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**
PICK A DATE TO DRAFT (1-28) ____________

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

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

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 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

DT084

SECTION III - INSTRUCTIONS TO TERMINATE EXISTING LIFE INSURANCE COVERAGE

Transamerica Life Insurance Company (the Company)
Existing contract(s)/coverage(s) for which a change or termination is requested will remain in effect only until the contract(s)/change(s) applied for is/are effective in accordance with this application and all contract terms.

- ☐ Upon issuance of contract applied for, terminate contract number(s) ______
- ☐ Upon issuance of contract applied for, change contract number(s) ______

Additional instructions: ______

I/WE, THE OWNER(S), UNDERSTAND THAT THE COMPANY MAKES NO REPRESENTATIONS AND ASSUMES NO LIABILITY FOR THE TAX IMPLICATIONS, IF ANY, OF THIS TRANSACTION.

NOTICE TO CONSUMER: The death benefit on many business related life insurance policies will be taxable to the extent it exceeds the premiums and other considerations paid by you for the policy under Section 101(j) of the Internal Revenue Code unless written Notice and Consent is obtained prior to policy issue and certain other requirements are met. These policies are often referred to as Employer-Owned Life Insurance Policies but can also include policies owned by others such as affiliates and business owners. The policy change(s) you have requested may require compliance with Section 101(j), including compliance with the Notice and Consent requirements prior to the effective date of any change, whether or not such section also applied when the policy was originally issued.

You are advised to consult with your qualified tax advisor prior to completing the requested policy acquisitions or change(s).

I/we, the undersigned, hereby represent that the statements and answers given in the Application are true, complete and correctly recorded. **I/we agree**: (1) This Application and any required application supplement(s)/amendment(s), in addition to any evidence of insurability required by the Company for this Application, including Application Part 2, shall be made part of the contract issued pursuant to this Application. (2) Except as otherwise provided in the conditional receipt, if issued, with the same Insured(s) as Part 1 of this Application, any change requested which requires evidence of insurability shall not take effect until after all of the following conditions have been met: (a) Any required payment for the change is paid in full, (b) The change is approved by the Company at its Administrative Office during the lifetime of all persons insured, (c) The Owner has personally received the contract during the lifetime of and while person(s) to be covered by such contract is/are in good health, and (d) All of the statements and answers given in this Application continue to 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) Any change requested which does not require evidence of insurability which is provided by the contract or is allowed by the Company shall be effective from the date determined by the Company unless a different date is specifically indicated and is allowed by the Company. (4) Until the change requested becomes effective, the contract without change shall continue subject to its provisions. (5) The Company may deposit or cash any payment without prejudice to its right to decline the request for change. (6) Unless the requested change is specifically allowed under the provisions of the contract, the Company may require satisfactory evidence of insurability before allowing the change. (7) No waiver or modification shall be binding upon 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 omissions or misstatements in this Application could cause an otherwise valid claim to be denied under any contract issued from this Application.

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at ______ (City-State) on ______ , ______ (Date)

X [signature] Signature of Primary Insured (or parent or guardian if Primary Insured is a minor)

X ______ Witness to Signature of Primary Insured

X ______ Signature of Joint Insured or Spouse, if applicable

X ______ Witness to Signature of Joint Insured or Spouse

Signed at ______ (City-State) on ______ , ______ (Date)

X ______ Signature of Owner (if other than Primary Insured)

X ______ Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Primary Insured must sign as Owner, give corporate title and full name of corporation below.

______

______

______

X ______ Signature of Licensed Producer

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

Amount paid with this Application: $ ______ ☐ Check # ______

☐ Credit Card Complete Credit Card Order Confirmation Form.

RESET

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Mailing Address: 4333 Edgewood Road NE
Cedar Rapids, IA 52499

Beneficiary/Additional Insured Information Form

PRIMARY INSURED

1. Last Name | First Name | 2. SS# Last 4 Digits

OWNER - if other than Primary Insured

1. Last Name | First Name | 2. TIN/SS# Last 4 Digits

ADDITIONAL/OTHER PROPOSED INSURED - if applicable

1. Last Name | First Name | M.I.

2. Address (Cannot be a P.O. Box) | City

State | Zip Code | 3. Home Phone | 4. Social Security Number

PRIMARY BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#

CONTINGENT BENEFICIARY - please provide any information not provided in the base application. If more space is needed use an additional form. Must equal 100% or will be divided equally.

Name / Address	DOB	Percent	Relationship	Phone # SSN / Tax ID#

AGENT

☐ I attest that, on behalf of the Company, I requested all information above and the applicant provided the information completed on the form. The applicant was unable/declined to provide any information missing from the form.

Date

Producer or Agent Signature | Owner Signature

ACKNOWLEDGEMENT

I/we, the undersigned, hereby represent that the statements and answers given in the application are true, complete and correctly recorded.

AUTHORIZATION TO OBTAIN INFORMATION

Transamerica Life Insurance Company (the Company)

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 Life Insurance Company, or its reinsurers, any such information. I authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal 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 know that I may request to receive a copy of this Authorization.

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

FRAUD WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at ______________________________ on ______________________, ____________
City-State Date

X ______________________________ X ______________________________
Signature of Primary Insured (or parent or guardian if Primary Insured is a minor) — Witness to Signature of Primary Insured

X ______________________________ X ______________________________
Signature of Joint Insured or Spouse, if applicable — Witness to Signature of Joint Insured or Spouse

Signed at ______________________________ on ______________________, ____________
City-State Date

X ______________________________ X ______________________________
Signature of Owner (if other than Primary Insured) — Witness to Signature of Owner

If Owner is a Corporation, an authorized officer, other than the Primary Insured must sign as Owner, give corporate title and full name of corporation below.

____
____
____

X ______________________________
Signature of Producer

DAVID PAUL DAMMON OR
TERESA L DAMMON
285 CROSS GATE BLVD (985)285-4657
SLIDELL, LA 70461

12-11

1330

14-9/650

Void
Date

Pay to the
Order of Void $ Void

Void Dollars

Photo Safe Deposit®
Details on back

Capital One
Capital One, N.A.

For Void

Void

AUTHORIZED SIGNATURE

MP

⑆065000090⑆562 67 47649⑈ 01330

Harland Clarke

LET FREEDOM RING®

TRANSAMERICA
LIFE INSURANCE COMPANY

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

GA #__________

Change of Plan Option/ Conversion Application

Insured: __________ Owner: __________

Insured's Address: __________ Owner's Address: __________

Social Security No.: __________ TIN or Soc. Sec. No.: __________

Birthdate: __________ Sex: ❑ Male ❑ Female E-mail: (Not for Policy/Billing Notices) __________

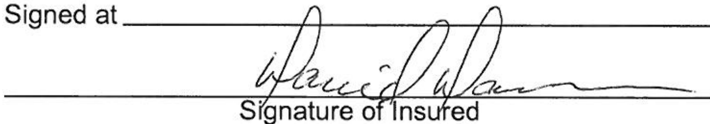
I WISH TO EXCHANGE MY CURRENT POLICY, NUMBER __________, FOR THE FOLLOWING POLICY:

1. Plan Name: __________ Kind Code: __________
2. Face Amount: __________ New Policy Date: __________
3. ❑ Nicotine ❑ Non-Nicotine *(Complete a Nicotine Questionnaire if applicable.)*
4. If the Automatic Premium Loan (APL) provision is available, do you want the provision to be in effect? ❑ Yes ❑ No (APL will be in effect unless no is checked.)
5. Riders to be included:
   - ❑ All riders currently allowed under present policy and available for continuance under new plan of insurance.
   - ❑ Only the following riders: (Specify) __________
   - ❑ Do not carry over any riders or options to the new policy.
6. Complete for Flexible Premium Plans:
   - Required Premium Per Year (RAP) $ __________
   - Planned Periodic Premium $ __________
   - Plus Initial Lump Sum + $ __________
   - Equals Total Initial Payment = $ __________

7. Mode of Premium Payment: ❑ A ❑ S ❑ Q ❑ M
   NOTE: Any premium refund on your current policy will be credited towards the premium due on your new policy.
8. Billing Type: ❑ Direct Collection (Not Available for Monthly)
   ❑ Pre-Authorized Withdrawal (Quarterly or Monthly only)
9. Unless designated otherwise, any new plan shall have the same beneficiary as the present policy. If a different beneficiary designation is desired, complete the following. *(State the full name of the new beneficiary and the beneficiary's relationship to the insured. If more than one beneficiary is designated, then proceeds will be payable equally to the survivors unless otherwise indicated.)*
10. Additional Instructions: __________

The notice and consent provisions of IRC sec. 101(j) may apply. These must be met prior to policy issue for death benefits under policies owned by employers and certain related parties to be tax-free. Consult your tax advisor.

Signed at __________ on __________, _____



Signature of Insured — Signature of Witness

Signature of Owner — Address of Witness

PRODUCER: _____ LAST | _____ FIRST **PRODUCER ID#:** _____ UP TO 10 DIGITS **SHARE %:** _____

PRODUCER: _____ LAST | _____ FIRST **PRODUCER ID#:** _____ UP TO 10 DIGITS **SHARE %:** _____

CASE MANAGER: __________ **E-MAIL:** __________