



LIFE INSURANCE APPLICATION

Detach this page and deliver to the proposed insured(s) and owner(s).

LIFE INSURANCE APPLICATION

Thank you for applying for insurance with Transamerica Life Canada (“Transamerica”, “we”, “us”).

Before submitting this application to Transamerica, please ensure that you have carefully read each of the notices on this page and all other pages of this application. On receipt of this application, we will assess the eligibility of each Proposed Life Insured for the insurance requested. We assess each Proposed Life Insured primarily on the basis of the information that is provided in this application and any other declaration made in connection to this application. Factors that we consider when underwriting an application for insurance include, but are not limited to, information concerning each Proposed Life Insured’s medical history, physical condition, occupation or avocation, lifestyle and financial situation. Once we have determined the degree of risk that each Proposed Life Insured represents, we will determine if the insurance applied for can be issued. Should you ever have any questions about your policy, please do not hesitate to contact your Transamerica advisor or write to us at **Life Client Service Department, Transamerica Life Canada, 5000 Yonge Street, Toronto, Ontario, M2N 7J8.**

NOTICES

NOTICE OF RESCISSION RIGHTS

Any policy issued in conjunction with this application may be cancelled by the owner within ten (10) days of delivery (i) by return of the policy either to us or to the advisor through whom it was purchased, or (ii) upon receipt by Transamerica of a written request for policy cancellation. Upon request for cancellation, this policy will be considered void as of the Issue Date and all premiums will be refunded.

NOTICE REGARDING THE MEDICAL INFORMATION BUREAU (MIB)

Information regarding your insurability will be treated as confidential. Transamerica or its reinsurers may, however, make a brief report thereon to MIB, a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its Members.

If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will provide the company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 416-597-0590. If you question the accuracy of information in MIB’s file, you may contact MIB. The address of MIB’s information office is 330 University Avenue, Toronto, Ontario, M5G 1R7.

Transamerica or its reinsurers may also release information in its file directly to another insurance company to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

NOTICE REGARDING INVESTIGATIVE CONSUMER REPORTS AND COLLECTION

In connection with this application, an investigative consumer report or credit report may be obtained from an investigative or consumer reporting agency and/or credit bureau. They will collect information for this report on behalf of Transamerica through personal interviews with your neighbours, colleagues, friends or others with whom you are acquainted.

Personal information collected may include information about your character, general reputation, personal characteristics, finances, credit and lifestyle. A representative who is employed to make such reports may contact you in person or by telephone in connection with this investigation. Information collected in the investigative report obtained by us is used for the purpose of evaluating risks for life and health insurance in connection with this application. For more details about this report, you may write to us at the Life Client Services address noted above.

NOTICE REGARDING COLLECTION, USE AND DISCLOSURE OF PERSONAL INFORMATION

Transamerica collects, uses and discloses your personal information as described in the Notices regarding the Medical Information Bureau, Investigative Consumer Reports and the Personal Information Authorization sections of this application. In addition, we collect personal information about you from this application and any supplementary forms and questionnaires, as described in the above Notices, and from the following sources:

- Physicians and other medical and health care practitioners and providers; hospitals, clinics and other medical facilities; the Medical Information Bureau and other insurers and reinsurers; investigation, consumer and credit reporting agencies; motor vehicle and driver record authorities in any relevant jurisdictions; Transamerica’s advisors and agents, including the Advisor’s Report section of your application; Transamerica’s affiliates.

The information collected from the above sources is used for the following purposes:

- Evaluating, assessing and investigating this application, our insurance risks and any claims you submit; evaluating your insurance and financial needs; administering and servicing the insurance and/or financial products we provide.

If you provide your Social Insurance Number, it will be used for identification and income reporting purposes only.

Your personal information may be shared with the entities and persons identified above for the purposes of obtaining the information required, and it may otherwise be shared with or disclosed to the agents and employees of Transamerica’s managing general agencies, distributors, market intermediaries, and your advisor of record for purposes identified above. Your banking information may be disclosed to the financial institution(s) processing your pre-authorized debit payments. If necessary, your personal information may also be shared with your beneficiaries in relation to a claim.

From time to time we may use your personal information to determine which other insurance and financial products and services may meet your needs and to offer them to you. We may disclose your personal information to our affiliated companies for their own use for such purposes. However, we will not disclose your health information to our affiliates for such purposes.

By signing and submitting this application on your own behalf and/or on behalf of any minor, you give your consent to the collection, use and disclosure of your and/or the minor’s personal information as described above and elsewhere in this application.

Upon receiving your application, Transamerica will establish and maintain a file containing your personal information, which will be accessible at our Head Office. Your file will be accessible to only those employees and authorized representatives of Transamerica responsible for administering your file, and other persons authorized by you or by law. Subject to exceptions set out in applicable legislation, you may access your file and request corrections to your personal information by sending a written request to: Privacy Officer, Transamerica Life Canada, 5000 Yonge Street, Toronto, Ontario, M2N 7J8. Your personal information will be collected, used, disclosed, shared and treated as described herein, or as otherwise described at or before the time of collection, use or disclosure, or as otherwise permitted by law. To review our privacy policy, please visit www.transamerica.ca.

DISCLOSURE BY TRANSAMERICA ADVISOR FOR BRITISH COLUMBIA

The insurance product you are being offered is supplied by Transamerica, a company licensed to conduct business in all provinces and territories of Canada. The advisor/distributor soliciting this insurance application is a licensed insurance advisor representing Transamerica and will receive compensation from us upon the completion of this transaction. You are not obligated to transact any other business with Transamerica, the advisor/distributor or any other person or entity as a condition of this application.

What type of policy are you applying for: Individual Life Joint First-to-Die Joint Last-to-Die Multiple Life Coverages

Life 1 will be the Primary Insured unless indicated otherwise: _____

Names of all proposed life insureds to be covered under this policy: _____

This is a: New Policy Replacement of Transamerica Policy # _____ Insured Exchange Option

Addition of coverage to Transamerica Policy # _____

PROPOSED LIFE INSURED – LIFE 1 Please print in block letters

1. Mr. Mrs. Ms. Miss Last Name First Name Middle Initial
 Other: _____

Identification Document* Identification Document Number* Issuing Jurisdiction*

*Please refer to an original passport, birth certificate, driver's license, Canadian Citizenship, Age of Majority or Canadian Armed Forces Identification (preferably photo I.D.).

2. **Date of Birth:** DD / MM / YYYY Gender: M F
 Age for premium: _____ Country of birth: _____ SIN: _____ (for identification and tax reporting purposes only)

Marital Status: Married Single Common-Law Separated Widowed Divorced Former Name(s): _____

3. Current address (no. and street, city, province, postal code) _____ # of years: _____

Home telephone: () - Business telephone: () -

Previous address: _____

4. I understand the language in which this application is written. Yes No
 If no, have the details of this application been fully explained to you in your preferred language and are they completely understood? Yes No

5. a) Canadian status: Canadian Citizen Landed Immigrant/Permanent Resident
 Contract worker (provide copy of work permit) Other (give details of current status) _____

b) Number of years in Canada: _____ c) Are you a Canadian Resident for income tax purposes? Yes No

6. Occupation: _____ Name of employer: _____ # of years: _____

Employer's address: _____ Duties: _____
 Average number of hours worked per week: _____ Annual earned income \$ _____ Annual unearned income \$ _____ Total net worth \$ _____

7. Policy on a Minor - If the Proposed Life Insured is less than 16 years of age (less than 18 years of age in the Province of Québec), complete this question.

Note: Either a parent or legal guardian of the Proposed Life Insured must sign this application as well as the Owner.

a) Are all other children in the family insured? Yes No If "No", please explain: _____

b) Amount of insurance on other siblings: \$ _____ Name of insurer: _____

c) Source of Premium (if not from parents): _____

d) If the Owner is other than a parent of the Proposed Life Insured, indicate relationship: _____

	Father	Mother
Full Name of Parents	_____	_____
Total amount of Life insurance in force	\$ _____	\$ _____
Occupation	_____	_____
Annual Income & Net Worth	\$ _____ (Annual Income)	\$ _____ (Net Worth)
	\$ _____ (Annual Income)	\$ _____ (Net Worth)



PROPOSED LIFE INSURED – LIFE 2 Please print in block letters

8. Mr. Mrs. Ms. Miss Other: _____ Last Name _____ First Name _____ Middle Initial _____

Identification Document* _____ Identification Document Number* _____ Issuing Jurisdiction* _____

**Please refer to an original passport, birth certificate, driver's license, Canadian Citizenship, Age of Majority or Canadian Armed Forces Identification (preferably photo I.D.).*

9. **Date of Birth:** DD / MM / YYYY Gender: M F
Age for premium: _____ Country of birth: _____ SIN: _____ (for identification and tax reporting purposes only)

Marital Status: Married Single Common-Law Separated Widowed Divorced Former Name(s): _____

10. Current address (no. and street, city, province, postal code) _____ # of years: _____

Home telephone: () - Business telephone: () -

Previous address: _____

11. I understand the language in which this application is written. Yes No
If no, have the details of this application been fully explained to you in your preferred language and are they completely understood? Yes No

12. a) Canadian status: Canadian Citizen Landed Immigrant/Permanent Resident
 Contract worker (provide copy of work permit) Other (give details of current status) _____
b) Number of years in Canada: _____ c) Are you a Canadian Resident for income tax purposes? Yes No

13. Occupation: _____ Name of employer: _____ # of years: _____
Employer's address: _____ Duties: _____
Average number of hours worked per week: _____ Annual earned income \$ _____ Annual unearned income \$ _____ Total net worth \$ _____

14. **Policy on a Minor** - If the Proposed Life Insured is less than 16 years of age (less than 18 years of age in the Province of Québec), complete this question.

Note: Either a parent or legal guardian of the Proposed Life Insured must sign this application as well as the Owner.

If the information is the same as for Life 1 specified in question 7, please indicate here: Same as Life 1 (If checked, continue to question 15).

a) Are all other children in the family insured? Yes No If "No", please explain: _____
b) Amount of insurance on other siblings: \$ _____ Name of insurer: _____
c) Source of Premium (if not from parents): _____
d) If the Owner is other than a parent of the Proposed Life Insured, indicate relationship: _____

	Father	Mother
Full Name of Parents	_____	_____
Total amount of Life insurance in force	\$ _____	\$ _____
Occupation	_____	_____
Annual Income & Net Worth	\$ _____ (Annual Income) (Net Worth)	\$ _____ (Annual Income) (Net Worth)

15. OWNER - The advisor must verify identity of all Owners

Policy ownership applies to all coverages. The owner must be at least 16 years of age (at least 18 years of age in Province of Québec). If the owner will be (any of) the Proposed Life Insured(s), complete client identification information in Question 1 (and, if applicable, Question 8).

a) What language do you request related documents be in? English Français

b) The Owner will be (all of) the adult Proposed Life Insured(s) unless indicated otherwise below:
 Proposed Life Insured 1 Proposed Life Insured 2
 Owner(s) other than as identified above

i)

Name	Relationship to Proposed Life Insured	Identification Document*	Identification Document Number*
Current Address	Issuing Jurisdiction*	SIN (for identification and tax reporting purposes only)	

ii)

Name	Relationship to Proposed Life Insured	Identification Document*	Identification Document Number*
Current Address	Issuing Jurisdiction*	SIN (for identification and tax reporting purposes only)	

*Please refer to an original passport, birth certificate, driver's license, Canadian Citizenship, Age of Majority or Canadian Armed Forces Identification. Required for all Universal Life.

c) Multiple Owners –

Where there are multiple owners, the type of joint ownership will be: (If not specifically indicated, the policy will be issued to all owners as Tenants in Common).

Outside Québec –

- Tenants in Common - should an Owner die while the policy is in effect, the deceased owner's interest will transfer to his/her estate unless a Contingent Owner has been named for such Owner; or
- Right of Survivorship - should an Owner die while the policy is in effect, the deceased owner's interest automatically transfers to the surviving Owner(s).

Québec – Ownership must be Tenants in Common. Tenants in Common (undivided co-ownership) means that should an Owner die while the policy is in effect, the deceased owner's interest will transfer to his/her estate unless a Contingent Owner has been named for such Owner.

d) Billing Address (complete only if other than address previously indicated)

No. and street	city	province	postal code
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e) Contingent Owner – If you wish to have your ownership interest transferred to another person in the event of your death, please complete this section.

Name of Owner	Name of Contingent Owner	Relationship to Owner
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Current address of Contingent Owner

Name of Owner	Name of Contingent Owner	Relationship to Owner
---------------	--------------------------	-----------------------

Current address of Contingent Owner

f) Corporation / Non-Corporate Owner – Where the Owner is a Corporation or Non-Corporate Entity, please complete this section and the Advisor MUST complete page 19 of application. Please provide a copy of the articles of incorporation.

Legal name and address of Corporation/Non-Corporate Entity

Company name	Corporate Registration Number
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No. and street	city	province	postal code
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16. BENEFICIARY – LIFE 1

For contracts signed in Québec, the designation of spouse of the owner as beneficiary is irrevocable unless otherwise specified. All other beneficiary designations in Québec, and all beneficiary designations for contracts signed elsewhere in Canada, are revocable unless otherwise specified. By naming a beneficiary irrevocably, you are giving up substantial control over your policy. Once an irrevocable beneficiary has been designated his/her consent will be required for future dealings with the policy (some exceptions apply in Québec). If more than one beneficiary is named, then the proceeds are to be equally shared unless otherwise specified. Any breakdown of proceeds MUST be stated in percentages rather than dollar amounts. Where a minor is designated as a beneficiary it is recommended that a Trustee be appointed for claims purposes.

First Name, Last Name	Age	Relationship to Proposed Life Insured	Relationship to Owner	Revocable Irrevocable (Check one)		Share %	Type (Check one)	
				Revocable	Irrevocable		Primary	Contingent
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If a minor is designated, indicate Trustee name and relationship to Proposed Life Insured:

17. BENEFICIARY – LIFE 2

Please refer to the information in Life 1 Beneficiary section above. The beneficiary for Life 2, if applicable, will be the same as for Life 1 unless otherwise specified.

First Name, Last Name	Age	Relationship to Proposed Life Insured	Relationship to Owner	Revocable Irrevocable (Check one)		Share %	Type (Check one)	
				Revocable	Irrevocable		Primary	Contingent
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

If a minor is designated, indicate Trustee name and relationship to Proposed Life Insured:

18. LIFE INSURANCE APPLIED FOR - LIFE 1

WealthADVANTAGE EstateADVANTAGE

Face Amount: \$ _____

Please provide an illustration including the Supplement to the Application for Life Insurance.

TERMSelect Face Amount: \$ _____

10 Year 20 Year 30 Year with **SelectOPTIONS**

PROTECTORPlus Face Amount: \$ _____

Life Pay 20 Pay

Additional TERMSelect Riders:

	Face Amount
<input type="checkbox"/> 10 Year Rider	\$ _____
<input type="checkbox"/> 20 Year Rider	\$ _____
<input type="checkbox"/> 30 Year Rider (Available only on TERMSelect 30 Policy)	\$ _____

Additional Benefits

Children's Insurance Face Amount: \$ _____

Accidental Death & Dismemberment Face Amount: \$ _____

Waiver of Premium

Payor Waiver of Premium*

The Payor must complete and attach sections 8 to 13, 28 to 47 and sign page 14 of a Life Insurance Application.

*Name of parent or legal guardian: _____

19. LIFE INSURANCE APPLIED FOR - LIFE 2

WealthADVANTAGE EstateADVANTAGE

Face Amount: \$ _____

Please provide an illustration including the Supplement to the Application for Life Insurance.

TERMSelect Face Amount: \$ _____

10 Year 20 Year 30 Year with **SelectOPTIONS**

PROTECTORPlus Face Amount: \$ _____

Life Pay 20 Pay

Additional TERMSelect Riders:

	Face Amount
<input type="checkbox"/> 10 Year Rider	\$ _____
<input type="checkbox"/> 20 Year Rider	\$ _____
<input type="checkbox"/> 30 Year Rider (Available only on TERMSelect 30 Policy)	\$ _____

Additional Benefits

Accidental Death & Dismemberment Face Amount: \$ _____

Waiver of Premium

20. OTHER PLAN DETAILS

a) Special Policy Dates:

Date to save age Name of Proposed Life Insured: _____

Future Date: / /

b) Alternate (Optional) Policy: Plan: _____

Face Amount: \$ _____

Life 1 Life 2

c) Additional Policy: Plan: _____

Face Amount: \$ _____

Life 1 Life 2

21. PAYMENT DETAILS

Amount Paid with Application \$ _____

Preferred Date of Withdrawal (days 1-28 only)

Mode of Premium Payment/Deposit: Monthly Pre-Authorized Debit*

Quarterly Pre-Authorized Debit*

Annual Direct Bill

Semi-Annual Direct Bill

Quarterly Direct Bill

Single Premium/Deposit – Source of Funds _____

*Complete authorization for Pre-Authorized Debit on page 15.

Premium Quoted Based on Mode Selected \$ _____ and / or Planned Periodic Premium/Deposit \$ _____

ALL CHEQUES MUST BE MADE PAYABLE TO TRANSAMERICA LIFE CANADA

INSURANCE HISTORY:

22. INSURANCE IN FORCE

Do you have any other insurance in force? YES NO If "Yes," complete the following:

Name of Insurer	Date of Issue	Personal/ Business		Amount	Type (ie life, disability, critical illness, accidental death benefit, etc.)
		P	B		
LIFE 1		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>	\$	

Do you have any other insurance in force? YES NO If "Yes," complete the following:

LIFE 2		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>	\$	
		<input type="checkbox"/>	<input type="checkbox"/>	\$	

If you answer "Yes" to any questions, please provide additional information in the Remarks section.

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
23. a) Has any insurer ever declined to issue, reinstate or renew, or has any insurer ever rated, modified, postponed or cancelled, any life or health insurance on your life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Is this insurance intended to replace, or will it cause a change in, or involve a loan under any insurance or annuity policy on you? If "Yes" attach the completed Replacement/Comparison Disclosure Form(s).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the insurance applied for in this application will replace an existing Transamerica policy, does the owner instruct Transamerica to cancel such policy on issuance of the policy applied for herein?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Within the last 6 months have you applied for life or health insurance with any insurer or is any coverage pending at this time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Have you ever applied for or received a pension, disability benefit or any compensation because of illness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FINANCIAL INFORMATION

Personal – where the face amount is \$750,000 or more, please complete questions 24 to 26.

Business – where the insurance is for business purposes, corporately owned or there is a corporate beneficiary, please complete 24 to 27.

24. PURPOSE: Personal Partnership Key Person Buy/Sell Creditor - Amount of Loan \$ _____
 Collateral Term Planned Giving Stock Repurchase Corporate Other _____

25. Please explain how the amount of insurance was determined: _____

26. PERSONAL

a) Financial Details

	Proposed Life Insured 1	Proposed Life Insured 2	Owner (for business purposes or where individual owner is other than Proposed Life Insured(s))
Earned Income (Last Year)	\$	\$	\$
Unearned Income (Last Year) Bonus, Dividends, Interest, etc.	\$	\$	\$
Assets: Cash, Real Estate, Stocks, Bonds, etc.	\$	\$	\$
Liabilities: Mortgages, Loans, etc.	\$	\$	\$
Total Net Worth	\$	\$	\$

b) Please provide source of Premium/Deposit (Where is the premium/deposit coming from?): _____

27. BUSINESS

a) Name of Business: _____

b) Nature of the Business: _____

c) Financial Details (attach a copy of audited financial statements, if available)

Assets	Book Value
Current	\$
Fixed	\$
Other:	\$
	\$
Total	\$

Liabilities	
Current	\$
Long Term	\$
Total	\$

Net Worth: \$ _____

Fair Market Value: \$ _____

Net Profit After Taxes Last Year: \$ _____

Year Before: \$ _____

d) All Owners and Officers

Name and Title	Insurance In Force	Applied For	% of Business Ownership

e) Are other partners, owners, executives insured for a similar amount? Yes No *If "No", please explain:* _____

Additional Comments:

HEALTH HISTORY

LIFE 1

33. Name of the Proposed Life Insured: _____

Height: _____ ft/in cm Weight: _____ lbs. kg

Weight change in last 12 months: None, or
Loss: _____ Gain: _____

Reason for loss/gain: _____

34. Who is your usual medical advisor? None, or
Name _____

Date of last visit: DD / MM / YYYY

Address: _____

Phone: _____

Reason for visit: _____

Results: _____

Treatment: _____

LIFE 2

35. Name of the Proposed Life Insured: _____

Height: _____ ft/in cm Weight: _____ lbs. kg

Weight change in last 12 months: None, or
Loss: _____ Gain: _____

Reason for loss/gain: _____

36. Who is your usual medical advisor? None, or
Name _____

Date of last visit: DD / MM / YYYY

Address: _____

Phone: _____

Reason for visit: _____

Results: _____

Treatment: _____

If you answer "Yes" to any questions, please provide additional information in the Remarks section.

WHERE A PARAMEDICAL OR MEDICAL IS REQUIRED, APPLICANTS DO NOT NEED TO COMPLETE QUESTIONS 37 to 47

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
37. Within the last 5 years, have you consulted any medical advisers other than as identified above? <i>If "Yes", please provide name and address in the Remarks section.</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Are you now being observed or treated by any medical adviser, or taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you ever had, or ever been told you had, or received treatment or advice for:				
a) the heart or blood vessels, such as chest pain, shortness of breath, palpitations, irregular pulse, high cholesterol levels, high blood pressure, heart attack, stroke or transient ischemic attack (TIA), rheumatic fever, murmur, poor circulation or phlebitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) the lungs, nose, throat, such as shortness of breath, persistent cough or hoarseness, blood spitting, chronic bronchitis, emphysema, asthma, tuberculosis, pneumonia, sleep apnea, tumor or any other respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) the digestive organs, such as ulcer, gallstones, hepatitis, hepatitis carrier or jaundice, liver or pancreas disease, colitis, bleeding, recurrent indigestion, persistent diarrhea, diverticulitis or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) the kidney, bladder, genital or urinary organs, such as nephritis, infection, stone, tumor, sexually transmitted diseases or sugar, protein, blood or pus in the urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) the nervous system, eyes or ears, such as vision or hearing disorders, chronic headaches, seizures, epilepsy, dizziness, tumor, inflammation, paralysis, mental or mood disorders (such as depression or anxiety), suicide attempt or ideation, chronic fatigue, memory loss, Alzheimer's disease or brain disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) the glandular system, such as anemia, enlarged glands, diabetes, hormone disorders, breast disorder, skin disorder, thyroid disorders or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) the musculo-skeletal system, such as arthritis, gout, amputation, paralysis, deformity, tumor of the bones, joints or muscles, back, neck or spinal discomfort including pain, strain or sprain?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) the immune system, such as an immune deficiency syndrome, AIDS or test results indicating exposure to the virus causing AIDS (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Remarks *Details of any "Yes" answers.
If applicable, attach the appropriate completed questionnaire(s).*

QUESTION #	LIFE #	DETAILS (Provide dates, diagnosis, results of investigations, names of medical advisors and medical facilities, and treatment).

FAMILY HISTORY

47. Have any of your immediate family members (father, mother, brothers, sisters) had Huntington’s chorea, cancer, diabetes, heart disease, stroke or polycystic kidney disease prior to age 61?
 If “Yes”, please complete the table below.

LIFE 1		LIFE 2	
YES	NO	YES	NO
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

LIFE 1

Family Member Condition Age at Onset Age if Living Age at Death Cause of Death

Father					
Mother					
Brothers/Sisters					

LIFE 2

Family Member Condition Age at Onset Age if Living Age at Death Cause of Death

Father					
Mother					
Brothers/Sisters					

THIS SECTION TO BE COMPLETED IF THERE ARE CHILDREN OF THE PROPOSED LIFE INSURED TO BE INSURED UNDER A CHILDREN’S RIDER.

48.

Child name (last, first)	Gender M / F	Date of Birth DD / MM / YYYY	Height <input type="checkbox"/> ft/in or <input type="checkbox"/> cm	Weight <input type="checkbox"/> lbs or <input type="checkbox"/> kg	Name and address of Family Doctor
A					
B					
C					
D					

If you answer "Yes" to any question(s), please identify child and provide additional information in the Remarks section.

Refer to Children named in Question 48

- 49.** Has there ever been an application for life or critical insurance on any of these children that was declined, postponed, offered with restrictions or modified with a rating in any way?
- 50.** Has any child to be insured ever had any illness, impairment or injury that required treatment, surgery or hospitalization?
- 51.** Was any child to be insured born prematurely?
 If “Yes”, please provide birth weight in the Remarks section.
- 52.** Has any child to be insured consulted or been treated by any physician or other practitioner for any known or suspected heart problem, cancer, mental impairment, acquired immunodeficiency syndrome or ever tested positive for HIV or exhibited any delay in physical or mental development?

A		B		C		D	
Y	N	Y	N	Y	N	Y	N
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Declaration

I/We have read all of the questions and answers in this application and I/we understand the meaning and importance of them.

THE STATEMENTS AND ANSWERS GIVEN IN THIS APPLICATION ARE TRUE, COMPLETE, AND CORRECTLY RECORDED TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF.

Acknowledgement and Agreement

I/We acknowledge and agree that:

- This application consists of pages i and 1 – 14, any supplement to it (if applicable) and any other declaration made in connection to this application. Together all of this information will form the basis for any policy/coverage issued.
- This application does not include any “Temporary Insurance Agreement.”
- No information acquired by any representative of Transamerica will be binding on Transamerica unless set out in writing in this application.
- Any policy issued on this application will not take effect unless all of the following conditions are satisfied:
 - the full amount of the first premium is received by Transamerica during the lifetime of all persons proposed to be insured under the policy;
 - the policy is delivered to the Owner during the lifetime of all persons to be insured under the policy;
 - all statements and answers given in this application continue to be true and complete on the date of delivery of the policy; and
 - no change has taken place in the insurability of any persons to be insured between the time this application is completed and the time the policy is delivered to the Owner.
- Only the President together with a Vice-President or Secretary of Transamerica has the authority to bind Transamerica or to make any change in this application or any policy issued. Transamerica will not be bound by any promise or representation made by any other person. No broker or agent is authorized to waive, amend or modify any of the terms or provisions in this application or any policy issued. However, Transamerica may make certain changes to this application as provided for in question number 58, Head Office Changes in Application. The owner accepting delivery of the policy constitutes approval of its provisions and ratification of any additions, endorsements or amendments.
- If the answer to any question(s) in this application is misstated, omitted or if any other material misrepresentation or fraudulent statement is made in this application, any policy issued as a result may be rendered void on the grounds of material or fraudulent misrepresentation.
- All premium payments must be made payable to Transamerica Life Canada.
- I/We have received and fully understand the contents of the Disclosure by Transamerica Advisor for British Columbia, if applicable.

Personal Information Authorization

I/We have read and fully understand the contents of the Notices regarding the Medical Information Bureau, Investigative Consumer Reports and Collection, Use and Disclosure of Personal Information (collectively, the “Notices”) and acknowledge and consent to the collection, use and disclosure of my/our personal information by Transamerica and its affiliates for the purposes identified in those Notices.

For the purposes of risk assessment, investigation and loss analysis, I/we authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or any other organization, institution, association or person identified in the Notices that now has or may in future have any records or knowledge concerning me/us or my/our health to disclose to Transamerica, its authorized representatives and its reinsurers, upon the request of Transamerica, any such information that is deemed to be material by Transamerica for the purposes identified in the Notices.

I/We further authorize a representative of Transamerica, to perform such tests, examinations, x-rays, electrocardiograms, blood or urine tests as may be required by Transamerica. I/We understand and agree that such tests may include, but are not limited to, tests for kidney disease, liver disease, bone disease, risk factors for heart disease, AIDS or evidence of exposure to the HIV virus, the presence of medications, drugs, nicotine or their metabolites. Transamerica may release the results of these tests and examinations to my personal physician(s).

A photocopy of this authorization shall be as valid as the original.

The consent you provided in the Notice Regarding Collection, Use and Disclosure of Personal Information relating to the use of your personal information to provide you with details about other insurance and financial services and products is optional.

If you do not wish your personal information to be used for this optional purpose, check here or you can write to us at: Transamerica Life Canada, 5000 Yonge Street, Toronto, Ontario, M2N 7J8, Attention: Privacy Officer.

Signed at _____ In the Province of _____ on DD / MM / YYYY

X _____
PROPOSED LIFE INSURED 1
(Parent or legal guardian, if Proposed Life Insured is minor)

X _____
PROPOSED LIFE INSURED 2
(Parent or legal guardian, if Proposed Life Insured is minor)

X _____
 Owner, if other than Proposed Life Insured

X _____
 Owner, if other than Proposed Life Insured

Print name and title if corporation

Print name and title if corporation

Witness to Signature(s)

If the Owner is a corporation, the signature name and title of the authorized signing officers thereof are required, as stated in the by-laws of the corporation, together with the full legal name of the corporation. If the Owner is a corporation, please attach articles of incorporation/amendment showing its correct legal name.

Transamerica Life Canada AUTHORIZATION FOR PRE-AUTHORIZED DEBIT (PAD)

I/We hereby authorize and direct Transamerica Life Canada (Transamerica) to debit the account at the financial institution which is identified on the attached sample cheque or bank letter of Direction (PAD Account) in the amount and frequency indicated below for the purpose of making premium payments to the policies listed below, and any policy that may be issued pursuant to the applicable application (the "Policy") (collectively the "Policies"), except that I/we authorize and direct Transamerica to increase the debit amount when required to maintain the Policies in force, including for renewal and conversion premiums, which may increase in accordance with the provisions of the Policies. I/We acknowledge and agree that the premiums/cost of insurance including any applicable increases for the Policies are expressly stated in the contract for the Policies and therefore I/we require no further notification from Transamerica of corresponding PAD increases. I/We request that Transamerica apply the PAD amount first to ensure that all such Policies remain in force and then to each of the Policies equally, unless I/we provide other instruction. I/We warrantee that all required signatures for the authorization of debits to the PAD Account are present in this Authorization. I/We further authorize such financial institution and any of its branches to deal with these debits as if authorized by me/us. I/We also understand and agree to all of the terms and conditions printed on the reverse side of this form. I hereby direct Transamerica to:

Establish a new PAD Account Change existing PAD Account information Add the policies shown below to an existing PAD Account _____
(Identify existing policy #)

Policy Number(s) to Which This Request Applies: _____

Application for Insurance: Name of Proposed Life 1: _____ Name of Proposed Life 2: _____

Account Type: Personal Chequing Chequing/Savings Current

Date: DD / MM / YYYY

Signature(s) of Payor(s)	Name(s) of Payor(s)	Signature of Policy owner(s), if other than Payor(s)
X _____	_____	X _____
X _____	_____	X _____

NOTE: A SAMPLE CHEQUE MARKED "VOID" OR A BANK LETTER OF DIRECTION MUST BE ATTACHED FOR THIS AUTHORIZATION TO TAKE EFFECT

AUTHORIZATION - LIFE 1

For the purposes of risk assessment, investigation and loss analysis, I, the Proposed Life Insured, hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or any other organization, institution, association or person that now has or may in future have any records or knowledge concerning me or my health to give Transamerica, its authorized representatives and its reinsurers any such information upon the request of Transamerica.

I further authorize Transamerica to release medical information to my usual medical advisor.

A photocopy of this Authorization shall be as valid as the original.

Signed at: _____ In the Province of _____
CITY
 on DD / MM / YYYY

LIFE 1 (Parent or legal guardian, if Proposed Life Insured is minor)

X _____

Witness to Signature: _____

AUTHORIZATION - LIFE 2

For the purposes of risk assessment, investigation and loss analysis, I, the Proposed Life Insured, hereby authorize and direct any physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau or any other organization, institution, association or person that now has or may in future have any records or knowledge concerning me or my health to give Transamerica, its authorized representatives and its reinsurers any such information upon the request of Transamerica.

I further authorize Transamerica to release medical information to my usual medical advisor.

A photocopy of this Authorization shall be as valid as the original.

Signed at: _____ In the Province of _____
CITY
 on DD / MM / YYYY

LIFE 2 (Parent or legal guardian, if Proposed Life Insured is minor)

X _____

Witness to Signature: _____

TERMS AND CONDITIONS OF PARTICIPATION IN THE PRE-AUTHORIZED DEBIT (PAD)

Effective Date

I/We understand and agree that the Authorization on the reverse side of this form will not take effect unless a sample cheque marked "VOID" or bank Letter of Direction has been provided with the Authorization. This cheque must identify the financial institution, branch and the account number specified as the PAD (PAD Account). Provided that the above condition is satisfied, the Authorization will take effect for the Policies identified in the Authorization, on the latest of the following dates:

- i) the date the Authorization is received by the Head Office of Transamerica;
- ii) the date the full amount of the first premium for the Policy is received by Transamerica's Head Office; and
- iii) the date when the Policy applied for is first placed in full force and effect by Transamerica.

General

I/We also understand and agree to all of the following terms and conditions:

- a) I/We certify that the information provided with respect to the PAD Account is accurate. I/We will provide Transamerica with a new sample cheque, if the PAD Account is changed.
- b) The amount drawn on the PAD Account shall be a total of all amounts required to pay the applicable premium payments for all Policies identified on the reverse and the Policy.
- c) The Authorization shall apply to all Policies listed on the reverse and the Policy, including any renewal, conversion or increase in cost of insurance specified in the contract.
- d) The Authorization and all its terms and conditions are subject to all of the terms and provisions of the applicable Policies.
- e) If Transamerica has not received a premium payment within the time required, for example, your PAD is not honoured, or for any other reason, then the Policy will lapse and become null and void, unless it is otherwise provided in the Policy.
- f) I/We consent to disclosure of any personal information that may be contained on this Authorization to Transamerica's designated financial institution to the extent necessary for the purposes described in the Authorization and these Terms and Conditions.

Termination

The Authorization will be terminated only on the earliest of the following dates:

- a) either I/we or Transamerica provide(s) written notice to the other to that effect;
- b) a PAD is not honoured by your financial institution when presented by Transamerica, in accordance with Transamerica's then current administrative procedures; and
- c) all of the Policies to which the Authorization applies are no longer in full force and effect.

The revocation of the Authorization does not affect your rights under the Policies.

I/We further understand and agree that (a) if the Authorization is terminated, a direct modal premium shall become payable for all Policies to which the Authorization applies; and (b) the amount and frequency of the premium payable under the Policies will be specified in the pages entitled "POLICY DATA"/"Schedule of Benefits and Premiums" attached to the Policy and may be different than the premium payable under a PAD plan.

Transamerica Life Canada,
5000 Yonge Street, Toronto, Ontario, M2N 7J8.

Transamerica Life Canada,
5000 Yonge Street, Toronto, Ontario, M2N 7J8.

APPLICATION FOR TEMPORARY INSURANCE

All of the following questions must be answered by the below-named Proposed Life Insured(s). If this Application is made in conjunction with an Application for a multiple or joint life policy, then this Temporary Insurance Application applies to each Proposed Life Insured separately in respect of the "Note" below.

PRINT FULL NAME OF PROPOSED LIFE INSURED(S): **LIFE 1** _____

LIFE 2 _____

Note: Temporary Insurance is not available for a person proposed to be insured who is less than 15 days old or more than 65 years of age. No advisor is authorized to waive, amend or modify any of the terms or provisions in this Application for Temporary Insurance or in the Temporary Insurance Agreement (TIA). No representative of Transamerica is authorized to provide temporary insurance coverage (a) if any question in this Application for Temporary Insurance is left blank or is answered "Yes", (b) if the total amount of pending life insurance with Transamerica on an above-named Proposed Life Insured does or will exceed \$2,000,000 (Cdn), or (c) if the first payment post dates the Application for Life Insurance.

	LIFE 1		LIFE 2	
	YES	NO	YES	NO
1. Have you had or ever been told you had, consulted a physician for or received treatment for any of the following:				
a) Disorder of the heart or blood vessels, chest pain, angina, heart attack or stroke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Cancer or tumor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Acquired Immune Deficiency Syndrome (AIDS), HIV infection or any other immunological disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Within the past two years, have you had any symptoms of, treatment for, any medical condition that resulted in hospitalization for more than five days?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Within the past 90 days have you been unable to perform the normal duties of your occupation for fifteen or more working days because of health reasons?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever applied for insurance which has been declined, rated or modified in any way?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

DECLARATION

I/We declare that I/we have read all of the questions, answers and statements in this Application for Temporary Insurance and all of the terms and provisions in the TIA, and understand their meaning and importance.

I/We further declare that the answers given in this Application for Temporary Insurance are true, complete and correctly recorded to the best of my/our knowledge and belief.

I/We understand and agree that this Application for Temporary Insurance and the TIA shall be the basis for any insurance provided thereunder.

Signed at _____ **In the Province of** _____ **on** DD / MM / YYYY

X _____
PROPOSED LIFE INSURED 1
(Parent or legal guardian, if Proposed Life Insured is minor)

X _____
PROPOSED LIFE INSURED 2
(Parent or legal guardian, if Proposed Life Insured is minor)

X _____
 Owner, if other than Proposed Life Insured(s)

X _____
 Owner, if other than Proposed Life Insured(s)

Print name and title if corporation

Print name and title if corporation

X _____
 Witness to Signature(s)

DETACH AND GIVE TO POLICYOWNER
APPLICATION NO. _____

RECEIPT for Temporary Insurance

Transamerica Life Canada (Transamerica) acknowledges receipt of \$ _____ which is at least the full amount of one monthly modal premium based on the Application for Life Insurance dated DD / MM / YYYY on the life of *(print full name of Proposed Life Insured)*

Name **LIFE 1** _____

Name **LIFE 2** _____

Signed at: _____

on DD / MM / YYYY

Print full name of Transamerica Advisor

Signature of Transamerica Advisor

X _____

THIS RECEIPT DOES NOT BIND TRANSAMERICA TO PROVIDE COVERAGE UNDER THE TEMPORARY INSURANCE AGREEMENT UNTIL ALL OF THE TERMS AND CONDITIONS THEREOF ARE SATISFIED.

Note: If you do not hear from Transamerica regarding the proposed life insurance within ninety (90) days of the date of your Application for Life Insurance, please contact your Transamerica Advisor or Transamerica at its Head Office, 5000 Yonge Street, Toronto, Ontario, M2N 7J8.

TEMPORARY INSURANCE AGREEMENT (the Agreement)

Transamerica hereby agrees to provide temporary, limited insurance on the life of each Proposed Life Insured named in the applicable Application for Temporary Insurance upon and subject to all of the following terms and conditions. If such Application for Temporary Insurance is made in conjunction with an application for a multiple or a joint life policy, this Agreement applies to each Proposed Life Insured separately.

Effective Date – This Agreement shall be effective on the date Part 1 of the Application was completed providing all of the following conditions are satisfied:

1. the Application for Temporary Insurance is completed, signed, dated and at least the full amount of one monthly modal premium based on the Application for Life Insurance has been paid on the same day;
2. any cheque delivered as the initial modal premium is honoured upon its first presentation for payment;
3. all of the questions in the applicable Application for Temporary Insurance are answered "No"; and
4. the Application for Life Insurance has been fully completed and signed on the same date as the Application for Temporary Insurance.

Death Benefit – Subject to all of the terms and conditions of this Agreement, if the Proposed Life Insured under this Agreement dies while this Agreement is in effect, then Transamerica agrees to pay to the applicable beneficiary named in the Application for Life Insurance, and upon receipt of proof of death satisfactory to Transamerica, a death benefit equal to the lesser of:

1. the amount of insurance applied for in the Application for Life Insurance in respect of such Proposed Life Insured, excluding any additional benefits applied for; and
2. \$1,000,000.00 (Cdn.)

If the applicable Application for Temporary Insurance is completed in conjunction with an Application for Life Insurance requesting a joint first-to-die or joint last-to-die policy, this Agreement in respect of the surviving Proposed Life Insured(s), will be rendered null and void upon the death of the first Proposed Life Insured.

Limitations – This Agreement becomes void if:

1. the sum of life insurance pending with Transamerica on the Proposed Life Insured does or will exceed \$2,000,000 (Cdn);
2. the Proposed Life Insured is less than 15 days old or more than age 65 years of age;
3. the death of the Proposed Life Insured under this Agreement results from suicide, while sane or insane;
4. the Proposed Life Insured under this Agreement dies while committing or attempting to commit a criminal act including, without limitation, driving a motor vehicle while under the influence of alcohol or drugs; or
5. a material fact has not been disclosed, or has been misrepresented in the Application for Life Insurance or any other declaration made in connection to this application, or in the Application for Temporary Insurance.

Termination – This Agreement will terminate on the earliest of the following dates:

1. the date on which the policy issued pursuant to the Application for Life Insurance becomes effective;
2. the date on which Transamerica mails a notice to the Advisor to notify the Owner and/or proposed insured in the application for Life Insurance either (a) terminating this agreement, or (b) declining to issue the policy as applied for;
3. the date on which the Owner in the Application for Life Insurance requests withdrawal of the Application for Life Insurance or the applicable Application for Temporary Insurance; and
4. the date which is ninety (90) days after the date of the Application for Life Insurance.

NOTE: NO ADVISOR IS AUTHORIZED TO WAIVE, AMEND OR MODIFY ANY OF THE TERMS OR PROVISIONS IN THE APPLICATION FOR TEMPORARY INSURANCE OR IN THIS AGREEMENT.

CORPORATION/NON-CORPORATE ENTITY IDENTIFICATION – This section must be completed by the Advisor for all Universal Life if the Owner is a Corporation or Non-Corporate Entity. Please provide a copy of the articles of incorporation/amendment showing its correct legal name.

1. Please provide the following information on the individual(s) submitting an application on behalf of a Corporation or Non-Corporate Entity.

Name of Individual	Job Title	Identification Document*	Identification Document Number*	Issuing Jurisdiction*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

*Please refer to an original passport, birth certificate, driver's license, Canadian Citizenship, Age of Majority or Canadian Armed Forces Identification (preferably photo ID).

2. Corporation – In addition to the information contained in Section 1, please provide Corporation information.
Please refer to Articles of Incorporation or similar document.

Official Corporate Name

Place of Federal or Provincial Incorporation _____ Corporation Registration Number _____

Name of All Directors of Corporation (If necessary, attach listing of all directors)

3. Non-Corporate Entity – In addition to the information in Section 1, please provide Non-Corporate Entity Information.
Please refer to Partnership Agreement, Articles of Association, Declaration of Trust or similar documents.

Official Name of Entity

Place of Issue _____ Registration Number _____

Type of Document/Entity

ADVISOR'S NOTES AND COMMENTS

ADVISOR'S REPORT – Must be completed in all cases

1. (THIRD PARTY DETERMINATION must be completed for ALL UNIVERSAL LIFE applications) Every reasonable effort must be made by you to determine if the owner is acting on behalf of a third party.
 When asked whether the owner(s) is/are acting on behalf of a third party the individual submitting the application answered: No Yes
 If "Yes", collect the following information relating to the third party.

Name of Third Party _____ Relationship of Third Party to Owner _____

Address of Third Party _____ Occupation/Business of Third Party _____

If a Corporation or other entity, registration # _____ Place of Issue _____

Unable to determine, however I have reasonable grounds to suspect there is a third party. Reason (attach separate page if necessary) _____

	<u>LIFE 1</u>	<u>LIFE 2</u>
2. What is your relationship to the Proposed Life Insured(s)?	_____	_____
3. Each Proposed Life Insured can read, speak and understand	<input type="checkbox"/> English <input type="checkbox"/> French	<input type="checkbox"/> English <input type="checkbox"/> French
If neither, have you fully explained the details of the Application to each Proposed Life Insured and are you satisfied that the application is fully understood?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "No", clarify in Advisor's Notes section.		

4. To be completed by all advisors:
 Have you provided the Client(s) with a copy of the signed policy illustration? (For Universal Life Only) Yes No
 Is a signed copy of the Illustration attached? (Required for Universal Life Only) Yes No

5. By signing below, I/we acknowledge that I/we have disclosed, where applicable, the following items to the owner of the policy resulting from this application:
 a) the company or companies I/we represent;
 b) that I/we will receive compensation (such as commissions or a salary);
 c) that I/we may receive additional compensation in the form of bonuses, conference programs or other incentives; and
 d) that I/we have disclosed any conflicts of interest that I/we may have with respect to this transaction.

Advisor's Notes:

Do you have any knowledge of each Proposed Life Insured's personal habits, health, avocations, finances or reputation that might affect the underwriting risk? If so, please give details below.

Advisor's e-mail address _____

I/We hereby declare that the statements and answers given in this application are true, complete and correctly recorded to the best of my/our knowledge and belief, and that I am/we are not aware of additional information material to the Proposed Life Insured(s) except as stated above in the Advisor's notes section on this page. When applicable, I/we have verified the identity of the individuals who submitted the application by referring to the original documents. I/We confirm that the information recorded was correctly copied from such document(s). Reasonable effort has also been exercised to determine if the owner(s) is/are acting on behalf of a third party.

Signed at _____ **In the Province of** _____ **on** DD / MM / YYYY

Signature of Transamerica Advisor _____ **Name of Transamerica Advisor (Please print)** _____

X _____

Signature of Transamerica Advisor _____ **Name of Transamerica Advisor (Please print)** _____

X _____

TO BE COMPLETED BY DISTRIBUTOR

The individual who wrote this application must be listed below as either Advisor 1, 2 or the Writing Advisor and MUST have his/her own SA code.

<p>1. Distributor Contact Name _____ Distributor Contact Email: _____</p> <p>Advisor 1: _____ Advisor 2: _____ Writing Advisor (if other than Advisor 1 or 2) _____ (Last Name) (Given name)</p>	<p>Distributor Name and Number _____ Distributor Contact Phone Number _____</p> <p>Advisor Code: _____ Share % _____ Advisor Code: _____ Share % _____ Advisor Code: _____</p> <p>If shared, who is the Servicing Advisor? <input type="checkbox"/> Advisor 1 <input type="checkbox"/> Advisor 2</p>
--	---

2. If you wish to have this policy issued on the same day as another policy or policies for families, partnership or other business reasons, please give the names of the other Proposed Life Insured(s) below.

Group With: _____ or _____
 _____ or _____
 (Last Name) (Given name) (Policy Number)

Please note: An underwriting decision needs to be made on ALL Proposed Insureds before any of the grouped policies will be issued, unless you inform us otherwise.

3. PAYMENT SUBMITTED WITH THIS APPLICATION

\$ _____

All cheques must be made payable to Transamerica Life Canada (no post dated cheques).

4. Additional Comments:

5. UNDERWRITING REQUIREMENTS – LIFE 1

Ordered	Submitted	Ordered From	Ordered	Submitted	Ordered From
<input type="checkbox"/>	<input type="checkbox"/> Medical	_____	<input type="checkbox"/>	<input type="checkbox"/> Aviation Q	_____
<input type="checkbox"/>	<input type="checkbox"/> Paramedical	_____	<input type="checkbox"/>	<input type="checkbox"/> Sport Q	_____
<input type="checkbox"/>	<input type="checkbox"/> Urine/HIV	_____	<input type="checkbox"/>	<input type="checkbox"/> Financial Q	_____
<input type="checkbox"/>	<input type="checkbox"/> Blood/HOS	_____	<input type="checkbox"/>	<input type="checkbox"/> Signed Illustration	_____
<input type="checkbox"/>	<input type="checkbox"/> ECG	_____	<input type="checkbox"/>	<input type="checkbox"/> Signed Supplement to Application	_____
<input type="checkbox"/>	<input type="checkbox"/> Stress Test	_____	<input type="checkbox"/>	<input type="checkbox"/> Replacement/Comparison Disclosure Form	_____
<input type="checkbox"/>	<input type="checkbox"/> X-RAY	_____	<input type="checkbox"/>	<input type="checkbox"/> MVR	_____
<input type="checkbox"/>	<input type="checkbox"/> APS	_____	<input type="checkbox"/>	<input type="checkbox"/> Other	_____
<input type="checkbox"/>	<input type="checkbox"/> DR. _____				
<input type="checkbox"/>	<input type="checkbox"/> Inspection/BBR	_____			

UNDERWRITING REQUIREMENTS – LIFE 2

Ordered	Submitted	Ordered From	Ordered	Submitted	Ordered From
<input type="checkbox"/>	<input type="checkbox"/> Medical	_____	<input type="checkbox"/>	<input type="checkbox"/> Aviation Q	_____
<input type="checkbox"/>	<input type="checkbox"/> Paramedical	_____	<input type="checkbox"/>	<input type="checkbox"/> Sport Q	_____
<input type="checkbox"/>	<input type="checkbox"/> Urine/HIV	_____	<input type="checkbox"/>	<input type="checkbox"/> Financial Q	_____
<input type="checkbox"/>	<input type="checkbox"/> Blood/HOS	_____	<input type="checkbox"/>	<input type="checkbox"/> Signed Illustration	_____
<input type="checkbox"/>	<input type="checkbox"/> ECG	_____	<input type="checkbox"/>	<input type="checkbox"/> Signed Supplement to Application	_____
<input type="checkbox"/>	<input type="checkbox"/> Stress Test	_____	<input type="checkbox"/>	<input type="checkbox"/> Replacement/Comparison Disclosure Form	_____
<input type="checkbox"/>	<input type="checkbox"/> X-RAY	_____	<input type="checkbox"/>	<input type="checkbox"/> MVR	_____
<input type="checkbox"/>	<input type="checkbox"/> APS	_____	<input type="checkbox"/>	<input type="checkbox"/> Other	_____
<input type="checkbox"/>	<input type="checkbox"/> DR. _____				
<input type="checkbox"/>	<input type="checkbox"/> Inspection/BBR	_____			



Member of the **AEGON** Group

5000 Yonge Street
Toronto, Ontario M2N 7J8
www.transamerica.ca