SOUTH DAKOTA APPLICATION PACKET

Helpful Hints: The applicant's signature is required on pages 6, 8 and 12.
The applicant's signature may be required on pages 5, 13, 14 and 15.
Page 5 could require 2 signatures.

Your signature is required on pages 7 and 12. Your signature could be required on page 15 and 16, if applicable.

RETURN ENTIRE APPLICATION PACKAGE

PLEASE RETURN ENTIRE PACKAGE

Application Instruction Sheet

PLEASE RETURN ENTIRE PACKAGE

To help save time in the application process, it is important that the application be filled out completely and accurately. Once the application has been completed, review all answers with the applicant and have the applicant sign where indicated. Your signature is also required on the application and on the personal worksheet. Your signature may be required on the replacement notice, if applicable.

Unless otherwise indicated below, all answers to the questions on the application form must be completed or checked off, both for the affirmative and negative responses. This includes the Rejection of 5% Compound Benefit Increase Option and the Rejection of Nonforfeiture Benefit, if applicable.

BUSINESS INFORMATION – Complete this section of the application to identify the Service Group Name, Service Group Number and who is applying for coverage (an employee, an employee's spouse/partner, or an employee's eligible family member), **if applicable**. This is required to ensure group program discounts are applied and billing is correct.

PERSONAL INFORMATION – If a spouse/partner is also applying, write the Spouse's/Partner's name in the APPLICANT STATUS section where requested [after the box for COUPLE].

CONTACT INFORMATION – Please indicate all contact information, CHECK a preferred method of contact and a best time to contact the applicant. The applicant's street address, city, state and zip code are included in this section.

DRIVER'S LICENSE NO. AND STATE – If an applicant does not have a driver's license, provide his/her Passport No.

SECTION A – This is the only section required for Modified Guarantee Issue (MGI).

SECTION A and B – These two sections are required for Simplified Issue (SI). If any question in Section B 1 – 4 is answered "Yes", the applicant is not eligible for coverage. Please provide physician information. List all medications prescribed or taken within the last 12 months.

SECTION A, B, and C – All sections are required for Full Underwriting.

FULL UNDERWRITING SECTIONS A, B, and C – If any questions in Section B 1 – 4 and/or Section C 1 or 2 are answered "Yes", the applicant is not eligible for coverage.

FULL UNDERWRITING SECTION C – Give details in question 7 for all "Yes" answers to questions 1 – 6 including medication prescribed or taken. Please provide complete physician and medication information.

PLAN SELECTION – Please note if a couple is applying, each must select the same coverage in order to get the maximum couple's discount.

REJECTION OF 5% COMPOUND BENEFIT INCREASE OPTION – If the applicant did not select the 5% Compound Benefit Increase Option, check the box rejecting the 5% Compound Benefit Increase Option. Please note the applicant's **signature** is required in this section if the box is checked.

REJECTION OF NONFORFEITURE BENEFIT – If the applicant did not select the Nonforfeiture Benefit, check the Rejection of Nonforfeiture Benefit box. Please note the applicant's **signature** is required in this section if the box is checked.

OTHER BENEFITS – Check the box next to the rider to be included as selected by the applicant. *Note: If the Shared Care Rider is checked, the Spouse/Partner must also apply for coverage, and the benefits that they select must be identical to the applicant's. The spouse/partner's name must also be completed.*

BENEFICIARY NAME – This section should be completed only if the applicant is applying for the Return of Premium Rider.

PREMIUM PAYMENT – Select the payment method for initial premium payment and recurring payments and check the applicable boxes. Unless premiums will be paid through Payroll Deduction, at least two months premium must be submitted with the application. If premium is submitted with the application, note the amount submitted in the box **Payment w/Application**. This amount should match the amount on the Conditional Receipt [in the Disclosure Package].

FAMILY HISTORY PROFILE – If information is known about the applicant's biological parents, complete this section. If information is not known, check the **Not Applicable** box, if appropriate.

PROTECTION AGAINST UNINTENDED LAPSE – If the applicant wishes to designate a third party to receive a notice if his/her policy is about to lapse, fill in the applicable information. This should probably be someone not living in the house with the applicant. If he/she does not wish to designate a third party, check the applicable box.

AGREEMENT, STATEMENT OF RECEIPT AND APPLICANT'S ACKNOWLEDGEMENT OF SUITABILITY – In this section of the application, the applicant will acknowledge: (1) that they understand that they are applying for an individual policy, (2) that all required disclosure forms have been received, and (3) that you have proposed a plan that is suitable for the applicant's needs. The applicant's **signature**, the **date** and the **place signed [City and State]** are required.

EFFECTIVE DATE – The Effective Date Rules for each worksite group are provided in the worksite Implementation Memo. Coverage is effective the date of the application if not part of a group program.

FOR AGENT/INSURANCE PRODUCER – Complete this part of the application. The Agent/Insurance Producer's writing number provided on this page will be used to process commissions.

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION – Please note the applicant's **signature** is required on the Authorization. Without his/her signature, we cannot proceed with the application process, and the application will be returned to you. Please **date** this form with the date that you complete the application.

LONG-TERM CARE INSURANCE PERSONAL WORKSHEET – The applicant must **sign** and **date** a separate personal worksheet. The Agent/Insurance Producer must sign and date it as well. If the applicant's income is below $30,000 and/or their assets are less than $50,000 we are **required** to send a **Suitability Letter** that must be signed by the applicant and returned to us. If the applicant does not wish to provide any financial information, they can check the applicable box in the **Disclosure Statement** and no Suitability Letter will be mailed. The application cannot be processed until the personal worksheet is completed.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – If the initial premium payment and/or recurring premium payments are to be drafted from the applicant's bank account, complete this form. Please note the applicant's **signature** and the **date** are required on this form, if applicable.

INITIAL CREDIT CARD PAYMENT AUTHORIZATION – If the initial premium payment is to be paid by credit card, this form should be completed. This authorization must be **signed** and **dated** by the Cardholder, if applicable.

NOTICE TO APPLICANT REGARDING REPLACEMENT – If the applicant is replacing coverage, this form should be completed. Please note the applicant's **signature** and the **date** are required on this form, if applicable. Your signature is required as well. Be sure to also complete the same form found in the Disclosure Package and tell the applicant to keep a copy of the form for his/her records.

SUITABILITY OF REPLACEMENT FORM – If the applicant is replacing coverage, this form must be completed. The Agent/Insurance Producer's signature and the date are required on the form, if applicable.

TRANSAMERICA®
LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Administrative Office
P.O. BOX 869090
Plano, TX 75086-9090
1-800-227-3740

Application for Long Term Care Insurance (ABC)

ID Number	Application No. (Home Office Use)
07044001	

APPLICANT INFORMATION - PLEASE PRINT

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade Please provide policy #:_____

BUSINESS INFORMATION (to be completed by the Agent/Insurance Producer)

SERVICE GROUP NAME (includes employers/association):	SERVICE GROUP # (from implementation memo):

☐ Employee: Date of Hire _____ ☐ Employee's Spouse/Partner ☐ Family Member

PERSONAL INFORMATION

First MI Last

Name:

Date of Birth: / /	**State of Birth:**	**Social Security No.:** / /
Sex: ☐ Male ☐ Female	**Height:** _____ Feet _____ Inches	**Weight:** _____ lbs.

APPLICANT STATUS:

☐ COUPLE, and Spouse/Partner is also applying for (or has) Transamerica Life coverage. Spouse's/Partner's name _____

☐ INDIVIDUAL, who is part of a couple, but Spouse/Partner is not applying. Why is Spouse/Partner not applying? _____

☐ INDIVIDUAL who is single, divorced or widowed.

TOBACCO STATUS:

Do you currently use any form of tobacco products? ☐ Yes ☐ No
If no, have you ever used any tobacco products? ☐ Yes ☐ No
If yes, have you used within the last ☐ 2 yrs. ☐ 3 yrs. ☐ 3+ yrs.

CONTACT INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT & COMPLETE PHONE NUMBER AND E-MAIL ADDRESS

☐ Home Phone:	☐ Work Phone:	☐ Cell Phone:
E-Mail Address:	BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.	

ADDRESS/Apt No.: _____ **CITY:** _____

_____ **STATE:** _____ **ZIP:** _____

OCCUPATION, PROFESSION OR BUSINESS (If retired, give year retired and from what occupation)

_____

_____

DRIVER'S LICENSE NO. AND STATE (If applicant does not have a driver's license, please give passport number instead)

☐ Driver's License No.	☐ Passport No.
# _____ State: _____	# _____ State: _____

OTHER INSURANCE INFORMATION

	Yes	No
1. Are you covered by Medicaid (not Medicare)?	☐	☐
2. Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits?	☐	☐

OTHER INSURANCE INFORMATION

	Yes	No
3. In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?	☐	☐

If Yes, give company name, when and why:

_____

_____

_____

_____

	Yes	No
4. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)?	☐	☐
If Yes, please give details in the chart below question 9.		
5. Do you currently have a rider in force that provides long term care benefits attached to a life insurance policy or an annuity contract?	☐	☐
If Yes, please give details in the chart below question 9.		
6. Did you have a long term care insurance policy or certificate in force in the last twelve (12) months?	☐	☐
If Yes, with which company? What is its 'paid to' date? Or if that policy lapsed, when did it lapse? Please provide details in the chart below question 9.		
7. Have you currently applied for, or do you intend to apply for any other long term care insurance?	☐	☐
If Yes, please provide details in the chart below question 9.		
8. Do you intend to replace any in force medical or long term care insurance with this policy?	☐	☐
If Yes, please provide details in the chart below question 9 and complete the required replacement form.		
9. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse?	☐	☐
If Yes, please provide details below.		

Name	Name of Company	Company Address	Policy #	Type of Plan	Paid to Date /Lapse Date

☐ Check here if more space is needed, attach a signed and dated additional sheet.

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A Only.
SIMPLIFIED ISSUE – Answer Questions in SECTIONS A & B.
FULL UNDERWRITING – Answer Questions in SECTIONS A, B & C.

A

	Yes	No
1. During the last 6 MONTHS, with the exception of vacation, have you been continuously and actively working for your current employer for a minimum of 30 hours per week? If NO, please give the number of hours you work per week. _____ hrs.	☐	☐
2. During the last 6 MONTHS, have you missed more than 5 consecutive days of work due to accidents, injury, sickness, or any physical or cognitive impairment?	☐	☐
3. During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting?	☐	☐

Please provide details if question 1 is answered 'NO' or if question 2 or 3 are answered 'YES'.

_____

_____

_____

_____

_____

If any question B 1-4 is answered Yes, You are not eligible for coverage.

B

	Yes	No
1. Have you EVER had, or been diagnosed or treated by a member of the medical profession, or had symptoms of any of the following conditions?	☐	☐

If Yes, please check the applicable condition(s):

- ☐ AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV
- ☐ Alzheimer's disease or Dementia
- ☐ Amputation due to disease
- ☐ ALS (Lou Gehrig's disease)
- ☐ Arthritis with narcotic pain medication
- ☐ Multiple Strokes/CVA's/TIA's*
- ☐ Organ Transplant (other than Corneal)
- ☐ Multiple Sclerosis
- ☐ Huntington's Chorea
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Organic Brain Syndrome
- ☐ Osteoporosis with fractures
- ☐ Parkinson's disease
- ☐ Polymyositis
- ☐ Scleroderma
- ☐ Memory loss
- ☐ Unplanned weight loss greater than 15 pounds within the last 2 years
- ☐ Polycystic Kidney Disease

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete Sections B & C.

	Yes	No
2. During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), alcohol abuse, drug or prescription drug addiction?	☐	☐
3. During the last 12 MONTHS:		
• Have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?	☐	☐
• Have you been advised to enter, do you reside in or are you confined to a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), rehabilitation facility, attended an adult day care facility, or required home health care?	☐	☐
4. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease?	☐	☐

PRIMARY PHYSICIAN'S NAME:	**TELEPHONE NUMBER:**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE LAST CONSULTED:	**YOUR HEALTH INSURANCE OR PPO MEDICAL ID#**(if known):

B

REASON LAST SEEN: _____

_____

_____

_____

_____

List All Medications Prescribed Or Taken Within The Last 12 Months

_____

_____

_____

_____

_____

_____

_____

If question C 1 or 2 is answered Yes, You are not eligible for coverage. For any other Yes answer, check the applicable box & provide details in question 7.

C

	Yes	No
1. In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?	☐	☐
2. Within the last 3 MONTHS, have you had:		
• Heart Attack (MI) or Chest Pain	☐	☐
• Uncontrolled Blood Pressure	☐	☐
• Cancer	☐	☐
• Hip or Back Surgery	☐	☐

Please answer each question in number 3 below by checking Yes or No. Each condition should have a separate answer.

3. In the last 5 YEARS, have you been diagnosed by or received treatment from a member of the medical profession for, or had symptoms of:

Y	N		Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Cardiomyopathy	☐	☐	Epilepsy
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Peripheral Vascular Disease	☐	☐	COPD
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Congestive Heart Failure (CHF)	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Thyroid disease	☐	☐	Stroke	☐	☐	Dizziness
☐	☐	Anemia	☐	☐	Aneurysm	☐	☐	Disorientation
☐	☐	Macular Degeneration	☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Emphysema
☐	☐	Arthritis	☐	☐	Irregular Heartbeat	☐	☐	Paralysis
☐	☐	Rheumatoid Arthritis	☐	☐	Carotid Artery Stenosis	☐	☐	Fainting
☐	☐	Osteoporosis	☐	☐	Transient Ischemic Attack (TIA)	☐	☐	Falls
☐	☐	Fractures	☐	☐	Mental or Cognitive Disorder including Memory Loss	☐	☐	Blurred Vision
☐	☐	Fibromyalgia	☐	☐	Heart Surgery	☐	☐	Loss of Balance
☐	☐	Heart Attack	☐	☐	Confusion	☐	☐	Loss of Strength
☐	☐	Joint Replacement	☐	☐	Asthma	☐	☐	Convulsions
☐	☐	Used a Straight Cane	☐	☐	Mental Retardation	☐	☐	Diabetes
☐	☐	Chest Pain	☐	☐	Depression	☐	☐	Ulcerative Colitis
☐	☐	High Blood Pressure				☐	☐	Crohn's Disease
☐	☐	Heart Murmur				☐	☐	Chronic Hepatitis
☐	☐	Heart Disease				☐	☐	Cirrhosis
						☐	☐	Sarcoidosis
						☐	☐	Systemic Lupus (SLE)

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Pancreas	☐	☐	Lungs
☐	☐	Liver	☐	☐	Bone and Joint			
☐	☐	Small or Large Intestine	☐	☐	Gastrointestinal Tract			

	Yes	No
4. Do you have a handicap sticker, handicap placard, or handicap license plate?	☐	☐
5. In the last 24 MONTHS, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?	☐	☐
6. In the last 12 MONTHS, have you had unplanned weight loss; or has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed?	☐	☐

7. **Give details for all Yes answers to C 1 - 6.**

☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

PLAN SELECTION

Rate Class Applying For:

☐ Preferred ☐ Standard ☐ Class 1 ☐ Class 2

Type of Policy: ☐ Partnership Policy ☐ Non-Partnership Policy

Daily Benefit: Facility/Home Care $_____

Policy Maximum Amount: $_____

Elimination Period: ☐ 0 ☐ 30 ☐ 60 ☐ 90 Days

Benefit Increase Option: ☐ Compound 5%

☐ Deferred ☐ Tailored ☐ Compound 3%

If not selecting the 5% Compound Benefit Increase Option, you must check and sign the Rejection of 5% Compound Benefit Increase Option statement below.

☐ **Rejection of 5% Compound Benefit Increase Option:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of my coverage with and without inflation protection. Specifically, I have reviewed the features of the 5% Compound Benefit Increase Option and I reject the option.

Signature:_____

Nonforfeiture Benefit:

☐ Shortened Benefit Period

If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture Benefit statement below.

☐ **Rejection of Nonforfeiture Benefit:** I understand that if I fail to pay my premium when due or prior to the end of the grace period, my policy will lapse and I will not be eligible for any future benefits because I have chosen not to purchase the Nonforfeiture Benefit. Nevertheless, I reject the option.

Signature:_____

Other Benefits:

☐ Shared Care Rider –
Spouse/Partner's name: _____

☐ Full Restoration of Benefits Rider

☐ Monthly Benefit Rider

☐ Return of Premium Rider

☐ Joint Waiver of Premium Rider

☐ Rate Guarantee _____ years

BENEFICIARY NAME:	**RELATIONSHIP:**

ADDRESS (Street, City, State, Zip Code)

PREMIUM PAYMENT (total premium cost may vary depending on mode of payment selected)

Initial Premium Payment:

☐ Check ☐ EFT ☐ Credit Card

Premium Payment Mode:

☐ Annual ☐ Semi-Annual ☐ Quarterly

☐ Monthly (available only with EFT and List Bill)

Recurring Payment Method:

☐ Direct Bill ☐ List Bill ☐ EFT

☐ Payroll Deduction

Premium Paying Period:

☐ Lifetime

Annual Premium:	Mode Premium:	Payment w/Application:
$	$	$

FAMILY HISTORY PROFILE – Please answer with biological parent information, if known

Father: Age: _____ ☐ Not Applicable
☐ Living ☐ Deceased Age at Death: _____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 - 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 - 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 - 64 ☐ 65 or older

Mother: Age: _____ ☐ Not Applicable
☐ Living ☐ Deceased Age at Death: _____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 - 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 - 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 - 64 ☐ 65 or older

PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

AGREEMENT: I understand that I am applying for an individual long term care insurance policy and not for coverage under a group policy. I understand and agree that no agent/insurance producer or other person except an officer of Transamerica Life Insurance Company has the authority to alter or waive any of the above conditions or any questions in the application, or to determine insurability. I understand and agree that the policy will not take effect unless it is issued by the company.

STATEMENT OF RECEIPT: I certify that I have received the Outline of Coverage, "A Shopper's Guide to Long Term Care Insurance," HIPAA Privacy Notice, the Potential Rate Increase disclosure form, South Dakota Senior Health Information and Insurance Education Notice, "Things You Should Know Before You Buy Long Term Care Insurance," the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

APPLICANT'S ACKNOWLEDGMENT OF SUITABILITY: I acknowledge that the agent/insurance producer identified in this application made the necessary inquiries concerning my insurance needs, and proposed a program of insurance that is suitable for my needs.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY, SUBJECT TO THE TIME LIMIT ON CERTAIN DEFENSES PROVISION IN THE POLICY.

ACKNOWLEDGEMENT: I, the undersigned applicant, acknowledge and represent that I have read, or had read to me, the complete application. I, the applicant, represent to the best of my knowledge and belief, that I am competent and the answers contained in this application are true, complete and correctly recorded. This application will be part of the policy for which I am applying.

Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive information or statements is guilty of insurance fraud.

SIGNATURE:

X

DATE

PLACE SIGNED (City/State)

EFFECTIVE DATE (if not date of application)

SPECIAL INSTRUCTIONS: _____

_____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGEMENT OF COMPLIANCE: I certify that I personally discussed with the applicant and followed the Company's written guidelines provided to me concerning comparisons of coverage and suitability in the marketing of this insurance coverage. I also certify, to the best of my knowledge and belief, that the answers contained in this application are true, complete, and correctly recorded.

AGENT/INSURANCE PRODUCER'S SIGNATURE x	**AGENT INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE x	**AGENT INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE x	**AGENT INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE x	**AGENT INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

FOR THE AGENT/INSURANCE PRODUCER

Yes No

1. Did you interview the applicant in person, ask all questions, and witness signatures? ☐ ☐
   If No, please give details: ____________________
2. Did you see, hear, or were you advised of any physical or cognitive impairments of the applicant including but not limited to walking, speaking, any form of tremor, or any signs of confusion? ☐ ☐
   If Yes, please give details: ____________________
3. To the best of your knowledge, is the information provided in this application true and complete? ☐ ☐

LIST ANY OTHER HEALTH INSURANCE POLICIES YOU HAVE SOLD TO THE APPLICANT

(1) List policies sold that are still in force; and

(2) List policies sold within the last five (5) years that are no longer in force.

COMPANY	POLICY #	TYPE OF COVERAGE	IN FORCE	LAPSE DATE
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This HIPAA authorization must be fully completed and signed as a condition of applying for insurance with Transamerica Life Insurance Company ("Transamerica"). Your application will not be accepted without a signed authorization. It is an act of fraud to intentionally withhold, or cause to be withheld, medical records or other health information material to the underwriting of an application for coverage.

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

(1) **Person(s) or group(s) of persons authorized to use or disclose the information:** Any physicians, medical practitioners, hospitals, clinics, laboratories, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies (including Transamerica), and insurance support organizations such as the MIB.

(2) **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** Transamerica and its authorized representatives, including affiliates, agents, business associates and insurance support organizations and/or any entity or individual, including my employer if applicable, who is designated as the owner of the policy for which I have applied.

(3) **Description of the information that may be used or disclosed:** This authorization specifically includes the release of ***all information related to my health*** (except psychotherapy notes) *and my insurance policies and claims*, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as AIDS.

(4) **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my application for long term care insurance with Transamerica, including providing a brief report of my personal health information to MIB, and, if a policy is issued, for evaluating contestability and eligibility for benefits and for the continuation or replacement of the policy. As applicable, in connection with the rights of any policyowner as it relates to the ownership of the policy for which I have applied.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to Transamerica is protected by federal privacy regulations and that Transamerica will only use and disclose such information as described in its Notice of Health Information Privacy Practices. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations, the disclosed information may no longer be protected by those regulations.

- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides Transamerica with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Transamerica Life Insurance Company, Underwriting Supervisor, P.O. Box 869090, Plano, TX 75086-9090. 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.

- I understand that I am entitled to receive a copy of this signed authorization.

- This authorization will expire 24 months from the date signed.

Applicant's Name: _____

Applicant's Signature: _____ Date Signed: _____

(Company Copy) A copy of this authorization will be considered as valid as the original.

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TRANSAMERICA®
LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Administrative Office
P.O. Box 869090
Plano, Texas 75086-9090
1-800-227-3740

Long-Term Care Insurance
Personal Worksheet

This worksheet will help you understand some important information about this type of insurance. State law requires companies issuing this policy to **give** you some important facts about premiums and premium increases and to **ask** you some important questions to help you and the company decide if you should buy this policy. Long-term care insurance can be expensive and it may not be right for everyone.

Premium Information

Policy Form Number TLC 2-P SD 0410

The premium for the coverage you are considering will be $_____per_____

or a total of $_____ per year.

The premium quoted in this worksheet is not guaranteed and may change during the underwriting process and in the future while this policy is in force.

Type of Policy & The Company's Right to Increase Premiums on the Coverage You Choose:

Guaranteed renewable - The company **can** increase your premiums on this policy in the future if it increases the premiums for all policies like yours in this state.

Premium Increase History

Through various related companies the Company has sold long-term care insurance since 1987 and has sold this policy since 2011.

The company has increased its premiums on similar policies in the last 10 years. A summary of those premium increases follows.

Policy Form Series	Years Available	Rate History
3132 (00) 288, 6122 (00) 688, GLTC 2 1289, LTC 2 390, GLTC 3 1091, LTC 3 1091, IP-70-00-794, LTC 5 196, FLEX 2 196	1988 - 2001	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.
GCC 1 387 CERT, LTC5 TQ 1096, FTQ 197	1987 - 2001	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.

LTCP 889, GCPLUS 1290 and GCPLUS 2 1290, GCPRO 193	1990 - 2001	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.
KLTCP 1 490, LI-LTCP 192, GCPRO-II 794	1990 - 2001	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.
LI-LTCP TQ 197, GCPRO-III TQ 197, LI-LTCP TQ 898, GC001 796	1996 - 2003	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.
1-811 11-190; 1-820 11-191 and 1-822 11-191; LTC-100 11-193; LTC 104-194	1991 - 1999	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.
LTC 124-197; LTC 304-198 and LTC 305-198	1997 - 2004	Varies by state, but the largest increases in any state were 25% in 2009, 25% in 2010, 25% in 2012, 17% in 2013 and 60% in 2017.
LI-FP 1102, TLC 1-FP 1102, TOL 1-FP 1102 and TLC 1-FP 1107	2002 – 2012	43%-65% in 2017

Questions About Your Income

You do **not** have to answer the questions that follow. They are intended to make sure you have thought about how you'll pay premiums and the cost of care your insurance does not cover. If you do not want to answer these questions, you should understand that the company might refuse to insure you.

What resources will you use to pay your premium?

❑ Current income from employment ❑ Current income from investments
❑ Other current income ❑ Savings ❑ Sell investments
❑ Sell other assets ❑ Money from my family
❑ Other _____

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Could you afford to keep this policy if your spouse or partner dies first?

❑ Yes ❑ No ❑ Had not thought about it ❑ Do not know ❑ Does not apply

What would you do if the premiums went up, for example, by 50%?

❑ Pay the higher premium ❑ Call the company/agent ❑ Reduce benefits
❑ Drop the **policy** ❑ Do not know

What is your household annual income from all sources? (check one)

❑ Under $10,000 ❑ $10,000-19,999 ❑ $20,000-29,999 ❑ $30,000-50,000 ❑ Over $50,000

Do you expect your income to change over the next 10 years? (check one)

❑ No ❑ Yes, expect increase ❑ Yes, expect decrease

If you plan to pay premiums from your income, have you thought about how a change in your income would affect your ability to continue to pay the premium?

❑ Yes ❑ No ❑ Do not know

Will you buy inflation protection? (check one)

❑ Yes ❑ No

Inflation may increase the cost of long-term care in the future.

If you do not buy inflation protection, how will you pay for the difference between future costs and your daily benefit amount?

❑ From my income ❑ From savings ❑ From investments ❑ Sell other assets
❑ Money from my family ❑ Other_____

The national average annual cost of long-term care in 2017 was $85,776, but this figure varies across the country. In ten years the national average annual cost would be about $ 139,720 if costs increase 5% annually.

What elimination period are you considering?

Number of days _____ in elimination period
Approximate cost of care for this period: $_____

($xxx per day times number of days in elimination period, where "xxx" represents the most recent estimate of the national daily average cost of long-term care)

How do you plan to pay for your care during the elimination period? (check all that apply)

❑ From my income ❑ From savings/investments ❑ My family will pay

Questions About Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20,000-$29,999 ❑ $30,000-$49,999 ❑ Over $50,000

Do you expect the value of your assets to change over the next ten years? (check one)

❑ No ❑ Yes, expect increase ❑ Yes, expect decrease

If you're buying this policy to protect your assets and your assets are less than $50,000, experts suggest you think about other ways to pay for your long-term care.

Disclosure Statement

❑ The answers to the questions above describe my financial situation. Or ❑ I choose not to complete this information. (Check one.)
❑ I agree that the company and/or its agent (below) has reviewed this worksheet with me including the premium, premium increase history and potential for premium increases in the future. I understand the information contained in this worksheet. (This box must be checked.)

Signed: _____
(Applicant) (Date)

❑ I explained to the applicant the importance of answering these questions.

Signed: _____
(Agent) (Date)

Agent's Printed Name: _____

In order for us to process your application, please return this signed worksheet to Transamerica Life Insurance Company, along with your application.

My agent has advised me that this long-term care insurance policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____
(Applicant) (Date)

Someone from the company may contact you to discuss your answers and the suitability of this policy for you.

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ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I, the undersigned, hereby authorize and request Transamerica Life Insurance Company to initiate electronic debit entries or effect a charge by any other commercially accepted practice to my account identified by the information provided below for premiums and other such payments that may become due in any amount under this policy. I request that this EFT Authorization, unless previously revoked, continue to apply to any conversion, renewal, or change later made in the policy. I agree that this EFT Authorization in no way affects the terms of the policy, other than the mode of payment and I 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, if any. No debit, check or other charge shall constitute payment until the Company actually receives payment from the financial institution within the period provided in the policy. This EFT Authorization may be terminated by either party by giving written notice to the other.

INITIAL PREMIUM PAYMENT

☐ **AUTOMATIC WITHDRAWAL:** By checking this box, I authorize Transamerica Life Insurance Company to withdraw from my account listed below, the amount indicated as the Initial Premium Payment with Application. **The Initial Premium Payment will be processed automatically on receipt of the application for insurance**. Also, at my request, I authorize an additional debit to my account for the balance of any initial premium, up to and including the balance due of the selected premium payment mode that is outstanding at the time the policy is issued.

I understand that completion of the EFT Authorization does not guarantee or otherwise indicate that any insurance coverage is in force and that any insurance coverage applied for becomes effective only as stated in the application for insurance, the Conditional Receipt or the insurance contract.

ACCOUNT INFORMATION

_____
Bank Name, Office, or Branch

_____
Bank Address City State Zip Code

_____ Check one: ☐ Checking ☐ Savings
Payor Name

_____ _____
Transit Routing Number Account Number

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

☐ Monthly
☐ Quarterly
☐ Semi-Annual
☐ Annual

☐ Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)
☐ Withdraw on a different day of the month; choose a day between 1 and 28 _____

SIGNATURE

Payor Signature – as on financial institution's records. A copy is as valid as the original.

X_____ **Date:** _____

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Plano, TX 75086-9090
1-800-227-3740
LTCQuestions@Transamerica.com

INITIAL CREDIT CARD PAYMENT AUTHORIZATION
For LONG TERM CARE INSURANCE

APPLICANT NAME:_____

POLICY NUMBER (if known):_____

Authorization Agreement for Credit Card Payment

I, hereby authorize Transamerica Life Insurance Company to charge my credit card, as indicated below for the amount indicated as the Initial Premium Payment with Application. The Initial Premium Payment will be processed automatically on receipt of the application for insurance. Also, at my request, I authorize an additional credit card charge for the balance of any initial premium, up to and including the balance of the annual premium due that is outstanding at the time the policy is issued.

I understand that completion of this Initial Credit Card Payment Authorization does not guarantee or otherwise indicate that any insurance coverage is in force and that any insurance coverage applied for becomes effective only as stated in the application for insurance, the Conditional Receipt or the insurance contract.

This Initial Credit Card Payment Authorization remains valid until the earlier of the final credit card processing date or such time as I provide written notice to terminate this authorization to Transamerica Life Insurance Company, at the address stated on this form or the policy, at least 30 days in advance of the intended termination date. I agree to contact Transamerica Life Insurance Company if there are any changes to the credit card account information indicated below.

Transamerica Life Insurance Company reserves the right to terminate this method of payment at any time.

SELECTED CREDIT CARD: ☐ **Discover** ☐ **Visa** ☐ **Master Card** ☐ **American Express**

CREDIT CARD #:_____

EXPIRATION DATE:_____
(MM/YYYY)

The complete credit card number and expiration date must be included to process any payment.

Cardholder Information (exactly as shown on card or bill):

CARDHOLDER NAME:_____

BILLING ADDRESS:_____

_____

CARDHOLDER PHONE:_____

X _____ _____
CARDHOLDER SIGNATURE **DATE**

FAX THIS COMPLETED FORM TO: 833-200-4102

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy to be issued by Transamerica Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new policy carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long-term care insurance policy is a wise decision.

STATEMENT TO THE APPLICANT BY AGENT/INSURANCE PRODUCER, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original coverage.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent/insurance producer regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present coverage and replace it with this new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

_____ _____

Signature of Agent/Insurance Producer, Broker or Other Representative

_____

Type or print Name & Address of Agent/Insurance Producer, Broker or Other Representative

_____ _____

Applicant's Signature

The "Notice to Applicant" was delivered to me on the above date

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Long Term Care Administrative Office
P.O. Box 869090
Plano, Texas 75086-9090
1-800-227-3740

SUITABILITY OF REPLACEMENT FORM

Applicant's Name: _____

It is the intention of this Applicant that this application for a new policy will replace a policy or certificate issued by _____.

The new Transamerica Life Insurance Company policy is substantially better for the following reasons (**at least one box must be checked**):

- ☐ Provides for no preexisting conditions limitation or waiting period
- ☐ Adds a benefit increase option
- ☐ Adds home health care benefits
- ☐ Adds assisted living facility coverage
- ☐ Increases the policy's lifetime maximum amount
- ☐ Increases the policy's daily benefit amount(s)
- ☐ Provides a Cash Benefit
- ☐ Provides Care Coordination benefits
- ☐ Provides more flexible benefits by integrating facility and home care coverage
- ☐ Is a DRA Partnership-qualified policy
- ☐ Other (**must provide details**)_____
  _____

Based on this information, I believe the benefits of the new policy are substantially greater for the Applicant.

_____ _____
Agent's/Insurance Producer's Signature Date Signed

_____ _____
Agent's/Insurance Producer's Printed Name Agent/Insurance Producer Number