

AUTHORIZATION TO OBTAIN INFORMATION

I authorize any physician, medical practitioner, hospital, clinic, medical or other medically related facility, insurance or reinsuring company, consumer reporting agency, or employer having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give Transamerica Life (Bermuda) Ltd. or its legal representative, any and all such information.

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

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

Signature of Proposed Insured

Witness to Signature of Proposed Insured

If an investigative consumer report is ordered by us in connection with this Application, you may elect to be interviewed in connection with the preparation of the report and, upon request, you will be provided with a copy of the report.

I elect to be interviewed if an investigative consumer report is prepared: Yes No