RESET

TRANSAMERICA OCCIDENTAL LIFE

Transamerica Occidental Life Insurance Company
Home Office: Cedar Rapids, IA 52499
Marketing Office: Los Angeles, CA 90015
Administrative Office: P.O. Box 419521
Kansas City, MO 64141-6521

Life Insurance Application For One Life Part 1

APA 40-697

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

Birthdate: Mo. _____ Day _____ Yr. _____ Birth Place: _____ Age _____ ☐ Male ☐ Female Soc. Sec. No. _____ — _____ — _____

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

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

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

Address: _____ (No. & Street / City / State / Zip) _____ — _____ — _____ (Soc. Sec. or Tax No.)

Beneficiary's Name and Relationship: _____

_____

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

1. Plan Applied For: _____ Kind Code: _____
   Preferred ☐ Standard ☐
2. Non-Nicotine Qualification ☐ Nicotine Qualification ☐
3. Amount Applied For $ _____
4. Additional Benefits by Rider: ☐ Waiver Provision ☐ Accident Indemnity $ _____ ☐ Other _____ $ _____
5. Rating Class of Risk Applied For: ☐ Standard ☐ Extra Rating of _____
6. Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly/PAC
7. Complete for Flexible Premium Plans:
   - Required Premium Per Year (RAP) $ _____
   - 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 ☐ Not Effective ☐
9. Total insurance in force with all companies:
   Life Insurance $ _____ Accidental Death $ _____ Waiver Provision Coverage $ _____
10. Mail Additional Premium Notices To: _____

    Address: _____ (No. & Street / City / State / Zip)

Yes	No	
☐	☐	11. May insurance, including annuities, in any company be discontinued or changed if the insurance applied for is issued? If "Yes", give company names. _____
☐	☐	12. 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. _____
☐	☐	13. Do you intend to travel outside the U.S. or Canada within the next two years, except purely for vacation travel? If "Yes" give destination, purpose of travel and length of stay in Remarks.
☐	☐	14. 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?
		15. Have you used nicotine at any time? Date Last Used
☐	☐	Cigarettes _____
☐	☐	Cigar/Pipe/Chewing Tobacco _____
☐	☐	Other _____
		16. Driver's license #: _____ State: _____
		In the past ten years, have you been convicted of or pleaded guilty to:
☐	☐	a. Moving violations? If "Yes", give dates and type. _____
☐	☐	b. Driving under the influence of alcohol and/or other drugs? If "Yes", give dates. _____
☐	☐	c. Reckless driving? If "Yes", give dates. _____
☐	☐	17. Do you intend to fly other than as a passenger or have flown other than as a passenger during the past two years? If "Yes", complete Aviation Questionnaire.

Remarks: Give details for any questions answered "YES"

Complete for TransSecure Applications Qualified?: Yes ☐ No ☐ If yes, 412(i)?: Yes ☐ No ☐

Fixed Modal Premium Amount: $ _____

Fixed Premium Duration: _____ Years; or To Age _____

It is represented that the statements and answers given in this Application are true, complete and correctly recorded to the best of my knowledge and belief. It is agreed: (1) This Application shall consist of Part 1 and Part 2 and shall be the basis for any policy 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 policy 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 policy 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 belief must be true and complete as of the date of Owner's personal receipt of the policy and that the policy will not take effect if the facts have changed; (3) No waiver or modification shall be binding upon Transamerica Occidental Life Insurance Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

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

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Occidental Life Insurance Company ("the Company")

I 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; HIV related test results or disorders; metabolic, pulmonary, or neurological disorders) and/or treatment of me and any other non-medical information of me 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 policy. 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 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** this Authorization shall be valid for two and one half years from the date shown below. (For Rhode Island applications, this shall be valid for 24 months from the policy issue date.)

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 THE COMPANY. DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE SPACE BLANK.

Amount paid with this Application $ _____ Check or M.O. # _____

Signed at (city-state) _____ on (date) _____ , _____

X _____
Signature of Proposed Insured

X _____
Owner (if other than Proposed Insured)

X _____
Witness to all signatures

X _____
If Owner is a corporation, an authorized officer, other than Proposed Insured must sign as owner, give Corporate title and full name of corporation.

X _____
Countersigned (Licensed Resident Agent, if your state requires)

(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

AUTHORIZATION FOR PARTICIPATION IN THE PRE-AUTHORIZED WITHDRAWAL PLAN

I (we) hereby authorize and request Transamerica Occidental Life Insurance Company to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my (our) account indicated on the attached check for premiums and other such payments indicated. I (we) request that this Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policies. I (we) agree that this Authorization in no way affects the terms of the policy, other than the mode of payment and I (we) understand that if premiums are not paid within the grace period allowed by the policy, as in the event of withdrawals being dishonored, or for any other reason, then the policy shall terminate subject to any nonforfeiture provision of the policy.

Proposed Insured **Amount**

_____ $ _____

Preferred Withdrawal Date: _____ Bank Name: _____

_____ _____

Policyowner Signature Date Signature of Bank Account Owner Date

If check is not submitted with the application, please attach "voided" check.

PLEASE DETACH IF PAC IS NOT REQUESTED

CONDITIONAL RECEIPT

Transamerica Occidental Life Insurance Company has received a payment of $ _____ from _____ for the life insurance applied for in the application for _____ as Proposed Insured.

This receipt is not valid unless it is signed by an agent of the Company. This receipt is not valid unless the amount paid with the application, if paid by check or draft, is honored on first presentation for payment.

IMPORTANT: The payment is received subject to the conditions of this receipt. This receipt does not provide any insurance until after all of its conditions are met.

Dated at _____ on _____

Agent Signature _____ Type of Policy _____

All premium checks must be made payable to the Company. Do not make payable to the agent or leave payee blank.

If you do not hear from the Company regarding the proposed insurance within 30 days, notify the Company at its Administrative Office at Post Office Box 419521, Kansas City, MO 64141 giving your full name, date of birth, the name of the agent, date and amount of this receipt.

If the person to be covered for the life insurance applied for on the Application dies while this temporary insurance is in effect, the Company will pay a death benefit to the designated beneficiary subject to all the following conditions:

1) Such life insurance does not start until both the Application Part 1 and the Application Part 2 Non-Medical Report and the initial premium payment shown on the other side of this receipt have been received by the Company.
2) The death benefit payable will be the lesser of: (a) the face amount applied for in the Application; or (b) (i) $250,000 of life insurance if such person is age 16 through 65 and is insurable as a standard class of risk, or (ii) $100,000 at all other ages and classes of risk; and (c) $50,000 of benefits for death by accident. The total benefit limit applies to all insurance applied for and in force with the Company and to any other Conditional Receipts issued by the Company.
3) There is no coverage under this Receipt if the check or draft submitted as payment is not honored by your bank.
4) Fraud or material misstatements in the Application will void coverage under this Receipt; and the Company's only liability is to refund any premium payment made.
5) If the person to be covered under the Application dies by suicide, the Company's liability is limited to a refund of any premium payment made.
6) Coverage under this Receipt ends on the earliest of the following: the date the life insurance applied for under the Application becomes effective; the date the Company mails notice of an adverse underwriting decision regarding the Application to the Applicant's last known mailing address along with the refund of unearned premium paid with this Receipt.
7) Any insurance applied for as alternate or additional to the plan and amount of insurance applied for in the Application shall not become effective under this Conditional Receipt.

NOTICE OF DISCLOSURE OF INFORMATION

Information regarding your insurability will be treated as confidential except that Transamerica Occidental Life Insurance 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 the 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 Post Office Box 105, Essex Station, Boston, MA 02112, 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 authorizations as permitted 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, P.O. Box 419521, Kansas City, MO 64141.