CALIFORNIA
APPLICATION PACKET

Helpful Hints:	Your signature is required on pages 7, 13, 14, 15 and 17 Your signature may be required on pages 6 and 16 Page 6 could require up to 4 signatures

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 your answers and sign where indicated. Please return the **entire** application package to us in the enclosed stamped return envelope.

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 the 5% Compound Benefit Increase Option and Nonforfeiture – Shortened Benefit Period, if applicable.

BUSINESS INFORMATION – Please complete. If you are a family member (other than a spouse), check the box next to "Family member" and write in the related employee's name.

PERSONAL INFORMATION – If you have a domestic partner who is also applying, enter your domestic partner's name on the line next to Spouse's name.

SECTION A – Only used for Modified Guarantee Issue (MGI).

SECTION A and B – Used for Simplified Issue (SI).

FULL UNDERWRITING SECTIONS A, B, and C, QUESTIONS 4 – 12 and 14 – 17. Please note if any question is answered Yes, you are not eligible for coverage.

FULL UNDERWRITING SECTIONS A, B, and C, QUESTIONS 18 – 20.
If any question 18-20 is answered Yes, circle the applicable diagnosis or condition(s) and give details in question 21. Please provide complete Physician and Medication information.

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

RATE CLASSIFICATION – Fill in appropriate information.

MODE OF PAYMENT – Select your payment method and check the applicable box. You should submit a full premium payment with this application. **In California, only one month's premium may be collected at the time of application.**

BANK DRAFT AUTHORIZATION – If you wish for the premium payments to be drafted from your bank account, complete this section and attach a voided check. If you chose a monthly payment method, you must complete this section. Please note a **signature** is required for this section.

PROTECTION AGAINST UNINTENDED LAPSE – If you wish to designate a third party to receive a notice if your policy is about to lapse, fill in the applicable information. If you do not wish to designate a third party, check the applicable box and sign where indicated.

REJECTION OF COMPOUND BENEFIT INCREASE OPTION – If you have not selected a 5% Compound Benefit Increase Option, check the applicable box. Please note a **signature** is required in this section if applicable.

REJECTION OF NONFORFEITURE BENEFIT – If you have not selected the Nonforfeiture Benefit, check the applicable box. Please note a **signature** is required in this section if applicable.

STATEMENT OF DELIVERY AND RECEIPT – Please note your **signature** is required in this section.

PAGE 7 – Please read the information found on this page and provide the information requested. Also note a **signature** is required in this section. The Disclosure of Information to You and Your Agent should not be completed.

FOR AGENT – Your Transamerica Long Term Care Agent will complete this part of the application.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET – Answer all questions. **Sign** and date the worksheet. If you do not wish to complete this information, check the applicable box and **sign** and date the worksheet.

AUTHORIZATIONS FOR THE RELEASE OF HEALTH INFORMATION – Read this information carefully. Please note **signatures** are required on all Authorizations. Without your signature, we cannot proceed with the application process and the application will be returned to you.

NOTICE TO APPLICANT REGARDING REPLACEMENT – If you are replacing coverage, read this section carefully. Please note a **signature** is required in this section if applicable. Be sure to also complete the same form found in the Disclosure Package and keep it for your records.

CONDITIONAL RECEIPT – Please complete the conditional receipt. Be sure to indicate the sum of money enclosed with the application. **Only one month's premium may be collected at the time of application.** Please note your **signature** is required in this section. This receipt will be signed by an agent and returned to you.

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TRANSAMERICA® LIFE INSURANCE COMPANY

TRANSAMERICA LIFE INSURANCE COMPANY
A Capital Stock Company
Home Office: Cedar Rapids, Iowa
Administrative Office: P.O. Box 95302,
Hurst, TX 76053-5302
1-800-227-3740

Application for Long Term Care Insurance (ABC)

THIS POLICY IS AN APPROVED LONG TERM CARE INSURANCE POLICY UNDER CALIFORNIA LAW AND REGULATIONS. HOWEVER, THE BENEFITS PAYABLE BY THIS POLICY WILL NOT QUALIFY FOR MEDI-CAL ASSET PROTECTION UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE. FOR INFORMATION ABOUT POLICIES AND CERTIFICATES QUALIFYING UNDER THE CALIFORNIA PARTNERSHIP FOR LONG TERM CARE, CALL THE HEALTH INSURANCE COUNSELING AND ADVOCACY PROGRAM AT THE TOLL-FREE NUMBER, 1 (800) 434-0222.

APPLICANT INFORMATION - PLEASE PRINT	ID Number 0701CA _ _	Application No. (Home Office Use)

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

BUSINESS INFORMATION

EMPLOYER/ASSOC. NAME	**EMPLOYER/ASSOC. NO.**	☐ Employee: date of hire_____ ☐ Employee's spouse ☐ Family member

PERSONAL INFORMATION

FIRST NAME	**MI**	**LAST NAME**	**SEX** ☐ Male ☐ Female	**DATE OF BIRTH** M	D	Y	**AGE**

SOCIAL SECURITY NO.	**ADDRESS** **Apt No.**	**CITY**	**STATE**	**ZIP**

TELEPHONE ( )	**BEST TIME TO CALL** ☐ _____ A.M. ☐ _____ P.M.	**E-MAIL ADDRESS**	**HEIGHT**	**WEIGHT**

STATE OF BIRTH	**OCCUPATION** (If retired, give year retired)

APPLICANT STATUS:

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

☐ INDIVIDUAL who is married, but spouse is not applying. Why is spouse not applying? _____

☐ INDIVIDUAL who is single.

BENEFICIARY NAME	**RELATIONSHIP**	**ADDRESS**

OTHER INSURANCE INFORMATION

1. Are you covered by Medicaid or Medi-Cal? ..... ☐ Yes ☐ No
2. Do you currently have another long term care policy or certificate in force? ..... ☐ Yes ☐ No
3. In the last 5 years, have you been declined long term care insurance or offered such insurance with an increased premium or restricted benefits? ..... ☐ Yes ☐ No

   If Yes, give company name, when and why: _____

4. Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits? If Yes, please provide details: _____ ☐ Yes ☐ No
_____

5. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse or do you intend to replace any in-force medical/health/long term care insurance with this policy? _____ ☐ Yes ☐ No

If Yes, please provide details and complete the required replacement form.

Name	Name of company	Company address	
Policy Number	**Type of Plan**	**Lapse Date**	**Amount of annual premium for policy being replaced**

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

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A only.

SIMPLIFIED ISSUE- Answer Questions in SECTIONS A & B.

FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.

A

1. During the last 6 MONTHS, have you been continuously and actively at work for your current employer for a minimum of 30 hours per week (away from home), except for vacation?..... ☐ Yes ☐ No

2. During the last 6 MONTHS, have you missed more than five consecutive days of work due to accidents, injury, sickness or any physical or cognitive impairment?..... ☐ Yes ☐ No

3. During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting? ..... ☐ Yes ☐ No

If any question 4 –12 is answered Yes, You are not eligible for coverage.

B

4. Have you EVER had, or been diagnosed or treated by a member of the medical profession for any of the following conditions?

Yes	No		Yes	No	
☐	☐	Alzheimer's disease	☐	☐	Huntington's Chorea
☐	☐	Amputation due to disease	☐	☐	Organic Brain Syndrome
☐	☐	Amyotrophic Lateral Sclerosis (Lou Gehrig's disease)	☐	☐	Osteoporosis with fractures
☐	☐	Arthritis with narcotic pain medication	☐	☐	Paraplegia or Quadriplegia
☐	☐	Mobility Deficit	☐	☐	Parkinson's disease
☐	☐	Memory loss requiring medical consultation	☐	☐	Polymyositis
☐	☐	Multiple Sclerosis	☐	☐	Scleroderma
☐	☐	Muscular Dystrophy	☐	☐	Dementia or Senility
☐	☐	Cerebrovascular Accident* (Stroke, CVA, TIA)	☐	☐	Myasthenia Gravis

*If applicant has had a single Cerebrovascular Accident more than 2 years ago, complete Section C.

5. Have you ever been diagnosed as having or been treated by a health professional for Acquired Immune Deficiency Syndrome (AIDS)?..... ☐ Yes ☐ No

B

6. Have you ever been diagnosed as having or been treated by a health professional for any immunodeficiency disorder other than HIV? ……..……..…... ☐ Yes ☐ No

7. During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes?. ☐ Yes ☐ No

8. During the last 3 YEARS, have you been diagnosed or treated by a member of the medical profession for:

☐ Yes ☐ No Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke)

☐ Yes ☐ No Chronic Hepatitis

☐ Yes ☐ No Cirrhosis

☐ Yes ☐ No Alcohol abuse

☐ Yes ☐ No Drug or prescription drug addiction

☐ Yes ☐ No Transient Global Amnesia

9. 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

10. During the last 12 MONTHS, have you been confined to a nursing home, assisted living facility, attended an adult day care facility, or required home health care?…… ☐ Yes ☐ No

11. Do you have a direct family history (parents or siblings) of Huntington's Chorea?……. ☐ Yes ☐ No

12. Do you have a direct family history (parents or siblings) of Polycystic Kidney Disease?…… ☐ Yes ☐ No

13. Are you currently taking or been prescribed any prescription drugs or medications? ☐ Yes ☐ No

If Yes, please list **all**: _____

_____

_____

PRIMARY PHYSICIAN'S NAME	**TELEPHONE NUMBER**	**HMO/PPO ID#** (if known)

ADDRESS

If any question 14 – 17 is answered Yes, You are not eligible for coverage. For questions 18 – 19, give details of any Yes answers in question # 21.

C

14. Have you EVER had, or been diagnosed with or treated by a member of the medical profession for:

a) COPD (Emphysema) with oxygen use or steroid medications?…… ☐ Yes ☐ No

b) Multiple Strokes (CVA's)?…… ☐ Yes ☐ No

c) Metastatic or Multi-site Cancer?…… ☐ Yes ☐ No

15. In the last 24 MONTHS, have you had a Single Stroke (CVA or TIA)? ..... ☐ Yes ☐ No

16. In the last 12 MONTHS, have you had Cardiomyopathy? ..... ☐ Yes ☐ No

17. Within the last 3 MONTHS, have you had:

Heart Attack (MI)	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No
Uncontrolled blood pressure	☐ Yes	☐ No
Back Surgery	☐ Yes	☐ No
Hip Surgery	☐ Yes	☐ No
Cancer	☐ Yes	☐ No

18. In the last 5 YEARS, have you had, or been diagnosed with or treated by a member of the medical profession for:

Chronic Lymphocytic Leukemia	☐ Yes ☐ No	Transient Ischemic Attack (TIA)	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Aneurysm	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Irregular heartbeat	☐ Yes ☐ No
Macular Degeneration	☐ Yes ☐ No	Heart surgery	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Mental or cognitive disorder including memory loss	☐ Yes ☐ No
Osteoporosis	☐ Yes ☐ No	Mental or cognitive disorder including confusion	☐ Yes ☐ No
Rheumatoid Arthritis	☐ Yes ☐ No	Mental or cognitive disorder including disorientation	☐ Yes ☐ No
Fibromyalgia	☐ Yes ☐ No	Mental retardation	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Depression	☐ Yes ☐ No
Joint Replacement	☐ Yes ☐ No	Chronic Obstructive Pulmonary Disease (COPD)	☐ Yes ☐ No
Used a straight cane	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Fainting	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Blurred vision	☐ Yes ☐ No
Congestive Heart Failure (CHF)	☐ Yes ☐ No	Convulsions	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No	Paralysis	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Falls	☐ Yes ☐ No
Cardiomyopathy	☐ Yes ☐ No	Loss of balance	☐ Yes ☐ No
Peripheral Vascular Disease	☐ Yes ☐ No	Loss of strength	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No
Cerebrovascular Accident (CVA)	☐ Yes ☐ No	Any condition requiring treatment, surgery, home care or hospitalization, but not mentioned above (NOT including routine Colds, Flu, etc.) or unplanned weight loss of 15 lbs. or more?	☐ Yes ☐ No

C

19. Do you have a handicap sticker, handicap placard, or handicap license plate? ☐ Yes ☐ No

20. In the last 12 MONTHS, has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed? If Yes, give details: ☐ Yes ☐ No

_____

_____

_____

21. Give details for all Yes answers.

Question #	Medication/Name and Address of Treating Physician(s)

If more space is needed, attach a signed and dated additional sheet and check this box: ☐

PLAN SELECTION

Plan Name: _____

Daily Benefit:

Nursing Facility $_____ Residential Care Facility 100% Home Care 100%
$50 - $400 (RCF must be at least $50 and 70% of NF) (HC must be at least $50 and 50% of NF)

Maximum Benefit: $_____

Elimination Period (Number of Days): ☐ 0 ☐ 30 ☐ 60 ☐ 90 ☐ 180

Benefit Increase Option:

☐ Compound ☐ Simple* ☐ Deferred*

_____%

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

Nonforfeiture Benefit:

☐ Shortened Benefit Period**
**If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture statement.

Other Benefits:

☐ Return of Premium

☐ Rate Guarantee _____ years

RATE CLASSIFICATION

☐ Domestic Partner: (living with another, unrelated person in a permanent stable relationship for at least 2 yrs.)

☐ Non-smoker: (no use of any tobacco product within the past 3 years)

☐ Driver: (driven an automobile at least 5 times during the past month)

☐ Other Discount:_____(type)

Premium Paying Period: ☐ Lifetime ☐ Limited Payment Period _____ Years ☐ Paid Up at Age 65

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

Mode of Payment: ☐ Monthly PAC ☐ Quarterly ☐ Semi Annual ☐ Annual ☐ Other _____

Annual Premium $_____ Mode Premium $_____ Payment w/App* $_____

*Cannot collect more than one month's premium

PROTECTION AGAINST UNINTENDED LAPSE

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

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

FULL NAME		**TELEPHONE NO.**	
ADDRESS	**CITY**	**STATE**	**ZIP**

☐ I elect **NOT** to designate any person to receive notice in the event of Transamerica Life Insurance Company's intent to cancel my long-term care insurance policy for nonpayment of premium:

_____ _____

Signature of Applicant Date

REJECTION OF COMPOUND BENEFIT INCREASE OPTION

☐ **Rejection of 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 Compound Benefit Increase Option and I reject the option.

_____ _____

Signature of Applicant Date

REJECTION OF NONFORFEITURE BENEFIT

☐ **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 Date

STATEMENT OF DELIVERY AND RECEIPT

- ☐ The Outline of Coverage;
- ☐ HICAP Notice;
- ☐ a copy of "Taking Care of Tomorrow";
- ☐ a copy of the "Shopper's Guide to Long-Term Care Insurance";
- ☐ "Long-Term Care Insurance Personal Worksheet";
- ☐ if applicable, "Notice to Applicant Regarding Replacement of Accident and Sickness or Long-Term Care Insurance";
- ☐ Privacy Notice;
- ☐ the Disclosure Notices for the MIB and Fair Credit Reporting; and
- ☐ If eligible for Medicare, the "Guide to Health Insurance for People with Medicare".

I certify that I have delivered the above: I certify that I have received the above:

_____ _____

Signature of Agent Signature of Applicant

COLLECTION OF INFORMATION AUTHORIZATION: Upon presentation of this authorization or a photocopy of it, I authorize any physicians, medical practitioners, hospitals, clinics, any medical or medically-related facilities, insurance companies, the Medical Information Bureau, or consumer reporting agencies to disclose any and all medical or non-medical information about me to Transamerica Life Insurance Company, its reinsurers, and its representatives. This authorization specifically includes, but is not limited to, release of any medical records including but not limited to those containing prescription drug information, psychiatric or psychological information, alcohol or drug abuse or information regarding communicable or infectious conditions. I understand and agree that Transamerica Life Insurance Company or its representatives may conduct an exam, a phone interview or a face-to-face assessment as part of the underwriting process. I authorize preparation of an investigative consumer report through personal interviews and other third parties in connection with this application for insurance. If Transamerica Life Insurance Company obtains an investigative consumer report, I understand that I have the right to be interviewed in connection with the investigation. I agree that this authorization will be valid for two years from the date signed. I know that I or my authorized representatives may have a photocopy of it. I understand that I may revoke this authorization at any time only by sending written notice to Transamerica Life Insurance Company.

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 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.

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

DISCLOSURE OF INFORMATION TO YOU AND YOUR AGENT:

In the event that Transamerica Life Insurance Company is unable to offer coverage or if a policy is offered at an extra premium, I authorize the company to disclose directly to me in writing the exact reason(s), either medical or non-medical, and the source of the information. ☐ Yes ☐ No

I also authorize the company to disclose directly to the agent/general agent the exact reason(s), either medical or non-medical, as to why the company is unable to offer coverage or is offering a policy at an extra premium and the source of the information. ☐ Yes ☐ No

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE MISSTATED OR UNTRUE, 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, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive information or statements is guilty of insurance fraud.

SIGNATURE OF APPLICANT **X**	**DATE**
PLACE SIGNED (City/State)	**EFFECTIVE DATE (if not date of application)**

SPECIAL INSTRUCTIONS: _____

_____

_____

FOR THE AGENT

1. Did you interview the applicant in person, ask all questions, and witness signatures? ..... ☐ Yes ☐ No
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?..... ☐ Yes ☐ No
3. To the best of your knowledge, is the information provided in this application true and complete? ..... ☐ Yes ☐ No

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

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

AGENT'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.

AGENT SIGNATURE **X**	**AGENT'S NAME (PRINTED)**	
AGENT WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	**GA/SA CODE**

AGENT SIGNATURE **X**	**AGENT'S NAME (PRINTED)**	
AGENT WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	**GA/SA CODE**

BANK DRAFT AUTHORIZATION (attach a voided check)

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks drawn on my account by and payable to the order of Transamerica Life Insurance Company, Cedar Rapids, Iowa, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check shall be the same as if it were drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you actually receive such notice. I agree that you shall be fully protected in honoring any such check.

I further agree that if any such check is dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever, even though such dishonor results in the forfeiture of insurance.

BANK NAME	**ACCOUNT NUMBER**	**BANK ROUTING NUMBER**	
ADDRESS	**CITY**	**STATE**	**ZIP**
SIGNATURE (As it appears on bank records) **X**		**DATE**	

TRANSAMERICA® LIFE INSURANCE COMPANY

A Capital Stock Company
Home Office: Cedar Rapids, Iowa
Administrative Office: P.O. Box 95302, Hurst, TX 76053
1-800-227-3740

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 Numbers TLC 1-FP (CA) 1001

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 that such revised rates are filed and approved by the Commissioner of Insurance. The premium rates for this Policy were initially approved by the Commissioner of Insurance and cannot be increased without prior approval, subject to the terms and conditions of California Insurance Code Section 10236.13.

Rate Increase History

The company has sold long-term care insurance since 1990 and sold this policy from 2003 until the March of 2005. We resumed selling this policy in 2007. Transamerica Life Insurance Company (formerly PFL Life Insurance Company) requested two separate nationwide rate increases, one in 2001, and another in 2003 for several previously sold policy forms (within the last 10 years) providing similar coverage.

The rate increase consisted of: (i) a 15%-30% rate increase in 2001 and a 25%-35% rate increase in 2003 on policy series 3132 (00) 288 (available 1988-1994); (ii) a 15%-30% rate increase in 2001 and a 25%-35% rate increase in 2003 on policy series LTC 2 390 (available 1990-1993); (iii) a 15%-30% rate increase in 2001 and a 25%-35% rate increase in 2003 on policy series GLTC 2 1289 (available 1989-1994); (iv) a 15%-30% rate increase in 2001 and a 25%-35% rate increase in 2003 on policy series LTC 3 1091 (available 1991-1996); (v) a 15%-30% rate increase in 2001 and a 25%-35% rate increase in 2003 on policy series GLTC 3 1091 (available 1991-1996); (vi) a 25%-35% rate increase in 2003 on policy series 6122 (00) 688 (available 1988-1994); (vii) a 25%-35 % rate increase in 2003 for policy series IP-70-00-794 (available 1994-1997); (viii) a 25%-35 % rate increase in 2003 for policy series LTC 5 196 (available 1996-2001); and (ix) a 25%-35 % rate increase in 2003 for policy series FLEX 2 196 (available 1996-2001).

For policy series 3132 (00) 288, the rate increase was applicable in AL, AZ, AR, CA, CO, FL, GA, ID, IL, IN, IA, KY, LA, MD, MI, MS, MO, MT, NE, NJ, NM, ND, OH, OK, TN, TX, UT, VA, WV and WY. For policy series LTC 2 390, the rate increase was applicable in CA, FL, KS, NC, PA, SD and VT. For policy series GLTC 2 1289, the rate increase was applicable in AL, AZ, AR, CO, GA, ID, IL, IN, IA, KY, LA, MD, MI, MS, MO, MT, NE, NJ, NM, ND, OH, OK, TN, TX, UT, VA, WV and WY. For policy series LTC 3 1091, the rate increase was applicable in AL, AZ, AR, CA, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, MD, MA, MI, MN, MS, MO, MT, NE, NV, NH, NJ, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI and WY. For policy series GLTC 3 1091, the rate increase was applicable in AL, AZ, CO, GA, HI, ID, IL, IA, KY, LA, MD, MA, MS, MO, MT, NE, NJ, OH, OK, TN, UT, VA and WY. For policy series 6122 (00) 288, the rate increase was applicable in CA, FL, KS, OR, PA, SD and WA. For policy series IP-70-00-794, the rate increase was applicable in AL, AZ, AR, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, MI, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PA, SD, TN, TX, UT, VT, VA, WA, WV and WY. For policy series LTC 5 196, the rate increase was applicable in AL, AZ, AR, CA, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV and WY. For policy series FLEX 2 196, the rate increase was applicable in AL, AZ, AR, CO, FL, GA, HI, IL, IN, IA, KS, KY, LA, MA, MI, MN, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, PA, SC, SD, TN, TX, UT, VT, VA, WA, WV and WY.

We also requested an additional rate increase in 2005 for several previously sold policy forms (within the last 10 years) providing similar coverage. The rate increase consisted of a 12%-35% rate increase on those increased in 2002 and also (i) a 12%-35% rate increase on policy series LTC 5 TQ 1096 (which was available from 1996-2001); (ii) a 12%-35% rate increase on policy series FTQ 197 (which was available from 1997-2001); and (iii) a 15%-35% rate increase on policy/certificate series GCC 1 387/GCC 1 387 CERT (which was available from 1987-1989).

For policy series LTC 5 TQ 1096, the rate increase was applicable in AR, CA, CO, CT, FL, GA, ID, IN, IA, KS, MA, MN, MS, MO, NE, NM, NC, OH, OK, OR, PA, TN, TX, UT, VA, WV and WI. For policy series FTQ 197, the rate increase was applicable in AL, AZ, AR, CO, CT, FL, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, MT, NE, NH, NM, NC, ND, OH, OK, OR, RI, SC, SD, TN, TX, UT, VT, VA, WA, WV, WI and WY. For policy series GCC 1 387 CERT, the rate increase was applicable in CA, CO, FL, GA, IN, IA, MS, MO, OH, OK, TN and TX..

The company requested an additional increase in 2006 for several previously sold policy forms (within the last 10 years) providing similar coverage. The rate increase consisted of a 10%-35% rate increase on those policies increased in 2002 and 2005. The rate increase was applicable in AZ, GA, ID, MD, MA, NV, ND, OH, OK, TX and WI.

The company will be requesting an additional rate increase for several previously sold policy forms in 2007.

The following is a summary of the California rate increases.

Policy Form Series	Date Available	Rate History
6122 (CA) 889	1989 - 1993	30% rate increase in 2003 35% rate increase in 2005
LTC 2 (CA) 590 LTCC 2 (CA) 690 LTC 2 (CA) 291 LTCC 2 (CA) 391	1991 - 1993	25% rate increase in 2001 30% rate increase in 2003 35% rate increase in 2005
LTC 3 (CA) (NHC) (REV93) LTC 3R (CA) (NHC) (REV93) LTC 3 (CA) (NHC) (REV93) [1295] LTC 3R (CA) (NHC) (REV93) [1295]	1993 - 1998	25% rate increase in 2001 30% rate increase in 2003 35% rate increase in 2005
LTC 5 COM (CA) 196 LTC 5 NFRCF (CA) 196 LTC 5 NF (CA) 196	1996 - 2001	30% rate increase in 2003 35% rate increase in 2005
LTC 5 TQ COM (CA) 1096 LTC 5 TQ NFRCF (CA) 1096 LTC 5 TQ NF (CA) 1096	1998 - 2001	35% rate increase in 2005

A rate guide is available that compares the policies sold by different insurers, the benefits provided in those policies, and sample premiums. The rate guide also provides a history of the rate increase, if any, for the policies issued by different insurers in each state in which they do business, since January 1, 1990. You can obtain a copy of this rate guide by calling the Department of Insurance's toll-free number, 1-800-927-HELP; by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free number, 1-800-434-0222; or by accessing the Department of Insurance's Internet web site, www.insurance.ca.gov.

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 2006 was $66,800, but this figure varies across the country. In ten years the national average annual cost would be about $108,800 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 (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) (Date)

Agent'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 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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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 Medical Information Bureau.

2) **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** Transamerica and its authorized representatives, including agents and insurance support organizations.

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 (except HIV exposure/testing).

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.

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 95302, Hurst, TX 76053-5302. 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: _____ Effective Date: _____

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

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This Health Insurance Portability and Accountability Act (HIPAA) authorization must be fully completed and signed as a condition of applying for insurance with Transamerica Life Insurance Company ("TLIC"). Your application may not be accepted without a signed authorization.

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

I. **Person(s) or group(s) of persons authorized to use and/or disclose the information**:
MIB, Inc., formerly Medical Information Bureau ("MIB"), a non-profit membership organization of life, health, long term care and disability insurance companies, which operates an information exchange on behalf of its members, and TLIC.

II. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:**
TLIC and its authorized representatives, including agents, reinsurers, service providers and other insurance support organizations including, but not limited to, MIB.

III. **Description of the information that may be used and/or disclosed:**
This authorization specifically includes the release and disclosure of my entire medical record and any other health information concerning me (excluding 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 Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.

IV. **The information will be used and/or disclosed only for the following purpose(s):**
For the purpose of underwriting my application for long term care insurance with TLIC and, if a policy is issued, for evaluating contestability and for the continuation or replacement of the policy. The information may also be disclosed by TLIC to MIB in the form of a brief coded report that will be stored for 7 years in the MIB database and may be released by MIB to another MIB member company if I apply for life, health or long term care insurance with that member company or a claim for benefits is submitted on my behalf to a member company. I understand that there may be additional uses and/or disclosures of my health information that are specifically permitted by law without my authorization (*i.e.*, TLIC may be obligated to disclose health information to government, regulatory and law enforcement entities).

STATEMENTS OF UNDERSTANDING AND ACKNOWLEDGEMENT:

- I understand that health information about me provided to TLIC is protected by federal and state privacy regulations and that, in addition to using such information as provided in this authorization, TLIC 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 TLIC with the right to contest a claim under the policy or the policy itself, by sending a notice to Transamerica Life Insurance Company, Underwriting Supervisor, P.O. Box 95302, Hurst, TX 76053-5302. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by TLIC while this authorization is in force.
- I understand that this authorization will be valid for 24 months from the date signed.
- I understand that a copy of this authorization will be as valid as the original.
- I understand that I am entitled to receive a copy of this signed authorization.

_____	_____
Name	Date
_____	_____
Signature of Individual or Individual's Personal Representative	Description of Authority of Personal Representative (if applicable)

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

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TRANSAMERICA® LIFE INSURANCE COMPANY

A Capital Stock Company
Home Office: Cedar Rapids, Iowa
Administrative Office: P.O. Box 95302, Hurst, TX 76053
1-800-227-3740

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/certificate to be issued by Transamerica Life Insurance Company. Your new policy/certificate provides 30 days within which you may decide, without cost, whether you desire to keep the policy/certificate. 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/certificate.

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

2. You may wish to secure the advice of your present insurer or its agent 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.

3. If, after due consideration, you still wish to terminate your present coverage and replace it with this new policy/certificate, 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/certificate 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.

COMPARISON TO YOUR CURRENT COVERAGE: I have reviewed your current long-term care coverage. To the best of my knowledge, the replacement of insurance involved in this transaction materially improves your position for the following reasons:

____ Additional or different benefits (please specify):

____ No changes in benefits, but lower premiums.

____ Fewer benefits and lower premiums.

____ Other (please specify):

Transamerica Life Insurance Company

_____ _____

(Signature of Agent, Broker or Other Representative) *(Name of Insurer)*

_____

(Type or print Name & Address of Agent, Broker or Other Representative)

_____ _____

(Signature of Applicant) *(Dated – City & State)*

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CONDITIONAL RECEIPT

All premium checks should be made payable to Transamerica Life Insurance Company. Do not make check payable to the agent or leave payee blank. Only one month's premium may be collected at time of application.

Received from _____ a) ☐ the sum of $ _____OR b) ☐ payroll deduction/employer paid

For payment received, this receipt is given and accepted with the express understanding that the insurance applied for will go into effect on the date of the accurately completed application (unless a later effective date is requested, in which case the coverage will be effective on the date requested) if the applicant is found to be insurable in accordance with the Company's underwriting standards as of the date of the application, the policy is issued and the initial premium has been received by the Company. Premiums will be applied from the effective date forward and there will be no coverage for any claims that begin prior to the effective date.

For payroll deduction/employer paid plans, the insurance applied for will go into effect on the date of the accurately completed application if the applicant is found to be insurable in accordance with the Company's underwriting standards as of the date of the application, and the policy is issued. If the initial premium has not been received prior to the date the policy is issued, this Conditional Receipt shall terminate 60 days after the date the policy is issued if the initial premium is not received by the Company prior to the 60th day after the policy is issued.

The Company reserves the right to disapprove the application by offering to issue coverage other than as applied for or by declining to issue coverage. If applicable, monies received with the application will be refunded if coverage, other than applied for, is offered but not accepted, or if the application is declined by the Company. Any delay in completion of the underwriting process or refunding of monies shall not be construed as approval of the application.

X_____
Signature of Agent

_____
Date

X_____
Signature of Applicant 1

_____
Date

X_____
Signature of Applicant 2 (If applicable)

_____
Date