

## Transamerica Life Insurance Company ("Insurer")

Home Office: Cedar Rapids, IA Administrative Office: P.O. Box 869094 Plano, TX 75086-9817

## Interest Sensitive Whole Life Insurance (ISWL) Application

Group Name Decatur County Board of Education Group Number Location Bainbridge, Georgia 39817							
Group Name Decatur County Board of Education Group Number Location Bainbridge, Georgia 39817							
Applicant (Last, First, M.I.) Date of birth Date of married Date of married Date of birth Date of birth Date of married Date of birth Date of birt	ge						
Spouse 1     Image: Constraint of the state							
Date of hire     Avg hours worked per week     Annual salary     Occupation     Applicant ID							
Have you or your spouse used tobacco products in the last year?     Home phone     Work phone/ext.							
Applicant 🗆 No 🗆 Yes Spouse 🗆 No 🗆 Yes							
Home address City State Zip code							
Life insurance contract owner (Last, First) Address Relationship Social Security No. (If different than applicant)							
Primary Beneficiary: (Last, First, M.I.)							
Contingent Beneficiary: Relationship:							
(Last, First, M.I.) Applicant will be the beneficiary for any spouse and/or child(ren) coverage							
<sup>1</sup> Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction, or as							
otherwise agreed upon between the policyholder and the Insurer.  Premium Mode:  Weekly Bi-Weekly Semi-Monthly Monthly Other							
I am applying for:     Face     Premium     Child(ren) Information     ISWL       Amount*     per Mode*     Name (List all children)     Date of Birth     Premium Arrows A	ot						
Amount" per Mode" Name (List all children) Date of Birth per Mode*	n						
Applicant ISWL							
Child Term Rider # of children Add to:  Applicant  Spouse							
Add to:  Applicant  Spouse Spouse ISWL							
Child(ren) ISWL (List total premium for all children)  \$25,000							
*For increases, list total Face and Premium Amounts. Total							
Children may apply for ISWL coverage OR a Term Rider, but not both.							
Eligibility Questions         1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation?          □ Yes □ No         □							
If "No", you and your dependents are not eligible for coverage.	1 N Io						
<ol> <li>If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled?</li></ol>							
Evidence of Insurability Questions - Part 1							
B. In the six months prior to the application date, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any of the conditions listed in Question # 6?							
If "Yes", List name(s), who will be excluded from coverage, unless included by special endorsement.	If "Yes", List name(s), who will be excluded from coverage, unless included by special endorsement.						
<ol> <li>Has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease?</li> </ol>							
If "Yes", List name(s), who will be excluded from coverage, unless included by special endorsement.							
Evidence of Insurability Questions - Part 2							
5. Indicate height and weight for: <u>Applicant</u> / <u>Spouse</u> /							
<ol> <li>In the ten years prior to the application date, has any proposed insured been treated for, been diagnosed as having, or had any indication, sign or symptom of having any heart, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, neurological,</li> </ol>							
rheumatoid, or other major organ disorders, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)?							
If "Yes", List Name(s), who will be excluded from coverage, unless included by special endorsement.							
If "Yes", List Name(s), who will be excluded from coverage, unless included by special endorsement. 7. Do you or any proposed insured have high blood pressure that is controlled by more than two medications?							

Guestion I         Name         Present file: Times, thugs: Condition, Medication, Date of least Treatment, Date Condition Degreeced, Duraton, Result, Current Health Status, Prognetis, Name & Address of Dostor or Heaptal                Present residents of AL, AK, ARF, AZ, CO, HL, KL, AM, DM, KL, MT, ME, NC, NH, MN, MO, CH, OR, RI, SC, SD, TX, UT, VA, VT, WT, OY W, Do you currently have any other existing life insurance on bioles or contracts?                 Present question for residents of AL, AK, ARF, AZ, CO, HL, NL, AM, DM, KL, SM, TT, ME, NC, NH, MN, MO, CH, OR, RI, SC, SD, TX, UT, VA, VT, WT, OY W, Do you currently have any other existing life insurance oblics or contracts?                 Preadoment question for residents of all other states:               Preadoment forms in previous any other existing life insurance on previous any other existing life insurance on previous and question.                 Accelerated Death Benefit Disconter Actionvoledgement: For coverage lissued in AL, ARD, CL, LL, MJ, NS, OH, or WA               WAG Previous Actionvoledgement for coverage lissued in AL, ARD, CL, LL, MJ, NS, OH, or WA                 Residential Death Benefit Disconter Actionvoledgement for or values glissued in AL, ARD, CL, LL, MJ, MS, OH, or WA               WiA                 Residential Death Death States:               Name on the previous and that they are not guaranteed queries in No/A                 Residential Death Disconter Actionvoledgement for coverage lissued in AL, ARD, CL, LM, ML, ML, MD, OH, OR AL, SL, WIA	Only needed for amounts over GIO limits Please provide details of all "Yes" answers to questions 2, 3, 4, 6 and 7. Use additional paper if needed. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.							
APPLICANT'S STATEMENTS AND AGREEMENTS:           Replacement question for residents of ALI, AK, AR', AZ, CO, HI, IA, LA, MD, ME, MS, MT, NE, NC, MJ, NI, MO, OR, RI, SC, SD, TX, UT, VA, II 'Yes', complete the replacement form(s) provided by your agent and return with this application.           Replacement question for residents of all other states:         Is the insurance being applied for intended to replace or optage or optage or male and return with this application.           Replacement question for residents of all other states:         Is the insurance being applied for intended to replace or optage or	Question #	<u> </u>	Please list: Illness, Injury, Condition, Medication	n, Date of last Trea				
Replacement question for residents of AL, AK, AR', AZ, CO, HI, JL, AL, MD, ME, KS, MT, NE, NC, NJY, MJ, MO, HO, RP, RJ, SC, SD, TX, UT, VA, VT, WI or WY: Do you currently have any other existing life insurances olicies or contracts? □ ves □ No N/A         Replacement question for residents of all other states:          Is the insurance being applied for intended to replace or change any existing life insurance coverage? □ Ves □ No			Health Status, Prognosis, Name & Address of Do	octor or Hospital				
Replacement question for residents of AL, AK, AR', AZ, CO, HI, JL, AL, MD, ME, KS, MT, NE, NC, NJY, MJ, MO, HO, RP, RJ, SC, SD, TX, UT, VA, VT, WI or WY: Do you currently have any other existing life insurances olicies or contracts? □ ves □ No N/A         Replacement question for residents of all other states:          Is the insurance being applied for intended to replace or change any existing life insurance coverage? □ Ves □ No								
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If "Yes", complete the replacement form(s) provided by your agent and return with this application.  Replacement question for residents of all other states: Is the insurance being applied for intended to replace or change any existing life insurance overage? □ Yes  No  Trees' list an ame of company complete replacement form if answering "Yes" to the second question.  Accelerated Death Benefit Disclosure Acknowledgement: For coverage issued in AL, AR, DC, LI, MJ, MS, OK, or WA NA  If applying for an Accelerated Death Benefit Rider, did you receive the applicable Disclosure(s) if required in your state?  Cronoic Condition Rider (Yes □ No Cinditica Care Rider □ Yes □ No  Terminal Illness Rider □ Yes □ No  Illustration Acknowledgement for all applicants:  Letrity that a life insurance illustration showing non-guaranteed values □ was of was not used during the sale of the insurance  coverage 1 ame applying for on this application. Inderstand that if my application is approved, an illustration confirming to the policy/certificate  as issued will be delivered to men to later than when I receive my policy/certificate. Understand that any non-guaranteed elements contained in  any illustration are subject to change and oculd be either higher or lower and that thay parson undo knowingly and with intent to defraud any insurance company or other person files an applying that any person who knowingly and with intent to defraud any insurance company or other person files an application  insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning  understand that any person who knowingly and with intent to defraud any insurance company or other person files an application  insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning  understand that coverage will become effective only after all of the following conditions have been met; a) I must be a mether of an e								
Beplacement question for residents of all other states:       Is the insurance being applied for intended to replace or change any existing life insurance coverage?       Yes       Yes       Yes         Residents of AR: Answer both replacement form(s) provided by your agent and return with this application:       Policy/certificate #	VT, WI or WV: Do you currently have any other existing life insurance policies or contracts?  Yes V No N/A							
It she insurance being applied for intended to replace or change any existing life insurance coverage.  Yes Visa and the Replacement form(s) provided by your agent and return with this application: Residents of AR: Answer both replacement questions. Complete replacement form if answering 'Yes' to the second question. Concented the Benefit Discourse Acknowledgement: For coverage is used in AL, AR, DC, Li, Mi, MS, OH, or WA N/A If applying for an Accelerated Death Benefit Discourse (show degement for all spolication). Condition Rider  Yes   No Critical Care Rider  Yes   No Terminal Illness Rider   Yes   No Critical Care Rider  Yes   No Terminal Illness Rider   Yes   No Critical Care Rider  Yes   No Terminal Illness Rider   Yes   No Critical Care Rider   Yes   No Terminal Illness Rider   Yes   No Critical Care Rider   Yes   No Criticate    used during the sale of the insurance ecverage   an applying for on this application is application is application is application are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgement, and will return a copy of the signed illustration to the insure. Irepresent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statement berein within materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is application is any benefit in the any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, whic								
If "Yes", list name of company								
complete the Replacement form(s) provided by your agent and return with this application.	lf "Ye	es", list name of company		, Policy/cert				
Accelerated Death Benefit Disclosure Acknowledgement: For coverage issued in AL, AR, DC, IL, MI, MS, OH, or WA       N/A         If applying for an Accelerated Death Benefit Rider, did you receive the applicatio Disclosure(s) if required in your state?         Chronic Condition Rider   Yes   No       No         Illustration Acknowledgement for all applicatos:       Internial Illuss Rider   Yes   No         Illustration Acknowledgement for all applicatons:       Internial Illuss Rider   Yes   No         Internity that a life insurance illustration showing non-guaranteed values   was @ was not used during the sale of the insurance ocverage   an applying for on this application. I and when I receive my policy/certificate. I understand that any non-guaranteed elements contained in any illustration are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgement, and will return a copy of the signed illustration to the insure.         I'represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.         I understand that any person who knowingly and with Intent to defraud any insurance company or other person files an application. I understand that coverage will become effective only after all of the following conditions have been met: a)   must be a member of an eligible class; b)   must have satisfied the policyholder waiting period; c) The policyholder group must have ent the Insurer's minimum participa	com	plete the Replacement form(s) pro-	vided by your agent and return with this a	pplication.				
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to which this application is attached. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. I understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) The policyholder group must have met the Insurer's minimum participation requirement, d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disable (unless included by special endorsement), on the effective date (according to the Insurer's rules); and f) The first month's premium must have been received by the Insurer at its administrative office. I understand that completion of this application in no way implies that 1 will be accepted for insurance coverage. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information. I understand the information obtained by use of this Authorization will be used by Insure to determine eligibility for insurance. Any information obtained will not be released by Insurer to any person or organization except to reinsuring companies, the Medical Information Bureau", or other persons or organization sperforming business or legal services in connection with my application or as may be otherwise lawfully required or as l authorize. I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be applicant. Signature								
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\*Information regarding your insurability will be treated as confidential. The Insurer, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Insurer, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.