

Policy No.:	Owner(s):
Insured:	Address of Owner: _____
Insured's Address: _____ _____	Owner's NRIC/SSN/Passport No.:
Insured's NRIC/SSN/Passport No.:	Owner's Entity ID:
Insured's Date of Birth (mm/dd/yyyy):	Owner's Date of Birth (mm/dd/yyyy):

**SECTION I - TYPE OF CHANGE REQUEST (Evidence of insurability may be required)**

1. Check those boxes that describe the type of proposed change:

A) Each of the following proposed changes require full new business underwriting requirements, completion of Section IV, a signed Authorization to Obtain Information and any additional requirements as required by the company.

1) **Non-contractual rewrite** (replacement of an existing Transamerica Life Bermuda contract with a new Transamerica Life Bermuda contract when not guaranteed by the existing contract). Also complete Section II.

2) **Face Amount increase.** Enter the new face amount applied for  
(i.e. current face amount + amount of increase) = \$ \_\_\_\_\_  
Submit full new business underwriting requirements for the amount of the increase.

B) Each of the following proposed changes require full new business underwriting requirements, completion of Section IV, a signed Authorization to Obtain Information and any additional requirements as required by the company.

1) **Change to non-smoker rate class.** Arrange for current Home Office urine specimen and complete Question #14 in Section IV.

2) **Rate class reduction.** Provide information detailing the aspect(s) of the risk that has/have changed that might warrant a rate class reduction.  
\_\_\_\_\_  
\_\_\_\_\_

3) **Add a rider/benefit.** Check the box/boxes that apply.

Waiver of Premium/Waiver Provision. Complete a Non-Medical Health History form (MPN 1SG) on the Insured.

Accident Indemnity - Amount: \$ \_\_\_\_\_ Complete a Non-Medical Health History form (MPN 1SG) on the Insured and Question #4 in Section IV.

APPLICATION (Change)



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C) Other changes. *Additional requirements may be requested by the Company.*

1) **Exercise Option for Additional Insurance (OAI)** (if available) - Amount: \$\_\_\_\_\_

Please check one:

Issue new contract for OAI amount.

Increase face amount of original contract to add OAI amount (if available).

Yes    No   a) If the original contract has a Waiver of Premium/Waiver Provision rider, should a Waiver of Premium/Waiver Provision rider also be included on this new amount?

**Complete the following and a signed Authorization to Obtain Information if the Insured was issue age 51 or older at original contract issue. Provide details of "yes" answers in the Remarks section.**

Yes    No   a) Is the Primary Insured now so disabled by sickness or injury as to be unable to perform any of the duties of his/her normal job?

Yes    No   b) Within the past five years, has the Insured had high blood pressure, heart disease, diabetes, or cancer?

2) **Change of Death Benefit option** (UL Plans only). Contact the branch office for requirements.

Change to Option:    Level    Plus    Other \_\_\_\_\_

3) **Other change:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Remarks:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SECTION II - DETAILS OF THE NEW CONTRACT

Complete only for non-contractual rewrites and conversions

- 1. Plan applied for: \_\_\_\_\_ 1a. Plan Code: \_\_\_\_\_
2. [ ] Select [ ] Preferred Plus [ ] Preferred [ ] Standard [ ] Other \_\_\_\_\_
3. [ ] Non-Smoker Class [ ] Smoker Class
4. Amount Applied for: \_\_\_\_\_
5. Risk Applied for: Standard Unless Otherwise Indicated
[ ] Rating (if applicable): \_\_\_\_\_
6. Additional Benefits:
[ ] Waiver of Premium/Waiver Provision [ ] Accident Indemnity \$ \_\_\_\_\_ [ ] Other \$ \_\_\_\_\_
7. Special dating instructions, if any. Unless otherwise indicated, the change will be effective on the policy's anniversary date closest to the date this form was received in good order. \_\_\_\_\_
8. If the Automatic Premium Loan provision is available, it is to be:
[ ] Effective [ ] Not Effective

Any new plan shall have the same beneficiary as the present contract. If a different beneficiary designation is desired, please complete the Beneficiary Designation for Life Insurance Policies form (TOB 306SG) as instructed on that form.

Remarks: \_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

9. Complete for Flexible Premium Plans:
Planned Periodic Premium (PPP) \$ \_\_\_\_\_ Years
or Required Annual Premium (RAP) (if applicable)
+ Initial Lump Sum \$ \_\_\_\_\_
= Total Initial Payment \$ \_\_\_\_\_

10. Premium Payment Mode:
[ ] Annual
[ ] Semi-Annual
[ ] Quarterly
[ ] Monthly
Premium Payment Method:
[ ] Wire/TT [ ] Bank Draft [ ] Check

SECTION III - INSTRUCTIONS TO TERMINATE EXISTING LIFE INSURANCE COVERAGE

Existing policy(ies)/coverage(s) for which a change or termination is requested will remain in effect only until the policy(ies)/ change(s) applied for is/are effective in accordance with this application and all policy terms.

- [ ] Upon issuance of policy applied for, terminate policy number(s) \_\_\_\_\_
[ ] Upon issuance of policy applied for, change policy number(s) \_\_\_\_\_

Additional instructions: \_\_\_\_\_
\_\_\_\_\_

I, THE OWNER, UNDERSTAND THAT TRANSAMERICA LIFE (BERMUDA) LTD. TO WHICH I HAVE APPLIED MAKES NO REPRESENTATIONS AND ASSUMES NO LIABILITY FOR THE TAX IMPLICATIONS, IF ANY, OF THIS TRANSACTION.

WARNING: It is usually disadvantageous to replace an existing life insurance policy with a new one. Some of the disadvantages are:

- (i) you may not be insurable on standard terms;
(ii) you may have to pay a higher premium in view of higher age;
(iii) this may result in losing the financial benefits accumulated over the years.

In your own interest, we would advise that you consult your present insurer before making a final decision. Hear from both sides and make a careful comparison.

You should be sure that you are making a decision that is in your best interest.

**SECTION IV- PARTIAL EVIDENCE OF INSURABILITY**

Insured: \_\_\_\_\_ Policy No.: \_\_\_\_\_

If evidence of insurability is required, complete this section and the other requirements as indicated in Section I.

**Complete this section on each person to be covered under the contract.**

- 1) Occupation: \_\_\_\_\_ 2) Employer: \_\_\_\_\_
- 3) Annual income: \$ \_\_\_\_\_
- 4) Total Life Insurance in Force All Companies:  
 Business: \$ \_\_\_\_\_ Personal: \$ \_\_\_\_\_  
 Accidental Death Insurance now in force: \$ \_\_\_\_\_  
 Waiver of Premium/Waiver Provision Coverage now in force: \$ \_\_\_\_\_

**Yes No**

- 5) May insurance, including annuities, in any company be discontinued or changed if the insurance applied for is issued? If "yes," provide company names. \_\_\_\_\_
- 6) Does any person to be insured have an existing annuity contract?
- 7) Is any application for life insurance on any person to be covered pending in any other company? If "yes," provide name of company, name of Proposed Insured and amount applied for in Remarks.
- 8) Within the last two years has any person to be insured participated in:
  - a) Aeronautics (including hang-gliding, ultra-light, soaring, sky diving, ballooning, etc.)?
  - b) Powered racing of competitive vehicles (including motorcycles, automobiles, powerboats, snowmobiling, etc.)?
  - c) Skin or scuba diving, mountain climbing, rodeos, competitive skiing or bobsledding?
 If "yes" to any part, complete Sports and Avocation Questionnaire.
- 9) Has any person to be insured ever been convicted of a criminal act? If "yes," give full details in Remarks.
- 10) Is any person to be insured a member of the armed forces, including reserves? Do you intend to become a member?
- 11) Does any person to be insured intend to fly other than as a passenger or have you flown other than as a passenger during the past two years? If "yes", complete Aviation Questionnaire.
- 12) Does any person to be insured plan to travel outside the U.S., Canada, Western Europe, Hong Kong, Singapore, Taiwan, Japan, Australia or New Zealand, for business or leisure, within the next 24 months? If "yes", complete Foreign Nationals & Foreign Travel Questionnaire.
- 13) Driver's License No. (U.S or Canadian drivers's license holders only): \_\_\_\_\_  
 Issue Location: \_\_\_\_\_
- 14) In the past five years, has any person to be insured been convicted of or pleaded guilty to any driving violations? If "yes," provide dates and types in Remarks.
- 15) Has any person to be insured used nicotine at any time?
  - a) Cigarettes Date Last Used \_\_\_\_\_
  - b) Cigar/Pipe/Chewing Tobacco Date Last Used \_\_\_\_\_
  - c) Other (e.g. patch, gum, etc.) Date Last Used \_\_\_\_\_
  - d) Was any person to be Insured advised to discontinue nicotine use by a physician? If "yes," provide details including name and address of the physician, date, and reason.
  - e) Has any person to be Insured been diagnosed with or told by a physician that he/she has emphysema, chronic bronchitis, any other disease or disorder of the respiratory system, cancer or heart disease? If "yes," provide complete details including name and address of physician, date last consulted, reason, etc.

REMARKS: (Specify question number, name of person(s) to which the answer applies and details)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ACKNOWLEDGEMENT**

I, the undersigned, hereby represent that the statements and answers given in the application are true, complete and correctly recorded to the best of my knowledge and belief.

**DECLARATION & CONSENT AND AUTHORIZATION TO OBTAIN INFORMATION**

**I, the undersigned, hereby represent** that the statements and answers given in the Application are true, complete and correctly recorded. **I agree:** (1) This Application and any required application supplement(s), in addition to any evidence of insurability required by the Company for this Application, including Application Part 2, shall be made part of the policy issued pursuant to this Application. (2) Any change requested which requires evidence of insurability shall not take effect until after all of the following conditions have been met: (a) Any required premium payment for the change is paid in full, (b) The change is approved by the Company at its Branch Office during the lifetime of the person insured, (c) The Owner has personally received the policy during the lifetime of and while the insured is in good health, and (d) All of the statements and answers given in this Application must be true and complete as of the date of Owner's personal receipt of the policy, and that the policy will not take effect if the facts have changed. (3) Any change requested which does not require evidence of insurability which is provided by the policy or is allowed by the Company, shall be effective from the date determined by the Company unless a different date is specifically indicated and is allowed by the Company. (4) Until the change requested becomes effective, the policy without change shall continue subject to its provisions. (5) The Company may deposit or cash any payment without prejudice to its rights to decline the request for change. (6) Unless the requested change is specifically allowed under the provisions of the contract, the Company may require satisfactory evidence of insurability before allowing the change. (7) No waiver or modification shall be binding upon the Company unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

**I understand that omissions or misstatements in this Application could cause an otherwise valid claim to be denied under any contract issued from this Application.**

**I, the Insured, hereby authorize** any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insuring or reinsuring company, consumer reporting agency or employer having information available as to testing, diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any non-medical information of me to give the Company or its legal representative, any and all such information.

**I understand,** the information obtained by use of the Authorization will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. Any information obtained will not be released by the Company to any person or organization except to reinsuring companies or other persons or organizations performing business or legal services in connection to my Application, claim or may be otherwise lawfully required as I may authorize.

**I know** that I may request to receive a copy of this Authorization. **I agree** that a photocopy of this Authorization shall be valid as the original. **I agree** this Authorization shall be valid for two and one half years from the date shown below, regardless of my condition and whether living or deceased.

Note: If information is to be released by a person or facility located in the U.S., the Authorization for Release and Disclosure of Health Related Information form must be compiled and attached.

**U.S. Tax Information**

The Proposed Owner represents and warrants that he/she/it is not a U.S. person for U.S. federal income tax purposes, nor acting on behalf of a U.S. person. A U.S. person is either a resident or a citizen of the U.S. or an entity organized in the U.S. A false statement or misrepresentation by a U.S. person could lead to penalties under U.S. law. If your tax status changes and you become a U.S. citizen or resident, you will notify us within 30 days.

**Authorized Signatures**

Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City, Country Date (mm/dd/yyyy)

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of Insured Witness to Signature of Insured  
 (or parent or guardian if Primary Insured is a minor)

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of Spouse, if applicable Witness to Signature of Spouse

Signed at \_\_\_\_\_ on \_\_\_\_\_  
 City, Country Date (mm/dd/yyyy)

X \_\_\_\_\_ X \_\_\_\_\_  
 Signature of Owner (if other than Primary Insured) Witness to Signature of Owner

If Owner is a corporation, an authorized officer, other than the Insured must sign as Owner, give full corporate title and name of corporation with the company stamp below. If Owner is a Trust, authorized Trustee(s) must sign as Owner, give full name and date of Trust below.

\_\_\_\_\_ X \_\_\_\_\_  
 Signature of Insurance Advisor

**REPORT BY DISTRIBUTOR**

\_\_\_\_\_  
Distributors's Name

\_\_\_\_\_  
Office ID

\_\_\_\_\_  
Producer ID (Distributor)

\_\_\_\_\_  
Solicitor's Name

\_\_\_\_\_  
Producer ID (Solicitor)

\_\_\_\_\_  
Administrative Staff Name