



NEW YORK APPLICATION PACKET

Helpful Hints: The applicant's signature is required on pages 6, 8 and 10
The applicant's signature may be required on pages 5, 11
and 12
Page 5 could require 2 signatures

Your signature is required on pages 7 and 10. Your
signature could be required on page 12, 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.

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.

FULL UNDERWRITING SECTION – If any question 1 – 8 is answered "Yes", the applicant is not eligible for coverage. Give details to any "Yes" answer in question 13. Please provide physician information. List all medications prescribed or taken within the last 12 months.

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. Note that 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 – Coverage is effective the date of the application.

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 – Answer all questions. The applicant must **sign** and **date** the personal worksheet. You must sign and date it as well. If the applicant does not wish to complete this information, check the applicable box and have the applicant sign and date the personal worksheet. The application cannot be processed until this 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.

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.

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: | <input type="checkbox"/> | <input type="checkbox"/> |
| <hr/> <hr/> <hr/> | | |
| 4. Do you currently have any long term care, nursing home or home health 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? And if that policy lapsed, when did it lapse? Please provide details in the chart below question 9. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 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. | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse?.....
If Yes, please provide details below. | <input type="checkbox"/> | <input type="checkbox"/> |

Name	Name of Company	Company Address	Policy #	Type of Plan	Lapse Date

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

FULL UNDERWRITING - Please check Yes or No. If Yes, give details in question 13. If any question 1-8 is answered Yes, You are not eligible for coverage.

- | | 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): | <input type="checkbox"/> | <input type="checkbox"/> | | |
| <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Alzheimer's disease or Dementia
 <input type="checkbox"/> Amputation due to disease
 <input type="checkbox"/> ALS (Lou Gehrig's disease)
 <input type="checkbox"/> Arthritis with narcotic pain medication
 <input type="checkbox"/> Multiple Strokes/CVA's/TIA's*
 <input type="checkbox"/> Organ Transplant (other than Corneal)
 <input type="checkbox"/> Multiple Sclerosis
 <input type="checkbox"/> Huntington's Chorea
 <input type="checkbox"/> Muscular Dystrophy </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Myasthenia Gravis
 <input type="checkbox"/> Organic Brain Syndrome
 <input type="checkbox"/> Osteoporosis with fractures
 <input type="checkbox"/> Parkinson's disease
 <input type="checkbox"/> Polymyositis
 <input type="checkbox"/> Scleroderma
 <input type="checkbox"/> Memory loss
 <input type="checkbox"/> Unplanned weight loss greater than 15 pounds within last 2 years
 <input type="checkbox"/> Polycystic Kidney Disease </td> </tr> </table> | <input type="checkbox"/> Alzheimer's disease or Dementia
<input type="checkbox"/> Amputation due to disease
<input type="checkbox"/> ALS (Lou Gehrig's disease)
<input type="checkbox"/> Arthritis with narcotic pain medication
<input type="checkbox"/> Multiple Strokes/CVA's/TIA's*
<input type="checkbox"/> Organ Transplant (other than Corneal)
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Huntington's Chorea
<input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis
<input type="checkbox"/> Organic Brain Syndrome
<input type="checkbox"/> Osteoporosis with fractures
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Polymyositis
<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Unplanned weight loss greater than 15 pounds within last 2 years
<input type="checkbox"/> Polycystic Kidney Disease | | |
| <input type="checkbox"/> Alzheimer's disease or Dementia
<input type="checkbox"/> Amputation due to disease
<input type="checkbox"/> ALS (Lou Gehrig's disease)
<input type="checkbox"/> Arthritis with narcotic pain medication
<input type="checkbox"/> Multiple Strokes/CVA's/TIA's*
<input type="checkbox"/> Organ Transplant (other than Corneal)
<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Huntington's Chorea
<input type="checkbox"/> Muscular Dystrophy | <input type="checkbox"/> Myasthenia Gravis
<input type="checkbox"/> Organic Brain Syndrome
<input type="checkbox"/> Osteoporosis with fractures
<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Polymyositis
<input type="checkbox"/> Scleroderma
<input type="checkbox"/> Memory loss
<input type="checkbox"/> Unplanned weight loss greater than 15 pounds within last 2 years
<input type="checkbox"/> Polycystic Kidney Disease | | | |

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete rest of application.

Yes No

- 2. Have you ever been diagnosed by a member of the medical profession as having AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-Related Complex)?..... Yes No
- 3. 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?..... Yes No
- 4. 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?..... Yes No
- 5. During the last 12 MONTHS, 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?..... Yes No
- 6. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease? Yes No
- 7. In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?..... Yes No
- 8. Within the last 3 MONTHS, have you had:
 - Heart Attack (MI) or Chest Pain..... Yes No
 - Uncontrolled Blood Pressure..... Yes No
 - Cancer..... Yes No
 - Hip or Back Surgery..... Yes No

Please answer each question in number 9 below by checking Yes or No. Each condition should have a separate answer.

9. 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
<input type="checkbox"/> <input type="checkbox"/> Cancer or Any Kind of Tumor	<input type="checkbox"/> <input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> <input type="checkbox"/> COPD
<input type="checkbox"/> <input type="checkbox"/> Chronic Lymphocytic Leukemia	<input type="checkbox"/> <input type="checkbox"/> Peripheral Vascular Disease	<input type="checkbox"/> <input type="checkbox"/> COPD (Emphysema) with Oxygen Use
<input type="checkbox"/> <input type="checkbox"/> Any Disorder or Disease of the Blood	<input type="checkbox"/> <input type="checkbox"/> Congestive Heart Failure (CHF)	<input type="checkbox"/> <input type="checkbox"/> Dizziness
<input type="checkbox"/> <input type="checkbox"/> Thyroid disease	<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Disorientation
<input type="checkbox"/> <input type="checkbox"/> Anemia	<input type="checkbox"/> <input type="checkbox"/> Aneurysm	<input type="checkbox"/> <input type="checkbox"/> Emphysema
<input type="checkbox"/> <input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> <input type="checkbox"/> Cerebrovascular Accident (CVA)	<input type="checkbox"/> <input type="checkbox"/> Paralysis
<input type="checkbox"/> <input type="checkbox"/> Arthritis	<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Fainting
<input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> <input type="checkbox"/> Carotid Artery Stenosis	<input type="checkbox"/> <input type="checkbox"/> Falls
<input type="checkbox"/> <input type="checkbox"/> Osteoporosis	<input type="checkbox"/> <input type="checkbox"/> Transient Ischemic Attack (TIA)	<input type="checkbox"/> <input type="checkbox"/> Blurred Vision
<input type="checkbox"/> <input type="checkbox"/> Fractures	<input type="checkbox"/> <input type="checkbox"/> Mental or Cognitive Disorder including Memory Loss	<input type="checkbox"/> <input type="checkbox"/> Loss of Balance
<input type="checkbox"/> <input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> <input type="checkbox"/> Heart Surgery	<input type="checkbox"/> <input type="checkbox"/> Loss of Strength
<input type="checkbox"/> <input type="checkbox"/> Heart Attack	<input type="checkbox"/> <input type="checkbox"/> Confusion	<input type="checkbox"/> <input type="checkbox"/> Convulsions
<input type="checkbox"/> <input type="checkbox"/> Joint Replacement	<input type="checkbox"/> <input type="checkbox"/> Asthma	<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Used a Straight Cane	<input type="checkbox"/> <input type="checkbox"/> Mental Retardation	<input type="checkbox"/> <input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> <input type="checkbox"/> Chest Pain	<input type="checkbox"/> <input type="checkbox"/> Depression	<input type="checkbox"/> <input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Epilepsy	<input type="checkbox"/> <input type="checkbox"/> Chronic Hepatitis
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur		<input type="checkbox"/> <input type="checkbox"/> Cirrhosis
<input type="checkbox"/> <input type="checkbox"/> Heart Disease		<input type="checkbox"/> <input type="checkbox"/> Sarcoidosis
<hr/>		
Any Disease or Disorder of the:		
<input type="checkbox"/> <input type="checkbox"/> Kidney	<input type="checkbox"/> <input type="checkbox"/> Pancreas	<input type="checkbox"/> <input type="checkbox"/> Lungs
<input type="checkbox"/> <input type="checkbox"/> Liver	<input type="checkbox"/> <input type="checkbox"/> Bone and Joint	
<input type="checkbox"/> <input type="checkbox"/> Small or Large Intestine	<input type="checkbox"/> <input type="checkbox"/> Gastrointestinal Tract	

- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| 10. Do you have a handicap sticker, handicap placard, or handicap license plate?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. 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?..... | <input type="checkbox"/> | <input type="checkbox"/> |

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

ADDRESS: _____

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

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

List All Medications Prescribed Or Taken Within The Last 12 Months

13. Give details for all Yes answers to questions 1 - 12.

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 Class 3 Class 4

Daily Benefit: Must be at least \$100 Facility/Home Care \$_____

Policy Maximum Amount: \$_____

Elimination Period: 0 30 60 90 180 Days

Benefit Increase Option: Compound 5%

Compound 3% Step Rated 3% Step Rated 5% Deferred

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: _____

Return of Premium Rider

Joint Waiver of Premium Rider

Full Restoration of Benefits Rider

Monthly Benefit Rider

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

Premium Payment Mode:

Annual

Semi-Annual

Quarterly

Monthly (available only with EFT)

Recurring Payment Method:

Direct Bill

EFT

Premium Paying Period:

Lifetime

10 years

Paid-Up to Age 65

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

Mother: 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

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.
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ADDRESS

CITY	STATE	ZIP
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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 Financial 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 Disclosure Statement, “A Shopper’s Guide to Long Term Care Insurance,” HIPAA Privacy 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 FAIL TO INCLUDE ALL MATERIAL MEDICAL INFORMATION REQUESTED, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY.

ACKNOWLEDGMENT: 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 willing and with intent to defraud an insurance company or other person, files an application for insurance or statement of claim which contains any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars (\$5,000) and the stated value of the claim for each violation.

SIGNATURE: X	DATE
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PLACE SIGNED (City/State)

EFFECTIVE DATE (if not date of application)

SPECIAL INSTRUCTIONS: _____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGMENT 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.

In addition, I have reviewed the current accident and health insurance coverage of the applicant and find that the indicated replacement or additional coverage of the type and amount applied for is appropriate for the applicant's needs.

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?.....	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
If Yes, please give details: _____		
3. To the best of your knowledge, is the information provided in this application true and complete?.....	<input type="checkbox"/>	<input type="checkbox"/>

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
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> 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 Financial 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 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 Financial Life Insurance Company, Underwriting Supervisor, P.O. Box 93003, Hurst, TX 76053. 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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Home Office:
440 Mamaroneck Ave
Harrison, NY 10528
A Stock Company

Long Term Care Division
Administrative Office
Mailing Address:
P.O. Box 93003, Hurst, TX 76053
Telephone: 1-866-655-4422

Long-Term Care Insurance Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be \$_____ per _____.

Type of Policy (noncancellable/guaranteed renewable): Guaranteed Renewable

The Company's Right to Increase Premiums: The Company has a right to increase your premiums on this policy form in the future, provided that it raises rates for all policies in the same class in this state. The Company has sold long term care insurance since 2001 and has sold this policy since 2011. Transamerica Financial Life Insurance Company has not had a rate increase on any of its policy forms.

Questions Related to Your Income

How will you pay each year's premium?

- From my Income From my Savings\Investments My Family will Pay

Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one)

- Under \$10,000 \$10-20,000 \$20-30,000 \$30-50,000 Over \$50,000

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

- No change Increase Decrease

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.

Will you buy inflation protection? (check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

- From my Income From my Savings\Investments My Family will Pay

The national average annual cost of care in 2008 was \$68,255, but this figure varies across the country. In ten years the national average annual cost would be about \$111,180 if costs increase 5% annually.

What elimination period are you considering?

Number of days _____ Approximate cost \$ _____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

- From my Income From my Savings\Investments My Family will Pay

Questions Related to 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-\$30,000 \$30,000-\$50,000 Over \$50,000

How do you expect your assets to change over the next ten years? (check one)

- Stay about the same Increase Decrease

If you are buying this policy to protect your assets and your assets are less than \$30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

The answers to the questions above describe my financial situation.
OR

I choose not to complete this information, but I do wish to purchase this coverage.
(Check one.)

I acknowledge that the carrier and/or its agent/insurance producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed: _____
(Applicant) (Date)

I explained to the applicant the importance of completing this information.

Signed: _____
(Agent/Insurance Producer) (Date)

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

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

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

Signed: _____
(Applicant) (Date)

The company may contact you to verify your answers.



Home Office: 440 Mamaroneck Ave
 Harrison, NY 10528
 A Stock Company

Long Term Care Division
 Administration Office
 Mailing Address: P.O. Box 93003,
 Hurst, TX 76053
 Telephone: 1-866-655-4422

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION

I, the undersigned, hereby authorize and request Transamerica Financial 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 Financial 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 _____

Payor Name _____ Check one: Checking Savings

Transit Routing Number _____ Account Number _____

COMPLETE THE FOLLOWING INFORMATION FOR FUTURE RECURRING PAYMENTS

Monthly Withdraw on day of the month matching the policy's effective date (this will be elected if no box is checked)

Quarterly Withdraw on a different day of the month; choose a day between 1 and 28 _____

Semi-Annual

Annual

SIGNATURE

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

X _____ Date: _____

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440 Mamaroneck Ave
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Long Term Care Division
Administrative Office
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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

Note: If you are replacing any insurance with this long term care policy, this form must be completed.

According to your application, you intend to lapse or otherwise terminate existing accident and health or long-term care insurance and replace it with a long-term care insurance policy to be issued by Transamerica Financial 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 health 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 accident and health insurance coverage. I believe the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for your needs. 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. 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.

You should be aware that the premium rate for the replacement policy may be higher than what you are paying for the existing policy that you plan to replace. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.

3. 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

