TRANSAMERICA®
Employee Benefits

TRANSAMERICA EMPLOYEE BENEFITS

APPLICATION BOOKLET

Thank you for considering our products to meet the needs of your clients.

Sign the pages listed and send them to:

Transamerica Employee Benefits
1400 Centerview Drive,
Little Rock, AR 72211
Fax: (866) 224-1923

tebcontracting@transamerica.com

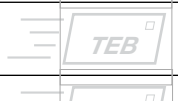
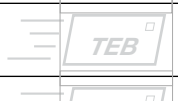
SIGNATURE CHECKLIST

SIGN the following pages:

4		Signed It!
5		Signed It!
9		Signed It!

SUBMISSION CHECKLIST

SEND the following pages:

2		Sent It!
3		Sent It!
4		Sent It!
5		Sent It!
6		Sent It!
7		Sent It!
8		Sent It!
9		Sent It!

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SEND TEB

LC: **RVP:** **Recruited By:**

APPLICATION FOR APPOINTMENT

Required for processing appointment and background investigation.

NATURAL PERSON INFORMATION

Complete this section if you are applying as a **Natural Person.**

1 Full Legal Name _____

2 SSN _____ E-mail _____

3 Home Address _____

_____

4 Home Phone _____ Home Fax _____

5 Spouse Name _____

6 Date of Birth _____ Gender: ◯ Male ◯ Female

7 Business Mailing Address _____

_____

8 Business Phone _____ Business Fax _____

Business Cell _____

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BACKGROUND INFORMATION

"YES" answers to questions 11 - 20, require explanation. Please attach it to the application.

9 Five-year Residential History (begin with the most recent, attach an extra sheet if necessary.)

From/To	*Street*	*City*	*State*	*Zip*
$11.43				

Have you:		Yes	No
10.	**EVER** plead guilty or no contest to, or been convicted of, any felony or misdemeanor (exclude minor traffic offenses), or are there any criminal charges currently pending against you?	○	○
11.	**EVER** had an organization over which you exercised management or policy control been charged with a felony or misdemeanor, during your tenure with such organization?	○	○
12.	**EVER** been the subject of disciplinary sanctions, reprimand, fine, assessment, consent order, license suspension, or license revocation for any insurance or securities activities?	○	○
13.	**EVER** or are you now involved in a complaint to or investigation by an insurance or securities department?	○	○
14.	**EVER** had a fidelity or fiduciary bond denied or revoked, or has a bonding company paid out on a bond for you?	○	○
15.	**EVER** or are you now involved in any litigation or bankruptcy or are there any unsatisfied judgments or liens outstanding against you?	○	○
16.	**EVER** been known personally or professionally or corporately by any other name, conducted business under any assumed name or carried bank accounts in any other name than that shown on this application?	○	○
17.	**EVER** been suspended or barred from the practice of any profession?	○	○
18.	**EVER** been discharged or permitted to resign because you were accused of:		
a.	Violating insurance or investment-related statutes, regulations, rules or industry standards of conduct?	○	○
b.	Fraud or the wrongful taking of property?	○	○
c.	Failure to supervise in connection with insurance or investment-related statutes, regulations rules or industry standards of conduct?	○	○
19.	Are you now the subject of any complaint investigation, or proceeding that could result in a "Yes" answer to any of the above questions?	○	○

NON-RESIDENT APPOINTMENT REQUEST

Please note if you sell our LTC-Rider products you will be required to send in your LTC certificate.
For questions about LTC Training & Continuing Education contact the State's Department of Insurance.

Appoint me in the following Non-Resident states? _____

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VIOLENT CRIME CONTROL AND LAW ENFORCEMENT ACT OF 1994

The Violent Crime Control and Law Enforcement Act of 1994 (the "1994 Crime Act") makes it a federal crime to: (1) knowingly make false material statements in financial reports submitted to insurance regulators; (2) embezzle or misappropriate monies or funds of an insurance company; (3) make material false entries in the records of an insurance company in an effort to deceive officials of the company or regulators regarding the financial condition of the company; or (4) obstruct an investigation by an insurance regulator. THE 1994 CRIME ACT ALSO MAKES IT A FEDERAL CRIME FOR INDIVIDUALS WHO HAVE BEEN CONVICTED OF A FELONY INVOLVING DISHONESTY, BREACH OF TRUST, OR ANY OF THE OFFENSES LISTED ABOVE TO WILLFULLY PARTICIPATE IN THE BUSINESS OF INSURANCE. WILLFULLY PARTICIPATING IN THE BUSINESS OF INSURANCE INCLUDES ACTING AS AN INSURANCE AGENT. Penalties for violating the 1994 Crime Act include Civil fines up to $50,000 and imprisonment for up to 15 years.

Will there be a violation of the 1994 Crime Act if you act as an insurance agent? ◯ **Yes** ◯ **No**

APPLICANT'S DECLARATION

1. I hereby certify my answers to the questions appearing in this application are true and complete.
2. If I have been notified by the IRS that I have previously given an incorrect taxpayer identification number, my signature below constitutes my certification under penalties of perjury to the following: (1) the taxpayer identification number on this form is my correct taxpayer identification number; and (2) I am not subject to backup withholding; and (3) I am a U.S. person (including a U.S. resident alien). I acknowledge that the IRS does not require my consent to any provision of this form other than the certification required to avoid backup withholding.
3. I hereby acknowledge that I have read, understand, received and retained for my records a copy of the Fair Credit Reporting Act Disclosure.

EXECUTION:

SIGN

_____ _____
Full Name of Natural Person *Date*

_____ _____
Full Name of Business Entity *Date*

✗ _____ _____
Signature of Natural Person, Authorized Officer or Partner *Title*

YOU MUST BE APPOINTED BY AND HAVE A FULLY EXECUTED CONTRACT WITH THE COMPANY PRIOR TO ANY SOLICITATION OF BUSINESS AND COLLECTION OF ANY MONIES. (Supplies, including policy applications, will be sent when all forms are processed and appointment is effective.)

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FAIR CREDIT REPORTING ACT AUTHORIZATION TO RELEASE INFORMATION

FAIR CREDIT REPORTING ACT DISCLOSURE

This is to notify you in connection with your application for appointment/contract, we may procure a consumer report on you and/or Business Entity as part of the process of considering your application. In the event information from the report is utilized, in whole or in part, in making an adverse decision, before making the adverse decision, we will provide you with a copy of the consumer report and a description in writing of your rights under the Fair Credit Reporting Act. Please be advised we may also obtain an investigative consumer report including information as to your character, general reputation, personal characteristics, and mode of living. This information may be obtained by contacting your present and previous employers or references supplied by you. Please be advised you have the right to request, in writing, within a reasonable time, that we make a complete and accurate disclosure of the nature and scope of the information requested. Additional information concerning the Fair Credit Reporting Act, 15 U.S.C. _ 1681 et seq. is available at the Federal Trade Commission's web site (http://www.ftc.gov).

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing below, I hereby authorize all entities having information about me, including, present and former employers, criminal justice agencies, departments of motor vehicles, schools, and credit reporting agencies, to release such information to Transamerica Employee Benefits. This release and authorization shall remain valid and in effect during the term of my appointment/contract. Transamerica Employee Benefits reserves the right to run subsequent consumer reports and/or investigative consumer reports on an as-needed basis

Maine and New York Applicants: Upon request, you will be informed whether or not a consumer report was requested, and if such a report was requested, the name and address of the consumer reporting agency furnishing the report. Maine residents will be provided a copy of your rights under the Maine Fair Credit Reporting Act.

Washington Applicants: The consumer reporting agency which furnished the report is Business Information Group, P.O. Box 286, Marlton, NJ, 08053; for consumer compliance officer contact 800-260-1680.

California, Minnesota, and Oklahoma Applicants: A consumer credit report will be obtained through Business Information Group, P.O. Box 286, Marlton, NJ, 08053. If a consumer credit report is obtained, I understand I am entitled to receive a copy. I have indicated below whether I would like a copy.

Yes _____ No_____
initials initials

If an investigative consumer report and/or consumer report is processed, I understand I am entitled to receive a copy. I have indicated below whether I would like a copy.

Yes _____ No_____
initials initials

In California if you choose to receive a copy of the consumer credit report, it will be sent within three days of the employer receiving a copy. You will receive a copy of the investigative consumer report within seven days of the employer's receipt of the report.

SIGN

✗ _____ _____
Applicant's Signature *Date*

_____
Applicant's Full Name

Date of Birth _____ Social Security # _____

Date of Birth required for background investigation purposes and will NOT be used for any other purpose.

Current Residence Address _____

_____

_____

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REQUEST FOR APPOINTMENT AND ACKNOWLEDGEMENT OF CONDITIONS

(Complete if Solicitor or Agent for Corporation)

TO: ❑ Transamerica Life Insurance Company ❑ Transamerica Financial Life Insurance Company *(NY only)*

(Whether one or more, hereinafter called "the insurer")

RE: **APPLICATION FOR APPOINTMENT:**

_____ *(hereinafter called "I", "me", "my", or "myself");*

The Insurer is hereby requested to make application to the Department of Insurance for my appointment as a life and/or disability insurance agent authorizing me to solicit applications for insurance on behalf of the insurer In that state.

I hereby agree that the Insurer's consent to such appointment (or appointment in any other state) is subject to, and I hereby agree to be bound by each and all of the following conditions:

That I shall be a solicitor assigned to one or more agent(s) of the insurer (the "Agent"), and

That the Insurer has no obligation to me for commissions, expense allowance or any form of compensation whatsoever in connection with the services performed and expenses incurred by me, and

In the solicitation of applications for Insurance issued by the Insurer, it being expressly understood that I am under direct contract with the Agent who has agreed to compensate me for such services, and

That I have no contractual relationship with the Insurer and that I am not, and I shall refrain from holding myself out as, an employee, partner, joint venturer or associate of the Insurer, and

That I shall comply with the rules and regulations of the Insurer and the laws and regulations of all applicable insurance regulatory authorities relating to my activities in the solicitation of insurance, and

That I shall not alter, modify, waive or change any of the terms, rates or conditions of any advertisements, receipts, policies or contract to the insurer in any respect, and

That I shall promptly remit to the Agent any and all monies received by me on behalf of the Insurer as full or partial payment of first year premium, and

That I shall not collect any premium in connection with an application to the Insurer for one of its policies other than the amount of the first premium which shall not exceed the premium for the first policy year, and

That I shall not publish, use or distribute any advertisement about the insurer or its policies unless such advertisement has been approved by the Insurer in writing, and

That I shall not obligate the insurer or incur expense on its behalf in any manner whatsoever, and

That insurer may, without liability to me whatsoever, upon request of the Agent or upon its own initiative, cancel my appointment at any time.

HIPAA BUSINESS ASSOCIATE AGREEMENT:

In connection with my Application for Appointment above, the undersigned (hereinafter called "I", "me", or "my") agrees to be bound by the following Business Associate Agreement (the "Agreement"). I acknowledge that this Agreement is between me and the health care components of the following insurance companies: Transamerica Life Insurance Company ("TLIC"), Transamerica Financial Life Insurance Company ("TFLIC"), Stonebridge Life Insurance Company, Monumental Life Insurance Company, and Western Reserve Life Assurance Co. of Ohio. These health care components are individually and collectively referred to as "the Covered Entity", "you" or "your." TLIC and TFLIC are individually and collectively referred to as "the insurer" and are authorized to act on behalf of the Covered Entity. The listed insurance companies have elected to adopt Affiliated Covered Entity status, as defined and permitted under the Health Insurance Portability and Accountability Act of 1996 and its rules and regulations (as any of the same may be amended or

superseded from time to time, "HIPAA"), and such designation has been appropriately adopted and documented. To the extent the HIPAA covered health care component of any of the listed insurance companies, or any of the companies themselves, merges with another affiliate or undergoes a corporate name change, this Agreement shall apply to any such merged and/or renamed component/company.

For purposes of this Agreement, the term "Policyholder" means either the owner of an insurance product issued by the Covered Entity or the insured under any certificate of insurance issued by the Covered Entity, to the extent either such type of insurance is covered by HIPAA.

(a) Compliance with HIPAA. I will comply with the privacy and security requirements of HIPAA. Compliance with HIPAA includes the following:

(i) I may use or disclose Protected Health Information only to perform the services described in my Application for Appointment, for the proper management and administration of my business (other than for cross-marketing and/or cross-selling of other policies or products, which are prohibited except to the extent specifically provided in subparagraph (c) below), to carry out my legal responsibilities, or otherwise as required by law. "Protected Health Information" has the same meaning as the term "protected health information" in 45 C.F.R. §164.501 (as the same may be amended or superseded from time to time), limited to information that I create or that I receive from the Covered Entity or on behalf of the Covered Entity, and includes information that relates to the past, present, or future physical or mental health or condition of a Policyholder, to the provision of health care to a Policyholder, or to the past, present, or future payment for the provision of health care to a Policyholder, and that identifies the Policyholder or for which there is a reasonable basis to believe that the information can be used to identify the Policyholder, in each case regardless of whether the Policyholder is living or deceased. By way of illustration only, the following information shall constitute Protected Health Information with respect to a Policyholder: (A) name, (B) street address, city, county, precinct, and zip code, (C) dates directly related to the Policyholder, including birth date, admission date, discharge date, and date of death, (D) telephone numbers, fax numbers, and electronic mail addresses, (E) social security number, (F) medical record numbers, (G) health plan beneficiary numbers, (H) account numbers, (I) certificate/license numbers, (J) vehicle identifiers and serial numbers, including license plate numbers, and (K) any other unique identifying numbers, characteristics, or codes.

(ii) I may not use or disclose Protected Health Information in any manner that would constitute a violation of 45 C.F.R. Parts 160 and 164.

(iii) I will comply with the Covered Entity's request to accommodate a Policyholder's access to his or her Protected Health Information including support for a request for electronic access as provided by 45 C.F.R. §164.524.

(iv) I will comply with the Covered Entity's request to amend Protected Health Information in accordance with a Policyholder's request as provided by 45 CFR 164.526.

(v) I will keep a record of disclosures of or access to Protected Health Information that must be provided under HIPAA to an individual to whom the Protected Health Information relates. I will comply with any request that the Covered Entity makes to provide the Covered Entity with information pertaining to such disclosures or access in such format as the Covered Entity reasonably may request. Such provided information shall include the content as required under HIPAA.

(vi) I will make my internal practices, books, and records relating to uses and disclosures of Protected Health Information available to the Covered Entity (or to the Covered Entity's designee) and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary"), or to the Secretary's designee, for the purpose of confirming my compliance and/or the Covered Entity's compliance with 45 C.F.R. Parts 160 and 164.

(vii) Upon termination of my appointment with the insurer, if feasible, I will return or destroy all Protected Health Information without retaining any copies and shall provide you with my written and signed certification to that effect. If such return or destruction is not feasible, I will limit all further uses and disclosures to those purposes that make such return or destruction of the Protected Health Information not feasible.

(viii) I will maintain appropriate administrative, physical and technical safeguards to prevent prohibited uses or disclosures, and to protect the confidentiality, integrity and availability, of any Protected Health Information that I create, receive, maintain or transmit. Such safeguards shall include development, implementation, and maintenance of a comprehensive written information security program compliant with applicable laws and designed to (A) protect the integrity and confidentiality of Protected Health Information, (B) protect against anticipated threats or hazards to the security, confidentiality and/or integrity of Protected Health Information, (C) protect against any unauthorized disclosure or use of Protected Health Information, (D) address computer and network security, (E) address physical security, and (F) provide for the secure disposal and destruction of Protected Health Information.

(ix) I will ensure that any subcontractors (as defined in 45 C.F.R. §160.101) that create, receive, maintain, or transmit Protected Health Information on my behalf agree to the same restrictions and conditions that apply to me with respect to such information. I agree to enter into appropriate written agreements outlining these obligations and to obtain satisfactory assurances (as that term is contemplated in HIPAA) of such compliance by all subcontractors. To the extent I make disclosures under 45 C.F.R. §164.504(e)(4), I will obtain reasonable assurances that Protected Health Information will be held in confidence and will not be used or disclosed outside of the intended purpose.

(x) To the extent that the Covered Entity may require me to carry out any of the listed insurance companies' obligations in accordance with this Agreement, under 45 C.F.R. §164 Subpart E, I will comply with the requirements of that Subpart which apply to the Covered Entity in the performance of such obligations.

(xi) I will require that my directors, officers, and employees who have access to Protected Health Information agree to the same restrictions and conditions that apply to the Covered Entity with respect to such information.

(b) Compliance with HITECH Act

(i) I agree and acknowledge that I am directly subject to HIPAA as amended by the Health Information Technology for Economic and Clinical Health Act and its rules and regulations (as any of the same may be amended or superseded from time to time, the "HITECH Act"), including, without limitation, Sections 164.308, 164.310, 164.312 and 164.316 thereof, including its provisions relating to security and privacy of Protected Health Information as well as its enforcement and penalty provisions. I will (i) comply with all applicable security and privacy provisions of HIPAA as amended by the HITECH Act and as it may be amended from time to time; (ii) not act in any way to interfere with or hinder the listed insurance companies' ability to comply with HIPAA as amended by the HITECH Act and as it may be amended from time to time; and (iii) use my best efforts to notify the listed insurance companies without unreasonable delay and in any event within three (3) business days of discovering a "breach," as the term "breach" is defined in 45 C.F.R. §164.402, and as the terms "breach" and "discover" are further described in 45 C.F.R. §164.410(a)(2).

(ii) In the event you learn of a pattern of activity or practice that constitutes a material breach or violation of my obligations relating to Protected Health Information under this Agreement, you will take reasonable steps to cure the breach or end the violation. If such steps are unsuccessful, the insurer will terminate my appointment. The insurer has the right, in its sole discretion, to terminate my appointment immediately upon notice in the event of any such material breach or security incident.

(iii) I acknowledge and agree to adhere to any limitations on the disclosure and/or sale of Protected Health Information as required under 45 C.F.R. §164.508(d) and/or under HIPAA.

(c). Additional Provisions Relating to Confidentiality Generally, Gramm-Leach-Bliley Act (GLBA), and HIPAA

(i) In response to an unsolicited direct Policyholder, Certificateholder, or Consumer inquiry, I may disclose Nonpublic Personal Financial Information and Protected Health Information directly to, and may discuss such information directly with, the Policyholder, Certificateholder, or Consumer to whom such information pertains, provided that such disclosure would not violate HIPAA if the Covered Entity made it.

(ii) I may have relationships with affinity groups and associations and, as a result, I may receive information ("Group Member Information") relating to their members (each a "Group Member") that constitutes Nonpublic Personal Financial Information and/or Protected Health Information. I agree that a Group Member's Group Member Information shall constitute Nonpublic Personal Financial Information and/or Protected Health Information only from and after the time that a Group Member applies for a Policy.

(iii) I may use Information, Nonpublic Personal Financial Information and/or Protected Health Information for cross-marketing and/or cross-selling of other policies or products to the extent, but only to the extent, that the Policyholder to whom such information pertains has authorized me specifically in a writing that complies with HIPAA to do so and such marketing or selling is conducted in adherence with the restrictions on marketing and sale of Protected Health Information as provided under HIPAA.

(iv) Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits compliance with GLBA and HIPAA.

(v) I will notify you in writing without unreasonable delay and in any event within three (3) business days upon becoming aware of a violation of subparagraphs (a), (b) or (c) of this paragraph 16, or of the occurrence of a "security incident," as defined in 45 C.F.R. §164.304. I agree to cooperate fully with you in any security-incident investigation or resolution and agree that no notifications or communications to any individual(s), media outlets, state or federal regulatory authorities, or other third parties regarding the incident shall be made without in each instance your specific prior written consent.

(vi) I will comply with all applicable state and local laws and regulations enacted to protect the privacy of individual personal information.

(vi) You can amend subparagraphs (a), (b) or (c) of this Agreement without my consent to reflect (i) future amendments of GLBA or HIPAA, or (ii) court orders interpreting the application of GLBA or HIPAA, or (iii) a material change in your business practices, but any such amendment shall be enforceable against me only after you have notified me.

(d). Covered Entity
This Agreement applies to services provided by me to any of the insurance companies listed and identified above, as that list may be amended or modified from time to time by notice to me of such change to the Covered Entity listing. Such notice will be treated as an addendum to this Agreement and be enforceable against me only after you have notified me.

IN WITNESS THEREOF, I have affixed my signature this _____day of _____ 20 _____

SIGN

_____ ✗ _____

Print Applicant's Name *Signature of Applicant*