GEORGIA
APPLICATION PACKET

Helpful Hints:

A signature is required on pages 8, 10, and 13.
A signature may be required on pages 7, 14, 15, 16 and 19.
Page 7 could require 2 signatures.

Your signature is required on pages 9 and 13. Your signature could be required on page 16 and 17, 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 required on the application and on the personal worksheet. Your signature is also required on the replacement notice and the suitability of replacement form, 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 on page 7, if applicable.

APPLICANT INFORMATION – Policy # applies only to Reinstatements or Upgrades. Complete the "Applicant is…" information.

BUSINESS INFORMATION – If applicable, complete this section of the application to identify the Service Group Name and Service Group Number. This is required to ensure group program discounts are applied and billing is correct.

CONTACT INFORMATION – Check the preferred phone number and a best time to contact the applicant.

APPLICANT STATUS – Select the correct box to receive any applicable discounts.

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

SECTION A and B – These two sections are required for **Abbreviated Application (AA) or Simplified Issue (SI). If any question in Section B #1 – 7 is answered "Yes", the applicant is not eligible for coverage.** Please provide complete primary physician information, as well as the first and last name of any additional physicians. List all medications prescribed or taken within the last 12 months.

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

SECTION C – Check "Yes" or "No" in each section and check applicable boxes. For question # 7 under disability "Type", please indicate the source of any disability payments (such as SSI, VA, etc.).

SECTION D – Complete if any health question **1-5** in Section C or the last 2 questions in **C 6** were answered "Yes."

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, the Rejection box must be checked and a **signature** is required in this section if the Rejection box is checked.

REJECTION OF NONFORFEITURE BENEFIT – If the applicant did not select the Nonforfeiture Benefit, the Rejection of Nonforfeiture Benefit box must be checked and a **signature** is required in this section if the Rejection box is checked.

OTHER BENEFITS – Check the box next to the rider(s) 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's/partner's name must also be completed.*

BENEFICIARY NAME – Please complete for the Return of Premium to Age 67 and the Return of Premium Upon Death Rider. If no beneficiary is named, the return of premiums will default to the estate of the insured.

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 and may be submitted via EFT. The amount entered in the **Initial Premium Payment w/Application** should match the amount on the Conditional Receipt in the Disclosure Package.

FAMILY HISTORY PROFILE – Complete this section with information about the applicant's biological parents. If information is not known, check the **Unknown** box. Even if the biological parents are Unknown, the question may still be answered for biological siblings, if known.

PROTECTION AGAINST UNINTENDED LAPSE – If the applicant wishes to designate a third party to receive a notice if their policy is about to lapse, fill in the applicable information. This should probably be someone not living in the house with the applicant and must be a U.S. address. If the applicant 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 medical underwriting may be performed, (3) that all required disclosure forms have been received, and (4) that you have proposed a plan that is suitable for the applicant's needs. The applicant's **signature**, the actual **date signed** 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, if applicable. If no such schedule is listed, coverage is effective the date of the application unless a later Effective Date is requested.

FOR AGENT/INSURANCE PRODUCER – Complete this part of the application. The Agent/Insurance Producer's writing number provided will be used to process commissions. Please put "pending" if not yet assigned. If more than one agent/insurance producer is sharing credit, indicate the percentages. Only the writing Agent's/Insurance Producer's signature is required.

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

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 income or assets are below $30,000 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 a bank account, complete this form. The **signature** of the applicant and the **date** are required on this form, if applicable. Funds will be drafted upon receipt of the application.

INITIAL CREDIT CARD PAYMENT AUTHORIZATION – If the initial premium payment is to be paid by credit card, this authorization must be signed and dated by the Cardholder. Credit Card is for **initial premium payment only**. If you are faxing your forms, the fax number for **just the Credit Card Authorization** is **833-200-4102.**

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 the form, if applicable. The Agent's/Insurance Producer's 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 for their 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.

DECLARATION OF DOMESTIC PARTNERSHIP – If a domestic partner is applying, the Declaration of Domestic Partnership form must be completed, notarized and submitted with the application.

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
LTCQuestions@Transamerica.com

Application for Individual Long Term Care Insurance

APPLICANT INFORMATION - PLEASE PRINT	ID Number 07042101	Application No. (Home Office Use)

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade

For Upgrades, complete all sections of this application. For Reinstatements, do not complete the Plan Selection page.

Please provide policy #:_____

Applicant is an: ☐ Individual ☐ Employee of approved service group: Date of Hire - ____/____/____ ☐ Association Member

☐ Employee's/Member's Spouse/Partner ☐ Family Member - Relationship _____

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

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

PERSONAL INFORMATION

Last Name: _____ First Name:_____ Middle Initial:_____

Date of Birth: ____/____/____ Age: _____ State of Birth: _____

Address (including Apt #): _____

City: _____ State: _____ Zip Code: _____

Social Security No.: _____-____-_____

Sex: ☐ Male ☐ Female

Height: _____ Feet _____ Inches Weight: _____ lbs.

CONTACT INFORMATION

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

☐ Primary Phone #:

☐ Alternate Phone #:

E-Mail Address:

BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.

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.

OTHER INSURANCE INFORMATION

		Yes	No
1.	Are you covered by Medicaid (not Medicare)?	☐	☐
2.	In the last 5 years, have you applied for or received any long term care benefits, disability income benefits, or Social Security Disability benefits?	☐	☐
3.	Do you currently have health care (group or individual) coverage in force?	☐	☐
4.	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?	☐	☐
5.	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.	☐	☐
6.	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.	☐	☐
7.	Did you have a long term care 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.	☐	☐
8.	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.	☐	☐
9.	Do you intend to replace any in force medical or health insurance coverage with this policy? If Yes, please provide details in the chart below and complete the replacement form.	☐	☐
10.	In the last 6 months, have you allowed any medical/health/long term care insurance to lapse? If Yes, please provide details in the chart below.	☐	☐

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.

NICOTINE USE

Have you smoked or used any form of tobacco or nicotine products within the past 24 months? ☐ Yes ☐ No

OCCUPATION / WORK HISTORY

If full-time actively at work, start health questions at Section "A." If not, start at Section "B"

Actively at Work? ☐ Yes ☐ No

☐ Full Time ☐ Part Time Hours per Week: _____ Profession: _____

If Retired, month and year of retirement: _____ Former Profession: _____

If not actively at work, please explain: _____

MODIFIED GUARANTEE ISSUE - Answer Questions in SECTION A Only.
SIMPLIFIED ISSUE OR ABBREVIATED APPLICATION - Answer Questions in SECTIONS A & B.
FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

SECTION A

	Yes	No
1. During the last 6 MONTHS, with the exception of vacation, have you been continuously and actively working full time for your current employer?	☐	☐
2. During the last 6 MONTHS, have you missed more than 5 consecutive days of work due to accidents, injury, sickness, or physical or cognitive impairment?	☐	☐
3. During the last 12 MONTHS, have you ever required mechanical or human assistance or supervision of any kind to perform any of the following activities: mobility (including the use of pronged canes), taking medications, dressing, eating, bathing, transferring, or toileting?	☐	☐

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

_____

_____

SECTION B (If any question B 1-7 is answered yes, you are not eligible for coverage.)

	Yes	No
1. Have you EVER been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions?	☐	☐

☐ Alzheimer's disease or Dementia
☐ Amputation due to disease
☐ ALS (Lou Gehrig's disease)
☐ Chronic Hepatitis
☐ Cognitive Impairment
☐ Cystic Fibrosis
☐ Dementia
☐ Memory Impairment (which includes symptoms of forgetfulness and memory loss)
☐ Insulin Dependent Diabetes
☐ Intellectual Disability
☐ Liver Cirrhosis
☐ Memory Loss
☐ Multiple Sclerosis
☐ Muscular Dystrophy
☐ Myasthenia Gravis
☐ Neurological condition affecting spinal cord or brain
☐ Organ Transplant (other than Corneal)
☐ Organic Brain Syndrome or Senility
☐ Osteoporosis with Fractures
☐ Parkinson's Disease
☐ Polycystic Kidney Disease
☐ Polymyositis
☐ Schizophrenia
☐ Scleroderma
☐ Spinal Cord Injury
☐ Stroke/CVA or TIA (multiple)

	Yes	No
2. During the last 3 YEARS, have you been diagnosed or treated by a member of the medical profession for alcohol abuse, illegal or prescription drug abuse; or Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke)?	☐	☐
3. During the last 12 MONTHS:		
• Have you used a catheter, daily narcotic pain medication, 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. Have you been diagnosed with or treated by a member of the medical profession for HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	☐	☐
5. Within the past 12 months, have you been diagnosed with or treated by a member of the medical profession for COPD/Emphysema with oxygen use, or Cardiomyopathy?	☐	☐
6. Within the last 3 MONTHS, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions?		
• Heart Attack (MI) or Chest Pain	☐	☐
• Uncontrolled Blood Pressure	☐	☐
• Cancer	☐	☐
• Hip or Back Surgery	☐	☐
7. Do you have a parent or sibling diagnosed with or treated by a member of the medical profession for Huntington's Chorea?	☐	☐

Please provide physician information below if you have consulted your physician within the last 5 years.

Primary Care Physician's Name: _____ Telephone No.: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Reason Last Seen: _____

_____

ADDITIONAL PHYSICIAN INFORMATION

Within the past 5 years, have you consulted with or been treated by a licensed health care practitioner, other than your primary care physician, for any reason (excluding eye or foot doctors, or dentists)? ☐ Yes ☐ No

If Yes, please complete the details below for each licensed health care practitioner.

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

Physician's Name	City and State	Specialty	Reason Consulted or Treated	Date(s)

MEDICATION INFORMATION

List ALL Medications Prescribed Or Taken Within The Last 12 Months

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

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician's Name

SECTION C - Please review each set of disorders below and check Yes or No.

1. In the last 5 YEARS, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions? **Please check each condition that applies and provide details in Section D - Medical History Details.**

Blood Disorders: ☐ Yes ☐ No

☐Anemia ☐Leukopenia ☐Thrombocytopenia
☐Any Disorder or Disease of the Blood ☐Polycythemia Vera ☐Hemochromatosis

Cancers:	☐ Yes ☐ No	
☐Cancer (excluding Basal Cell of the Skin)	☐Lymphoma	☐Sarcoma
☐Hodgkin's Disease	☐Melanoma	☐Squamous Cell
☐Leukemia	☐Multiple Myeloma	☐Tumors
Circulatory Disorders:	☐ Yes ☐ No	
☐Amaurosis Fugax	☐Embolism	☐High Blood Pressure
☐Aneurysm	☐Heart Arrhythmias or Atrial Fibrillation	☐Irregular Heartbeat
☐Angioplasty	☐Heart Attack	☐Peripheral Vascular Disease
☐Blood Clots	☐Heart Disease	☐Stroke/CVA
☐Cardiomyopathy	☐Heart Murmur	☐Transient Ischemic Attack (TIA)
☐Carotid Artery Stenosis or Disease	☐Heart Surgery	☐Vascular Disease
Endocrine and Pituitary Disorders:	☐ Yes ☐ No	
☐Addison's Disease	☐Diabetes	☐Pancreatitis
☐Cushing's Disease	☐Disease or Disorder of the Pancreas	☐Thyroid Disease
Eye and Ear Disorders:	☐ Yes ☐ No	
☐Blurred Vision	☐Labyrinthitis	☐Meniere's/Vertigo
☐Dizziness	☐Macular Degeneration	☐Retinitis Pigmentosa
☐Glaucoma		
Gastrointestinal Disorders:	☐ Yes ☐ No	
☐Crohn's Disease	☐Liver Disorders	
☐Disease or Disorder of the Small or Large Intestine	☐Ulcerative Colitis	
	☐Unspecified Gastrointestinal Disorder	
Genitourinary Disorders:	☐ Yes ☐ No	
☐Bladder Disorders	☐Kidney Failure	
☐Incontinence	☐Prostate Disorders	
☐Disease or Disorder of the Kidney	☐Renal Insufficiency	
Musculoskeletal Disorders:	☐ Yes ☐ No	
☐Arthritis	☐Fractures	☐Polymyalgia Rheumatica
☐CREST Syndrome	☐Joint replacement	☐Rheumatoid Arthritis
☐Degenerative Joint Disease	☐Loss of Strength	☐Scoliosis
☐Disabling Back or Spine Condition	☐Fibromyalgia	☐Spinal Stenosis
☐Discoid Lupus	☐Osteopenia	☐Systemic Lupus (SLE)
☐Disease or Disorder of the Bone and Joint	☐Osteoporosis	☐Use of a Straight Cane
☐Falls	☐Paralysis	
Neurological Disorders:	☐ Yes ☐ No	
☐Anxiety	☐Disorientation	☐Neuropathy
☐Brain Disorder	☐Dizziness	☐Polyneuropathy
☐Cerebral Atrophy	☐Epilepsy, Seizures or Convulsions	☐Post-Polio Syndrome
☐Cerebral Palsy	☐Fainting Spells or Blacking Out	☐Spinal Cord Injury
☐Chronic Fatigue Syndrome	☐Loss of Balance	☐Syncope
☐Confusion	☐Mental or Cognitive Disorder	☐Tremor
☐Depression		
Respiratory Disorders:	☐ Yes ☐ No	
☐Asbestosis	☐Bronchitis	☐Pulmonary Fibrosis
☐Asthma or Chronic Bronchitis	☐Disease or Disorder of the Lungs	☐Sarcoidosis
☐Bronchiectasis	☐Emphysema/COPD with or without Oxygen	
Miscellaneous:	☐ Yes ☐ No	
☐Alcoholism	☐Immune System Disorders	
☐Amputation	☐Skin Ulcers	

	Yes	No
2. Within the past 5 years have you been hospitalized or been treated by a member of the medical profession for any condition, disease, disorder or symptoms not previously stated?	☐	☐
3. Within the past 5 years, has any surgery or test(s) been recommended by a member of the medical profession and not performed or any medication been prescribed and not taken?	☐	☐
4. Within the past 24 Months, have you received or been advised to receive home health care, or been medically advised to enter, been confined to, or used: an adult day care facility; nursing home, assisted care facility or other long term care facility?	☐	☐
5. Do you have a handicap sticker, handicap placard, or handicap license plate?	☐	☐
6. Do you:		
• regularly run, swim or golf?	☐	☐
• regularly participate in strength training, yoga?	☐	☐
• have a regular walking schedule?	☐	☐
If Yes, please answer the following two questions. If Yes to questions below, please provide details in section D.		
If you do participate in these activities, have you decreased the time that you spend doing these activities within the past 6 months?	☐	☐
Have you been medically advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?	☐	☐
7. In the last 5 years, have you applied for or are you receiving any disability benefits? If Yes, give Type, Percentage, and Medical Reason in the chart below	☐	☐

Type	Percentage of Disability	Medical Reason

SECTION D - Medical History Details

If you answered YES to any health question 1-5 in Section C, or to the last 2 questions within question C 6, provide full details below.

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

Question Number	Diagnosis/Disorder/Reason	Diagnosis Date	Last Treatment Date	Physician's Name	Medications

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 ☐ 180 Days

Benefit Increase Option: ☐ Compound 5%

☐ Deferred ☐ Tailored ☐ Step Rated 3% ☐ Step Rated 5% ☐ 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 of Applicant:_____

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 of Applicant:_____

Other Benefits:

☐ Monthly Benefit Rider

☐ Shared Care Rider –

Spouse/Partner's name: _____

☐ Joint Waiver of Premium Rider

☐ Full Restoration of Benefits Rider

☐ Return of Premium 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 ☐ 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: $	Initial Premium Payment w/ Application: $

SPECIAL INSTRUCTIONS: _____

_____

SECTION E - FAMILY HISTORY PROFILE (for all applicants)

Please answer with biological family member information.
If not known or for an applicant who was adopted, please check "Unknown."

Father: Is your father living? ☐ Yes ☐ No ☐ Unknown If Yes, what is his current age? _____

Mother: Is your mother living? ☐ Yes ☐ No ☐ Unknown If Yes, what is her current age? _____

Have any of your family members (mother, father, or siblings) been diagnosed or treated by a member of the medical profession for any of the following conditions? ☐ Yes ☐ No If Yes, check all that apply.

- ☐ Alzheimer's Disease
- ☐ ALS (Lou Gehrig's Disease)
- ☐ Dementia
- ☐ Diabetes
- ☐ Heart Disease
- ☐ Huntington's Chorea
- ☐ Parkinson's Disease
- ☐ Stroke

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:

Designee's Full Name: _____

Telephone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

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

APPLICANT'S AGREEMENT, SIGNATURES AND EFFECTIVE DATES

AGREEMENT: I understand that I am applying for an individual 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. I understand that my statements and answers in the application will be the basis for any policy issued by the company and that no information about me will be considered to have been given to the company unless it is stated in the application. The application means any form required by Transamerica Life Insurance Company to apply for long term care insurance whether or not the form is attached to the policy at issue.

I understand that the company may require an attending physician statement, medical records, an underwriting assessment, a medical exam, a MIB report, a Department of Motor Vehicle report or other questionnaire, test or prescription drug or medication report.

STATEMENT OF RECEIPT: I certify that I have received the Outline of Coverage, the Long Term Care Insurance Personal Worksheet, "A Shopper's Guide to Long Term Care Insurance," HIPAA Privacy Notice, the Potential Rate Increase disclosure form, "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, TRANSAMERICA LIFE INSURANCE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY.

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

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURE of Applicant: _____

Date Signed: _____ **Place Signed (City and State):** _____

EFFECTIVE DATE (if not date of application): _____

FOR THE AGENT / INSURANCE PRODUCER

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: ______________________ **Date Signed:** ____________

Agent/Insurance Producer's Name (Please Print): ______________________

Agent/Insurance Producer's Writing No.: ______________________ **Phone #:** ____________

E-Mail Address: ______________________ **Share %:** ____________

Agent/Insurance Producer's Name (Please Print): ______________________

Agent/Insurance Producer's Writing No.: ______________________ **Phone #:** ____________

E-Mail Address: ______________________ **Share %:** ____________

Agent/Insurance Producer's Name (Please Print): ______________________

Agent/Insurance Producer's Writing No.: ______________________ **Phone #:** ____________

E-Mail Address: ______________________ **Share %:** ____________

Agent/Insurance Producer's Name (Please Print): ______________________

Agent/Insurance Producer's Writing No.: ______________________ **Phone #:** ____________

E-Mail Address: ______________________ **Share %:** ____________

AGENT'S / INSURANCE PRODUCER'S REPORT

	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 polices sold within the last five years that are no longer in force.

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

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

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HOME OFFICE: CEDAR RAPIDS, IOWA
Long Term Care Administrative Office
P.O. Box 869090
Plano, Texas 75086-9090
1-800-227-3740
LTCQuestions@Transamerica.com

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: _____ Date of Birth: ____/____/_____

Applicant's Signature: _____ Date Signed: _____

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

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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.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number ICC10 TLC-3

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 premiums on this policy form in the future, provided it raises rates for all policies in the same class.

Rate Increase History

Through various related companies the Company has sold long-term care insurance products since 1987 and has sold this policy since 2011. The Company has requested nationwide rate increases for several previously sold policy forms (within the last 10 years) providing similar coverage. Following is a summary of the rate increases.

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 35% in 2003, 35% in 2005, 25% in 2007 and 25% in 2009.
GCC 1 387 CERT, LTC 5 TQ 1096, FTQ 197	1987 – 2001	Varies by state, but the largest increases in any state were 35% in 2005, 25% in 2007 and 25% in 2009.
LTCP 889, GCPLUS 1290 and GCPLUS 2 1290, GCPRO 193	1990 – 2001	Varies by state, but the largest increases in any state were 30% in 2001, 45% in 2003, 35% in 2005, 29% in 2007 and 25% in 2009.
KLTCP 1 490, LI-LTCP 192, GCPRO-II 794	1990 – 2001	Varies by state, but the largest increases in any state were 45% in 2003, 35% in 2005, 29% in 2007 and 25% in 2009.

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 35% in 2005, 29% in 2007 and 25% in 2009.
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 45% in 2003, 35% in 2005 and 25% in 2009.
LTC 124-197; LTC 304-198 and LTC 305-198	1997 – 2004	Varies by state, but the largest increase in any state was 35% in 2005 and 25% in 2009.

This represents the largest increases that have been filed with and approved by various state insurance departments. Some states have allowed two (or more) smaller increases and some states have approved the increases in years different than those shown above.

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 premium schedule you were initially shown 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 2013 was $82,855, but this figure varies across the country. In ten years the national average annual cost would be about $134,962 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 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.

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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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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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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

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DECLARATION OF DOMESTIC PARTNERSHIP

Domestic Partnership Standards

We attest:

1. We share the same primary, regular and permanent residence and have **lived together** for the previous six (6) months; (see definition)
2. We have a committed personal relationship with each other that is mutually interdependent and intended to be lifelong;
3. We agree to be jointly obligated and responsible for the **necessities of life** for each other; (see definition)
4. We are not married to anyone or legally separated from anyone;
5. We are each eighteen (18) years of age or older;
6. We are competent to enter into a contract;
7. We are not related by blood closer than would bar marriage in the State of Georgia;
8. We are each other's sole domestic partner;
9. We agree to file a termination of Domestic Partnership with Transamerica Life Insurance Company within 30 days if any of the above facts change;
10. Any prior domestic partnership in which either of us participated with a third party was terminated not less than six (6) months prior to the date of said Declaration, and, if such earlier domestic partnership had been acknowledged under provisions of this section, that notice of termination of such earlier domestic partnership was provided to Transamerica Life Insurance Company;
11. We agree to promptly inform Transamerica Life Insurance Company of any changes in the status of this Domestic Partnership;
12. We hereby make application to register as Domestic Partners pursuant to these terms and conditions.

Definitions:

"Live together" means that two people claiming Domestic Partnership share the same primary, regular and permanent residence. It is not necessary that the legal right to possess the residence be in both names. Whether the relationship between these two people is or is not sexual is in no way relevant for the purposes of determining eligibility under this Declaration.

"Necessities of Life" means the cost of basic food, shelter, clothing and medical care. The individuals need not contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible and obligated for the cost.

DECLARATION OF DOMESTIC PARTNERSHIP
(CONTINUED)

We declare under penalty of perjury and insurance fraud under the laws of the State of Georgia that the statements above are true and correct.

Signature _____ Social Security Number _____

Print Name:_____

Signature_____ Social Security Number _____

Print Name:_____

Notarization:
State of Georgia
County of _____

On this _____ day of _____ in the year _____, before me personally

appeared _____ and _____

known to be (or provided to me on the basis of satisfactory evidence) the persons whose names are subscribed to this instrument, and acknowledged that they executed it on the above date.

_____ _____
(witness) Notary Public

(Seal)

Primary residence address:

Address: _____

City, State and Zip Code: _____

To complete the registration of this Domestic Partnership, you must:

a. File this form with Transamerica Life Insurance Company;
b. Provide two (2) forms of acceptable identification verifying joint residency, (i.e. Georgia Drivers License, Georgia I.D., voter registration, passport with current residency, or utility bill);
c. Sign this form in front of a Notary Public and complete the notarization.