Life Insurance Company.

Signed in (City/State) _______________________ Date: ______________ Signature ____

Applicant

Signatures of Adult Dependents____

Spouse Minor Child over age 14 ½ Minor Child over age 14 ½

*Information regarding your insurability will be treated as confidential. Transamerica Financial 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, Massachusetts 02184-8734. Transamerica Financial 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.