

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

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

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

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

Owner's Name: _____ Birthdate: _____
If other than Proposed Insured 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"

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 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 _____
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 _____
Witness to all signatures

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



REPORT BY AGENCY OFFICE

DATE: _____

AGENCY NAME: _____ AGENCY CODE: _____ AGENCY CLERK: _____

AGENT 1: _____ | _____ | _____ | _____ | _____ | _____
LAST FIRST GA/SA CODE (4 DIGITS) (6 DIGITS) SHARE %:

Complete the Solicitor information below if Agent is a Firm Name.

SOLICITOR'S NAME AND I.D. NUMBER _____

AGENT 2: _____ | _____ | _____ | _____ | _____ | _____
LAST FIRST GA/SA CODE (4 DIGITS) (6 DIGITS) SHARE %:

Indicate City/County Code as required in Alabama and Kentucky _____

What is the purpose for insurance? _____

How long have you known the Proposed Insured? _____

Proposed Insured is: Single Married Divorced Widowed

Yes No Is this insurance in the category for which commission payment may be restricted under the laws of your state?

Yes No If "Yes", are you qualified to receive commissions?

Yes No To the best of your knowledge could replacement be involved? _____

Signature of Agent

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 on the other side 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.

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IMPORTANT: This Conditional Receipt does not provide any insurance until after its conditions are met.

The payment for premiums is received subject to the following conditions:

- *(A) 1. If all the underwriting requirements by the Company are completed; and
- 2. If the Company at its Home Office 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 class of risk applied for in Part 1 of the application;

Then, but only after these conditions are met, the policy applied for shall be effective from the date of Part 1, the date of Part 2, or the date requested in the application, whichever is the latest, regardless of any change of insurability of each person to be covered occurring after completion of both parts of the application. If less than the full first premium has been paid for such policy, it shall remain in effect only for the fraction of one year that the payment made for such policy bears to the annual premium for such policy.

The Company shall not be required to make insurance effective for an amount which, together with any amount effective in the Company on each person to be covered would exceed the following limits: (a) \$250,000 of life insurance if such person is age 16 through 65 and is insurable as a standard class of risk, or \$100,000 at all other ages and classes of risk; and (b) \$50,000 of benefits for death by accident.

Any insurance applied for as an alternate or additional to the plan and amount of insurance applied for in the application shall not become effective under this conditional receipt.

(B) If the conditions of (A) are met for the insurance applied for in the application, except that if any person to be covered is not insurable under the Company's rules for benefits for disability or accidental death as applied for, the life insurance, and any portion of such benefits for which the Proposed Insured is insurable under the Company's rules, shall be effective as provided in (A).

*Except as provided in this conditional receipt, any policy issued by the Company shall not take effect until after all of the following conditions are met: (a) The full first premium is paid, (b) The Owner has personally received the policy during the lifetime and while the Proposed Insured(s) is (are) in good health, and (c) All of the statements and answers given in this application to the best of my (our) belief must also be true and complete as of the date of the Owner's personal receipt of the policy and that the policy will not take effect if the facts have changed. Neither the agent nor the medical examiner is authorized to accept risks or pass upon insurability, to make or modify contracts, or to waive any of the Company's rights or requirements.

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

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 (617) 426-3660.

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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.