Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: UNI2	SERFF Tr Num: AEGJ-126778143	State: Arkansas
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed-Approved-Closed	State Tr Num: 46551
Sub-TOI: LTC03I.004 Partnership	Co Tr Num: 2061	State Status: Approved-Closed
Filing Type: Form/Rate		Reviewer(s): Marie Bennett, Harris Shearer, Stephanie Fowler
	Author: Laura Aleman	Disposition Date: 10/11/2010
	Date Submitted: 08/20/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:
State Filing Description:		

General Information

Project Name: Product-Original Filing
Project Number: 1948
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 10/11/2010

Deemer Date:
Submitted By: Laura Aleman
Filing Description:
See Cover Letter on Supporting Documentation Tab.

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 07/06/2010
Domicile Status Comments: Iowa is the state of domicile
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 10/11/2010
Created By: Laura Aleman
Corresponding Filing Tracking Number:

Company and Contact

Filing Contact Information

Laura Aleman, Senior Policy Analyst
P.O. Box 93007

LAleman@aegonusa.com
800-553-7600 [Phone] 3353 [Ext]

Bedford, TX 76053-3007 817-285-3394 [FAX]

Filing Company Information

Transamerica Life Insurance Company	CoCode: 86231	State of Domicile: Iowa
P O Box 93005	Group Code: 468	Company Type:
Hurst, TX 76053-3005	Group Name:	State ID Number:
(800) 553-7600 ext. [Phone]	FEIN Number: 39-0989781	

Filing Fees

Fee Required?	Yes
Fee Amount:	$1,850.00
Retaliatory?	No
Fee Explanation:	$50 per form x 36 forms = $1800
	$50 per rate = $50
	Total = $1850
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	$1,850.00	08/20/2010	38915763

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	10/11/2010	10/11/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Status Check	Note To Reviewer	Laura Aleman	10/11/2010	10/11/2010
Status	Note To Reviewer	Laura Aleman	09/21/2010	09/21/2010

Disposition

Disposition Date: 10/11/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	No
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Cover Letter	Approved	Yes
Supporting Document	Partnership Certification	Approved	Yes
Form	Long Term Care Insurance Policy	Approved	Yes
Form	Accident Benefit Endorsement	Approved	Yes
Form	Contingent Nonforfeiture Benefit Endorsement	Approved	Yes
Form	Limited Premium Payment Period Contingent Nonforfeiture Benefit Endorsement	Approved	Yes
Form	Return of Premium To Age 67 Endorsement	Approved	Yes
Form	Relocation Benefit Endorsement	Approved	Yes
Form	Shared Care Benefit Rider	Approved	Yes
Form	Monthly Benefit Rider	Approved	Yes
Form	Full Restoration of Benefits Rider	Approved	Yes
Form	Simple Benefit Increase Option Rider	Approved	Yes
Form	Compound Benefit Increase Option Rider	Approved	Yes
Form	Step-Rated Compound Benefit Increase Option Rider	Approved	Yes
Form	Tailored Benefit Increase Option Rider	Approved	Yes
Form	Full Compound Benefit Increase Option Rider	Approved	Yes
Form	Full Simple Benefit Increase Option Rider	Approved	Yes
Form	Full Step-Rated Compound Benefit Increase Option Rider	Approved	Yes
Form	Full Tailored Benefit Increase Option Rider	Approved	Yes
Form	Deferred Benefit Increase Option Endorsement	Approved	Yes
Form	Guaranteed Purchase Option Endorsement	Approved	Yes
Form	Waiver of Premium Rider - Cash Benefit	Approved	Yes

Form	Waiver of Premium Rider - Home Care and Adult Day Care	Approved	Yes
Form	Joint Waiver of Premium Rider	Approved	Yes
Form	Full Survivorship Rider	Approved	Yes
Form	Survivorship Rider	Approved	Yes
Form	Return of Premium Upon Death Rider	Approved	Yes
Form	Nonforfeiture Benefit - Shortened Benefit Period Rider	Approved	Yes
Form	Outline of Coverage	Approved	Yes
Form	Application	Approved	Yes
Form	Application	Approved	Yes
Form	Application	Approved	Yes
Form	Application	Approved	Yes
Form	Personal Worksheet	Approved	Yes
Form	Personal Worksheet - Single Premium	Approved	Yes
Form	Potential Rate Increase Disclosure Form - Limited Pay	Approved	Yes
Form	Disclosure Form	Approved	Yes
Form	Disclosure Form - Single Premium	Approved	Yes
Rate	Rates	Approved	Yes

Note To Reviewer

Created By:

Laura Aleman on 10/11/2010 09:25 AM

Last Edited By:

Stephanie Fowler

Submitted On:

10/11/2010 02:56 PM

Subject:

Status Check

Comments:

I just wanted to check on the status of this filing. It was submitted on 8/20/10 and we have not received any correspondence yet. Let me know if there is anything you need to process this filing. Thanks!

Note To Reviewer

Created By:

Laura Aleman on 09/21/2010 03:30 PM

Last Edited By:

Stephanie Fowler

Submitted On:

10/11/2010 02:56 PM

Subject:

Status

Comments:

I just wanted to check on the status of this filing. It has been pending at your department for a month. Let me know if you need anything from me to process this filing. Thanks!

Form Schedule

Lead Form Number: TLC 2-P AR 0410

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 10/11/2010	TLC 2-P AR 0410	Policy/Contract/Fraternal Certificate	Long Term Care Insurance Policy	Initial			TLC 2-P AR 0410.pdf
Approved 10/11/2010	TLC 2-ACCB-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Accident Benefit Endorsement	Initial			TLC 2-ACCB-E 0410.pdf
Approved 10/11/2010	TLC 2-CNFB-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Contingent Nonforfeiture Benefit Endorsement	Initial			TLC 2-CNFB-E 0410.pdf
Approved 10/11/2010	TLC 2-CNFB-LP-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Limited Premium Payment Period Contingent Nonforfeiture Benefit Endorsement	Initial			TLC 2-CNFB-LP-E 0410.pdf

Approved 10/11/2010	TLC 2-ROP-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Return of Premium To Age 67 Endorsement	Initial	TLC 2-ROP-E 0410.pdf
Approved 10/11/2010	TLC 2-RELB-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Relocation Benefit Endorsement	Initial	TLC 2-RELB-E 0410.pdf
Approved 10/11/2010	TLC 2-SC-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Shared Care Benefit Rider	Initial	TLC 2-SC-R 0410.pdf
Approved 10/11/2010	TLC 2-MB-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Monthly Benefit Rider	Initial	TLC 2-MB-R 0410.pdf
Approved 10/11/2010	TLC 2-FROB-R	Policy/Contract/Fraternal	Full Restoration of Benefits Rider	Initial	TLC 2-FROB-R 0410.pdf

	0410	al Certificate: Amendment, Insert Page, Endorsement or Rider				
Approved 10/11/2010	TLC 2-SBIOLC-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Simple Benefit Increase Option Rider	Initial		TLC 2-SBIOLC-R 0410.pdf
Approved 10/11/2010	TLC 2-CBIOLC-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Compound Benefit Increase Option Rider	Initial		TLC 2-CBIOLC-R 0410.pdf
Approved 10/11/2010	TLC 2-SRBIOLC-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Step-Rated Compound Benefit Increase Option Rider	Initial		TLC 2-SRBIOLC-R 0410.pdf
Approved 10/11/2010	TLC 2-TBIOLC-R 0410	Policy/Contract/Fraternal Certificate:	Tailored Benefit Increase Option Rider	Initial		TLC 2-TBIOLC-R 0410.pdf

		Amendment, Insert Page, Endorsement or Rider				
Approved 10/11/2010	TLC 2-FCBIO-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Full Compound Benefit Increase Option Rider	Initial		TLC 2-FCBIO-R 0410.pdf
Approved 10/11/2010	TLC 2-FSBIO-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Full Simple Benefit Increase Option Rider	Initial		TLC 2-FSBIO-R 0410.pdf
Approved 10/11/2010	TLC 2-FSRBIO-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Full Step-Rated Compound Benefit Increase Option Rider	Initial		TLC 2-FSRBIO-R 0410.pdf
Approved 10/11/2010	TLC 2-FTBIO-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert	Full Tailored Benefit Increase Option Rider	Initial		TLC 2-FTBIO-R 0410.pdf

		Page, Endorsement or Rider				
Approved 10/11/2010	TLC 2-DBIO-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Deferred Benefit Increase Option Endorsement	Initial		TLC 2-DBIO-E 0410.pdf
Approved 10/11/2010	TLC 2-GPO-E 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Guaranteed Purchase Option Endorsement	Initial		TLC 2-GPO-E 0410.pdf
Approved 10/11/2010	TLC 2-WOPCB-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Waiver of Premium Rider - Cash Benefit	Initial		TLC 2-WOPCB-R 0410.pdf
Approved 10/11/2010	TLC 2-WOPHC-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorseme	Waiver of Premium Rider - Home Care and Adult Day Care	Initial		TLC 2-WOPHC-R 0410.pdf

		nt or Rider			
Approved 10/11/2010	TLC 2-JWP-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider Joint Waiver of Premium Rider	Initial		TLC 2-JWP-R 0410.pdf
Approved 10/11/2010	TLC 2-FSWP-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider Full Survivorship Rider	Initial		TLC 2-FSWP-R 0410.pdf
Approved 10/11/2010	TLC 2-SWP-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider Survivorship Rider	Initial		TLC 2-SWP-R 0410.pdf
Approved 10/11/2010	TLC 2-ROP-R 0410	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider Return of Premium Upon Death Rider	Initial		TLC 2-ROP-R 0410.pdf
Approved	TLC 2-	Policy/Cont Nonforfeiture Benefit	Initial		TLC 2-NFB-R

10/11/2010	NFB-R 0410	ract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	- Shortened Benefit Period Rider			0410.pdf
Approved 10/11/2010	TLC 2-P AR 0410 OC	Outline of Coverage	Outline of Coverage	Initial		TLC 2-P AR 0410 OC.pdf
Approved 10/11/2010	TLC 2-ABCAPP 0410	Application/Enrollment Form	Application	Initial		TLC 2-ABCAPP 0410.pdf
Approved 10/11/2010	TLC 2-JABCAPP 0410	Application/Enrollment Form	Application	Initial		TLC 2-JABCAPP 0410.pdf
Approved 10/11/2010	TLC 2-CAPP 0410	Application/Enrollment Form	Application	Initial		TLC 2-CAPP 0410.pdf
Approved 10/11/2010	TLC 2-JCAPP 0410	Application/Enrollment Form	Application	Initial		TLC 2-JCAPP 0410.pdf
Approved 10/11/2010	TLC 2-PWS 0410	Other	Personal Worksheet	Initial		TLC 2-PWS 0410.pdf
Approved 10/11/2010	TLC 2-PWS-SP 0410	Other	Personal Worksheet - Single Premium	Initial		TLC 2-PWS-SP 0410.pdf
Approved 10/11/2010	TLC 2-PRI-DF-LP 0410	Other	Potential Rate Increase Disclosure Form - Limited Pay	Initial		TLC 2-PRI-DF-LP 0410.pdf
Approved 10/11/2010	TLC 2-DF 0410	Other	Disclosure Form	Initial		TLC 2-DF 0410.pdf
Approved 10/11/2010	TLC 2-DF-SP 0410	Other	Disclosure Form - Single Premium	Initial		TLC 2-DF-SP 410.pdf

TRANSAMERICA
® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

THIS IS A LONG TERM CARE INSURANCE POLICY. PLEASE READ IT CAREFULLY.

We are pleased to issue this Policy to You. It has many important features. We urge You to read it carefully. It is issued in exchange for Your application and payment of the initial premium.

This Policy is intended to be a federally tax-qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended. If a change to Your Policy is required as a result of future IRS rulings, You will be given a choice of accepting the change or keeping the Policy without change as a non-tax qualified contract.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE
OR UNTIL THE POLICY MAXIMUM AMOUNT HAS BEEN EXHAUSTED

Your timely payment of premiums is all that is needed to keep this Policy in force until the Policy Maximum Amount has been exhausted. We cannot cancel this Policy if the required premium payments are paid on a timely basis. To continue this Policy during the Premium Paying Period, You must pay any premium due on or before the Premium Due Date. It must be received by Us at Our Administrative Office before the end of the Grace Period.

WE HAVE A RIGHT TO CHANGE PREMIUMS

We can change Your premiums based on Your premium class, subject to approval by the Department of Insurance, if such approval is required under state regulations. Any change in premium may occur only after the Rate Guarantee has expired. Any change in premium can occur only during the Premium Paying Period shown on the Schedule. We must give You at least 60 days written notice before We change Your premiums. Your premiums will not increase due to a change in Your age or health.

30-DAY RIGHT TO REVIEW YOUR POLICY

You have 30 days from the day You receive this Policy to review it and return it to Us if You decide not to keep it. You do not have to tell Us why You are returning the Policy. Within 30 days of when You receive it, simply return it to Us at Our Administrative Office or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any premium paid within 30 days after Our receipt of the returned Policy. The Policy will be void as if it had never been issued.

IMPORTANT CAUTION ABOUT THE APPLICATION

We have issued this Policy based on the answers to the questions on the application. A copy of the application is attached. If any answers are incorrect or untrue, We may have the right to deny benefits or rescind this Policy. The best time to clear up any question is now, before a claim arises! If, for any reason, any of the answers are incorrect or untrue, contact Us at Our Administrative Office. Our address is shown above and the toll-free number is shown above and on the Schedule page.

Notice to Buyer: This Policy may not cover all the costs associated with long term care incurred during the period of coverage. The buyer is advised to review carefully all Policy limitations.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from Us.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

TABLE OF CONTENTS

Guaranteed Renewable; Right to Change Premiums	1
30-Day Right to Review Your Policy	1
Important Caution about the Application	1
Schedule	3
General Information	[8]
Eligibility for the Payment of Benefits	[8]
Limitations or Conditions on the Eligibility for Benefits	[8]
Conditions	[8]
Eligibility Definitions	[9]
Benefits	[10]
Cash Benefit	[10]
Home Care and Adult Day Care Benefit	[11]
Optional Care Coordination Benefit	[11]
Remain At Home Benefit	[12]
Respite Care Benefit	[12]
Long Term Care Facility Benefit	[12]
Extension of the Long Term Care Facility Benefit	[13]
Long Term Care Facility Bed Reservation Benefit	[13]
Global Coverage Benefit	[13]
Waiver of Premium Benefit	[14]
Hospice Care Benefit	[15]
Alternate Plan of Care Benefit	[15]
General Exclusions and Limitations	[16]
Nonduplication of Coverage	[16]
Other Insurance With Us	[17]
Claims Information	[17]
General Provisions	[20]
Effective Date, Premium and Termination Provisions	[21]
General Definitions	[24]
[Contingent Nonforfeiture Benefit Endorsement]	
[Limited Payment Period Contingent Nonforfeiture Benefit Endorsement]	
[Accident Benefit Endorsement]	
[Relocation Benefit Endorsement]	
[Return of Premium To Age 67 Endorsement]	
[Deferred Benefit Increase Option Endorsement]	
[Guaranteed Purchase Option Endorsement]	

SCHEDULE

Policy Number: [1234567]
Insured: [John Doe]

Effective Date: [10-01-10]
Insured's Issue Age: [45]

Premium Paying Mode: [Monthly, Quarterly, Semi-annual, Annual, Single Premium, Other]

Premium Paying Period: [Lifetime, 20 years, 15 years, 10 years, 5 years, Single Premium and Pay to Age 65]

Initial Annual Premium: [$XXX.XX]

Initial Modal Premium: [$XXX.XX]

Our toll-free number for Customer Service: [1-800-227-3740]

Early notification to Our Claims Department will help Us make a timely review of Your claim. Please let Us know immediately, or in advance whenever possible, when You need care or services covered by this Policy. Please call the Claims Department at [1-866-745-3544].

Note: The benefits shown on this Schedule are those that You elected and which became effective on the Effective Date of this Policy. Any changes to Your coverage will be shown by endorsement. This includes any benefits You add or delete and their respective effective dates.

The Initial Annual Premium is the total amount You will pay per year only if You choose the Annual Premium Paying Mode. It will be exceeded if You pay premiums more frequently than once a year (for example - Semi-Annually, Quarterly or Monthly). See the Modal Premium Disclosure section.

BENEFITS

Policy Maximum Amount	[$14,600 - Unlimited]
Elimination Period	[0, 20, 30, 50, 60, 90, 100, 120, 150, 180, 365 Days]

The Long Term Care Facility Benefit, the Long Term Care Facility Bed Reservation Benefit, the Global Coverage Benefit and the Alternate Plan of Care Benefit are subject to the Elimination Period.

[The Home Care and Adult Day Care Benefit is not subject to, nor will it be applied towards the satisfaction of, the Elimination Period.]

[The Home Care and Adult Day Care Benefit is subject to the Elimination Period.]

Cash Benefit	Included
Monthly Cash Benefit	[Dollar amount equal to 10 X LTC Facility Maximum Daily Benefit]
Home Care and Adult Day Care Benefit	Included
Maximum Daily Benefit	[Same dollar amount as LTC Facility Maximum Daily Benefit]
Optional Care Coordination Benefit – one selected from Our list	Included
Maximum	Unlimited

Optional Care Coordination Benefit – one not selected from Our list	Included
Maximum Lifetime Optional Care Coordination Benefit	$2,500
Remain At Home Benefit	Included
Maximum Benefit	[Dollar amount equal to 60 X LTC Facility Maximum Daily Benefit]
Long Term Care Facility Benefit	Included
Maximum Daily Benefit	[$40-400]
Long Term Care Facility Bed Reservation Benefit	Included
Number of Days Per Calendar Year	[30, 45, 60 Days]
Respite Care Benefit	Included
Number of Days Per Calendar Year	[30, 45, 60 Days]
Maximum Daily Benefit	[Same dollar amount as LTC Facility Maximum Daily Benefit]
Global Coverage Benefit	Included
Maximum Daily Benefit	[Dollar amount equal to 75% of the LTC Facility Maximum Daily Benefit]
Global Monthly Cash Benefit	[Dollar amount equal to 10 X the LTC Facility Maximum Daily Benefit]
Maximum Benefit Amount	[Dollar amount equal to 75% of the LTC Facility Maximum Daily Benefit X 365 Days]
Waiver of Premium Benefit	Included
Hospice Care Benefit	Included
Maximum Daily Benefit	[Same dollar amount as LTC Facility Maximum Daily Benefit]
Alternate Plan of Care Benefit	Included
Rate Guarantee	Included
Period of Time	[5 Years - 20 Years]
[Contingent Nonforfeiture Benefit Endorsement]	[Included]
[Limited Premium Payment Period Contingent Nonforfeiture Benefit Endorsement]	[Included]
[Accident Benefit Endorsement]	[Included]
[Maximum Daily Benefit]	[Same dollar amount as LTC Facility Maximum Daily Benefit]
[Relocation Benefit Endorsement]	[Included]
[Maximum Benefit]	[Dollar amount equal to 15 X LTC Facility Maximum Daily Benefit]

[Return of Premium To Age 67 Endorsement]	[Included]
[Deferred Benefit Increase Option Endorsement]	[Included]
[Guaranteed Purchase Option Endorsement]	[Included]

OPTIONAL BENEFITS

[Shared Care Benefit Rider]	[Elected] [Premium $XXX.XX]
[Monthly Benefit Rider]	[Elected] [Premium $XXX.XX]
[Maximum Monthly Benefit for Long Term Care Facilities]	[Number of days in the Calendar Month X LTC Facility Maximum Daily Benefit]
[Maximum Monthly Benefit for Home Care and Adult Day Care]	[Number of days in the Calendar Month X Home Care and Adult Day Care Maximum Daily Benefit]
[Full Restoration of Benefits Rider]	[Elected] [Premium $XXX.XX]
[Waiver of Premium Rider - Home Care and Adult Day Care]	[Elected] [Premium $XXX.XX]
[Waiver of Premium Rider – Cash Benefit]	[Elected] [Premium $XXX.XX]
[Joint Waiver of Premium Rider]	[Elected] [Premium $XXX.XX]
[Survivorship Rider]	[Elected] [Premium $XXX.XX]
[Full Survivorship Rider]	[Elected] [Premium $XXX.XX]
[Simple Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Percentage]	[3%][5%]
[Compound Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Percentage]	[3%][5%]
[Step-Rated Compound Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Benefit Increase Percentage]	[3%][5%]
[Premium Increase Percentage]	[3%][5%]
[Tailored Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Percentage Under Age 61]	[5%]
[Percentage Age 61-75]	[3%]
[Full Simple Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Percentage]	[3%][5%]
[Full Compound Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Percentage]	[3%][5%]

[Full Step-Rated Compound Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Benefit Increase Percentage]	[3%][5%]
[Premium Increase Percentage]	[3%][5%]
[Full Tailored Benefit Increase Option Rider]	[Elected] [Premium $XXX.XX]
[Percentage Under Age 61]	[5%]
[Percentage Age 61-75]	[3%]
[Nonforfeiture Benefit Rider]	[Elected] [Premium $XXX.XX]
[Return of Premium Upon Death Rider]	[Elected] [Premium $XXX.XX]
TOTAL PREMIUM FOR INCLUDED BENEFITS	[$XXX.XX]
TOTAL PREMIUM FOR ELECTED BENEFITS	[$XXX.XX]

MODAL PREMIUM DISCLOSURE

You may choose to pay Your premium annually (once a year), semi-annually (2 times a year), quarterly (4 times a year), monthly (12 times a year) or in some cases, by payroll deduction at the frequency determined by Your employer. [Other premium payment options may be available.]The premiums may be paid monthly in 12 payments only by electronic funds transfer[,] [or] list bill[or credit card]. You may change Your mode of premium payment by sending a written request to Our Administrative Office.

Please note that the more often You pay, the higher Your total premium amount will be per year. Additional premium charges are included for all premium payment periods other than annual. These charges are called "modal factor charges". These charges are based upon modal factors that are used to determine the premium amount for all payment options. The modal factors are 1.00 for annual, [.52] for semi-annual, [.265] for quarterly, and [.09] for monthly.[Payroll deduction modal factors vary depending on the frequency of payment by Your employer's payroll system.]

Cost Comparison of Premium Paying Modes				
Premium Paying Mode	Number of Premium Payments Per Year	Amount of Each Modal Premium Payment	Total of Modal Premium Payments per Year	Total Additional Payment per Year
Annual	1	[$1,000.00]	[$1,000.00]	[$0.00]
Semi-Annual	2	[$520.00]	[$1,040.00]	[$40.00]
Quarterly	4	[$265.00]	[$1,060.00]	[$60.00]
Monthly	12	[$90.00]	[$1,080.00]	[$80.00]

To calculate the total amount of premiums You will pay in a year based on Your current premium payment selection:

(1) multiply the Initial Annual Premium shown on this Schedule by the factor for Your chosen Premium Paying Mode; and then
(2) multiply that result by the number of premium payments per year based on Your chosen Premium Paying Mode.

[LIMITED PREMIUM PAYING PERIOD INFORMATION

Premiums for this Policy are required to be paid for the Premium Paying Period shown on this Schedule. Upon completion of premium payments for that Period, Your payments will end and no further premium payments will be required. Your Policy will then be paid up.

Premiums for any benefits added during or after Your Premium Paying Period will need to be paid for the number of years in Your Premium Paying Period, starting on the effective date of their addition to Your Policy.

For example: If Your Premium Paying Period is 10 years, You must pay the premium for the added benefits for 10 years from the effective date of their addition to Your Policy.]

GENERAL INFORMATION

This Policy uses terms that have certain meanings within this Policy. Defined terms are shown with capital letters to help You better identify them. Most of the definitions are in the General Definitions section at the end of this Policy. Definitions related to eligibility for benefits are in the Eligibility Definitions section. We suggest that You closely read the facility and care provider definitions.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any benefits provided under this Policy and any Rider(s) or Endorsement(s) attached, We must receive a Plan of Care that specifies what Qualified Long Term Care Services are needed. These Services must be needed because You are a Chronically Ill Individual. This means that You have been certified within the last 12 months by a Licensed Health Care Practitioner as:

(1) being unable to perform, without Substantial Assistance from another individual, at least 2 out of the 6 Activities of Daily Living (ADLs) for an expected period of at least 90 days due to a loss of functional capacity; or

(2) requiring Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

This Policy provides coverage for mental and nervous conditions, including Alzheimer's disease, Parkinson's disease and senile dementia as long as You are certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in this Policy. Benefits are subject to the Elimination Period, provisions, exclusions and limitations of this Policy.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Conditions

In order for benefits to be payable under this Policy:

- You must satisfy the Eligibility for the Payment of Benefits provision;
- all Qualified Long Term Care Services must begin while Your coverage is in force;
- all charges must be incurred for services rendered or goods provided while the applicable benefit is in force;
- You must satisfy the Elimination Period if it applies to the benefits You are receiving;
- all care and services must be in accordance with accepted medical and nursing standards of practice; and
- all care and services must be consistent with Your current Plan of Care. You must provide Us with both an acceptable Plan of Care and Proof of Loss documentation.

The Elimination Period, benefits, benefit limits and Policy Maximum Amount are shown on the Schedule. The Schedule and the benefit sections indicate if the Elimination Period is applicable to each Benefit.

Limitations

All benefits are subject to the Policy Maximum Amount of this Policy, except for the Optional Care Coordination Benefit. Benefits are payable as specified in the Benefits section of this Policy. We will not pay benefits during the Elimination Period. Benefits are subject to: the General Exclusions and Limitations; Nonduplication of Coverage; and Other Insurance With Us provisions of this Policy.

NOTE: If more than one type of covered care or service is received on the same day, only the daily benefit providing the largest payment will be payable, unless otherwise stated in the Benefits section of this Policy.

We will not pay for: Physician's charges; hospital or laboratory charges; prescription or non-prescription medications; medical supplies; durable medical equipment (except as provided under the Remain At Home Benefit); payments in-kind; transportation; or personal expenses, such as items and services furnished at Your request for comfort, convenience, beautification or entertainment.

ELIGIBILITY DEFINITIONS

Chronically Ill Individual

Any individual who has been certified by a Licensed Health Care Practitioner as:

(1) being unable to perform, without **Substantial Assistance** from another individual, at least 2 out of the 6 **Activities of Daily Living (ADLs)** for an expected period of at least 90 days due to a loss of functional capacity; or

(2) requiring **Substantial Supervision** to protect You from threats to health and safety due to **Severe Cognitive Impairment**.

Substantial Assistance

Hands-on Assistance or Standby Assistance.

(1) Hands-on Assistance
The physical assistance (minimal, moderate or maximal) of another person without which You would be unable to perform the Activity of Daily Living.

(2) Standby Assistance
The presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to You while You are performing the Activity of Daily Living.

Activities of Daily Living (ADLs)

Each of the following six (6) functional areas is considered an Activity of Daily Living (ADL):

(1) Bathing: The ability to wash oneself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.

(2) Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).

(3) Dressing: The ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.

(4) Eating: The ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.

(5) Toileting: The ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.

(6) Transferring: The ability to move into and out of a bed, chair or wheelchair.

Substantial Supervision

Continual supervision by another person that is necessary to protect You as a Severely Cognitively Impaired person from threats to Your health or safety (such as may result from wandering). This includes cuing by verbal prompting, gestures, or other demonstrations. Supervision that is intermittent or periodic is not considered Substantial Supervision.

Severe Cognitive Impairment (including the term "Severely Cognitively Impaired")
A severe loss or deterioration in intellectual capacity that is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in Your:
(1) short-term or long-term memory;
(2) orientation as to people, places or time;
(3) deductive or abstract reasoning; and
(4) judgment as it relates to safety awareness.

The evaluation shall include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

BENEFITS

The following sections describe the coverage available for care and services under this Policy. Please read the benefit provisions carefully. Each of the Benefits of this Policy is subject to all applicable requirements and limitations of this Policy. Use of a Care Coordinator is not required to access benefits under this Policy unless otherwise specified in a Benefit.

CASH BENEFIT
We will pay You the Monthly Cash Benefit shown on the Schedule, subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) Our receipt of a Plan of Care; and
(3) the Policy Maximum Amount.

We will pay You for each Calendar Month You continue to meet those requirements. We will pay this benefit instead of all other benefits under this Policy, except for the Optional Care Coordination Benefit.

If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of Care for only part of a Calendar Month, We will prorate the Monthly Cash Benefit payment. Prorate means We will divide the Monthly Cash Benefit by the actual number of days in the month, then multiply that number times the number of days in that month for which We have received a Plan of Care.

For example: If it is April and Your Monthly Cash Benefit is $3,000 but We receive a Plan of Care for only 10 days, We will divide $3,000 by 30 (days) to get a daily pro rata amount of $100 and then multiply that by 10 (days) for a payment of $1,000.

We will not pay this benefit for any time period prior to the date We receive the Plan of Care. We must receive a Plan of Care at least once each 90 days. Bills to show Out of Pocket Expenses are not required for this benefit to be payable.

Payment of this benefit will end when You no longer meet the requirements in the Eligibility for the Payment of Benefits provision. We will stop paying this benefit if We do not receive a Plan of Care as required. We will also stop paying this benefit when You choose to receive other benefits for care and services that are covered under this Policy. Simply call or write to tell Us that You want to switch to other benefits payable under this Policy and We will let You know what You need to do.

If You are confined as an overnight bed patient in a facility and are receiving the Cash Benefit, those days of confinement while receiving the Cash Benefit cannot be applied toward satisfaction of the Elimination Period. The Cash Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

This benefit does not entitle You to a waiver of premium.

HOME CARE AND ADULT DAY CARE BENEFIT

Home Care Services, Home Health Care Services and/or Adult Day Care will not be payable on any day that You are confined as an inpatient in a hospital or Long Term Care Facility.

We will pay You for the Out of Pocket Expenses for each day You receive Home Care Services, Home Health Care Services, or Adult Day Care. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Home Care and Adult Day Care Maximum Daily Benefit;
(3) the Policy Maximum Amount; and
(4) the Elimination Period, if Your Schedule indicates that it applies to this benefit.

Home Care Services and Home Health Care Services must be provided by or through a Home Care Agency in Your Home under a Plan of Care. Adult Day Care must be received for at least 4 hours during any day for which benefits are payable. Adult Day Care must be provided by and at an Adult Day Care Center.

OPTIONAL CARE COORDINATION BENEFIT

We will pay for the Care Coordinator to facilitate an assessment of Your care needs and the development of a Plan of Care. This is in addition to any other benefits paid under this Policy. We will pay for the Care Coordinator to provide Care Coordination services as long as You are certified as meeting the requirements in the Eligibility for the Payment of Benefits provision.

While working with You, Your family, and Your Physician, the Care Coordinator may help to establish an individualized Plan of Care. Upon Your request, the Care Coordinator may provide You with a list of care providers and services in Your area for You to consider. Neither the Care Coordinator nor We will suggest or recommend providers or guarantee the quality of care by any of the providers or services listed. However, it will be a starting point that You may use when seeking care providers. If You desire, the Care Coordinator may assist You in obtaining the services recommended in the Plan of Care. This assistance will be limited to referring You to providers and help in coordinating such referrals.

The Optional Care Coordination Benefit includes the services of the Care Coordinator to help to arrange for services to assist You in remaining at Home. These services may include:
(1) home health care services;
(2) durable medical equipment;
(3) emergency medical call system; and
(4) caregiver training.

You may choose to use a Care Coordinator from Our list or one of Your own choosing. In order to obtain a Care Coordinator from Our list, You may contact Us at the Claims Department's toll-free number shown on the Schedule. You may then select a Care Coordinator contracted and approved by Us from Our list.

For a Care Coordinator who is selected from Out list, there will be no charge to You for the covered Care Coordination services of the Care Coordinator. No amount will be subtracted from the Policy Maximum Amount.

For a Care Coordinator who is not selected from Our list, the Optional Care Coordination Benefit is limited to the Maximum Lifetime Optional Care Coordination Benefit shown on the Schedule, and any amount paid for such covered Care Coordination services will be deducted from the Policy Maximum Amount.

The Optional Care Coordination Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

REMAIN AT HOME BENEFIT

If You are receiving the Optional Care Coordination Benefit and using a Care Coordinator from Our list, this benefit is available. To qualify for this benefit, the Care Coordinator from Our list must approve the provider selected by You, as well as the labor, equipment and/or supplies in advance.

While You are living in Your Home, the Remain At Home Benefit can be used to pay for the following Qualified Long Term Care Services:
(1) Home Modification;
(2) Caregiver Training for a Volunteer Caregiver;
(3) Therapeutic Device or Technology; and
(4) Medical Alert System.

We will pay You for the Out of Pocket Expenses for care or services You receive under the Remain At Home Benefit. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Remain At Home Maximum Benefit; and
(3) the Policy Maximum Amount.

The care or services provided under the Remain At Home Benefit must be consistent with Your care needs and provided according to a Plan of Care approved by the Care Coordinator from Our list. The Remain At Home Benefit is available even if You are receiving the Home Care and Adult Day Care Benefit at the same time. The Remain At Home Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

RESPITE CARE BENEFIT

If You are being cared for by Your Volunteer Caregiver on a continuous basis, We will pay You for the Out of Pocket Expenses for Respite Care. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Respite Care Maximum Daily Benefit;
(3) the Policy Maximum Amount; and
(4) Respite Care must be provided in a Long Term Care Facility or in Your Home.

The Respite Care Benefit is available for up to the Number of Days Per Calendar Year shown on the Schedule. Benefits for Respite Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period.

LONG TERM CARE FACILITY BENEFIT

We will pay You for the Out of Pocket Expenses for each day You are confined as an overnight bed patient in a Long Term Care Facility. This includes room and board and Qualified Long Term Care Services. Payment is subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Elimination Period;
(3) the Long Term Care Facility Maximum Daily Benefit;
(4) the Policy Maximum Amount; and
(5) care and services provided while You are confined as an overnight bed patient in a Long Term Care Facility as defined in this Policy.

We will not pay more than the charge for a one-bedroom unit.

EXTENSION OF THE LONG TERM CARE FACILITY BENEFIT
If Your Policy Lapses while You are receiving the Long Term Care Facility Benefit, benefits will be continued until the earliest of the following: You no longer qualify for benefits; You are discharged from the Long Term Care Facility; You exhaust the Policy Maximum Amount; or You die. No other Policy benefits or benefits added by rider or endorsement to this Policy will be continued under this benefit.

LONG TERM CARE FACILITY BED RESERVATION BENEFIT
When You are absent for any reason (except discharge) during a Long Term Care Facility confinement, We will pay You for the Out of Pocket Expenses while the room in the Long Term Care Facility is being reserved. We will pay You for each day of Your absence, up to the Long Term Care Facility Maximum Daily Benefit.

You must have satisfied the Elimination Period before the Bed Reservation Benefit is available. The Bed Reservation Benefit is available for up to the Number of Days Per Calendar Year shown on the Schedule. It is subject to the Eligibility for the Payment of Benefits provision and the Policy Maximum Amount.

GLOBAL COVERAGE BENEFIT
If You are outside of the fifty (50) United States and the District of Columbia, or Canada, We will pay You for the Out of Pocket Expenses for care or services that otherwise would be covered under this Policy. Payment is subject to:
(1) the Elimination Period;
(2) the Global Coverage Maximum Daily Benefit;
(3) the Global Monthly Cash Benefit, if You are receiving the Cash Benefit under Global Coverage;
(4) the Global Coverage Maximum Benefit Amount; and
(5) the Policy Maximum Amount.

If You receive the Cash Benefit under Global Coverage, it is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

Benefits that are available under this Global Coverage Benefit are limited to:
(1) the Long Term Care Facility Benefit;
(2) the Home Care and Adult Day Care Benefit;
(3) the Cash Benefit; and
(4) the Hospice Care Benefit

The following benefits are not available under this Global Coverage Benefit: (1) the Respite Care Benefit; (2) the Remain At Home Benefit; (3) the Long Term Care Facility Bed Reservation Benefit; (4) Extension of the Long Term Care Facility Benefit; (5) the Alternate Plan of Care Benefit; (6) the Optional Care Coordination Benefit; and (7) the Accident Benefit, if You have this Endorsement attached to Your Policy.

All of the terms of this Policy apply to this benefit. The Global Coverage Benefit will pay benefits in lieu of all other benefits under this Policy. Premiums will not be waived while You are receiving the Global Coverage Benefit.

The following requirements must be satisfied:
(1) You must provide Us with a written certification that is acceptable to Us that You meet the requirements of the Eligibility for the Payment of Benefits provision; and
(2) You must provide Us with written proof that is acceptable to Us that You meet the requirements of the Conditions section; and
(3) You must provide Us with written proof that is acceptable to Us that You have satisfied the Elimination Period; and

(4) You must provide Us with a current written Plan of Care. You must also provide Us with any updates to it; and
(5) You must provide Us with properly completed claim forms; and
(6) You must provide Us with proof that is acceptable to Us that You are receiving covered care or services. This means that all care and services must be Qualified Long Term Care Services according to this Policy. No proof of receipt of services is required for the Cash Benefit to be payable under Global Coverage; and
(7) You must provide Us with proof acceptable to Us that You are outside of the fifty (50) United States and the District of Columbia, or Canada; and
(8) all documentation must be provided to Us in English at Your own expense.

We reserve the right to require that You provide Us with updates to Your documentation and other information. This includes an on-site assessment acceptable to Us that You are a Chronically Ill Individual. In no case will We require updates more frequently than each 30 days.

If You have a restoration of benefits provision or rider attached to Your Policy, no benefits paid under this Global Coverage Benefit will be restored under that rider.

Once You exhaust Your Global Coverage Maximum Benefit Amount, Your Policy continues in force. Any benefits remaining under this Policy are available to You as long as You receive them within the fifty (50) United States and the District of Columbia, or Canada. All benefits paid are subject to the Policy Maximum Amount.

Benefits paid under the Global Coverage Benefit will be paid in U.S. currency only. We will determine any foreign exchange rate to be used. You may not assign payments for this benefit.

WAIVER OF PREMIUM BENEFIT

We will automatically change Your Premium Paying Mode to monthly and not require the payment of Your monthly premium when You qualify for the Waiver of Premium Benefit.

To qualify for the Waiver of Premium Benefit, You must:
(1) meet the requirements in the Eligibility for the Payment of Benefits provision;
(2) satisfy the Elimination Period, if it applies to the benefits You are receiving; and
(3) be confined as an overnight bed patient and receiving either the Long Term Care Facility Benefit or the Accident Benefit, if You have the Accident Benefit Endorsement attached to Your Policy; or
(4) be receiving the Hospice Care Benefit.

We will stop waiving the premium when You no longer qualify for the Waiver of Premium Benefit. The Waiver of Premium Benefit will end on the date the Policy Maximum Amount has been exhausted.

To keep Your Policy in force when the Waiver of Premium Benefit ends or after You no longer qualify for the Waiver of Premium Benefit, premiums must be paid as they become due. Any unearned premiums paid which apply to the period that premiums are being waived will be refunded to You following the Policy monthly anniversary on which the Waiver of Premium began.

If benefits are added while the premium is being waived, the premium for those added benefits must continue to be paid.

If You are receiving any benefits other than those specified in numbers (3) and (4) above, the Waiver of Premium Benefit will not apply.

HOSPICE CARE BENEFIT

We will pay You for the Out of Pocket Expenses for each day You receive Hospice Care. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) a certification that You are Terminally Ill;
(3) the Hospice Care Maximum Daily Benefit;
(4) the Policy Maximum Amount; and
(5) Hospice Care must be provided by a Hospice Care Provider.

Benefits for Hospice Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period. We will not pay for more than 180 days of Hospice Care.

Benefits for Hospice Care will not be payable when other benefits are payable under this Policy, except for: the Optional Care Coordination Benefit; and the Global Coverage Benefit.

ALTERNATE PLAN OF CARE BENEFIT

Your Policy provides coverage for a wide range of long term care services. Because there may be new and evolving long term care services that We could not anticipate at the time Your Policy was issued, the Alternate Plan of Care Benefit gives Us the discretion to consider whether We may want to cover alternate Qualified Long Term Care Services not otherwise expressly covered by this Policy.

We will consider paying benefits to You based on the Out of Pocket Expenses You incur for services requested under an Alternate Plan of Care only if:

(1) You are currently receiving benefits under this Policy; and
(2) You request in writing, prior to receipt of such alternative services, that We consider payment for services not identified in this Policy; and
(3) We determine that You satisfy and continue to satisfy the requirements under the Eligibility for the Payment of Benefits provision of this Policy; and
(4) the cost of services under the Alternate Plan of Care You request is less expensive than the amount We would otherwise pay for Qualified Long Term Care Services; and
    - the services are clearly specified in Your Plan of Care; and
    - the Alternate Plan of Care Benefit amount is agreed to in a written Alternate Plan of Care agreement that is signed by You and Us.

We have the sole discretion to determine the amount, if any, We are willing to pay toward the cost of such services. Any benefits paid under this provision will reduce Your Policy Maximum Amount. Days on which You receive alternative Qualified Long Term Care Services on or after the effective date of the Alternate Plan of Care agreement may count toward satisfaction of the Elimination Period. If so, We will not pay this benefit until Your Elimination Period has been satisfied, depending on what the alternative services are. You will qualify for a waiver of premium under this benefit only if the benefits You are currently receiving qualify for a Waiver of Premium Benefit.

The Alternate Plan of Care Benefit may not be used to pay for any charges for services described in the General Exclusions and Limitations, or Nonduplication of Coverage provisions of this Policy. The Alternate Plan of Care Benefit will not extend any benefit listed in this Policy that You have exhausted. Except for the Optional Care Coordination Benefit, the Alternate Plan of Care Benefit will not be paid when any other benefits for care or services are being provided under this Policy. The Alternate Plan of Care Benefit may not be used to pay for services at any type of facility that is otherwise excluded from coverage under the terms of this Policy.

An Alternate Plan of Care agreement will specify an agreement effective date and an agreement termination date. We reserve the right to review and develop a new Alternate Plan of Care agreement with You at the agreement termination date of the current Alternate Plan of Care agreement. However, You may choose to discontinue the use of the Alternate Plan of Care Benefit at any time. Our consideration and/or payment of the Alternate Plan of Care Benefit does not waive any of Your or Our rights under this Policy.

GENERAL EXCLUSIONS AND LIMITATIONS

This Policy will not pay benefits when You are eligible for confinement, care or services:
(1) resulting from alcoholism, drug addiction or chemical dependency, unless as a result of medication prescribed by a Physician;
(2) resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
(3) due to participation in a felony, riot or insurrection;
(4) for which no charge is normally made in the absence of insurance;
(5) received outside the fifty (50) United States and the District of Columbia, or Canada; or
(6) performed by a member of Your Immediate Family. Your Immediate Family member can provide covered care or services if he or she is a regular employee of an organization that is engaged in providing the Qualified Long Term Care Services. The organization he or she works for must receive the payment for the care or service. Your Immediate Family member must receive no compensation other than the normal compensation for employees in his or her job category.

We will not pay for any confinement, care or service that is not included in Your Plan of Care. We will not pay for anything that is prohibited by state or federal law, including any law governing economic and trade sanctions.

The exclusion regarding a member of Your Immediate Family will not apply to the Cash Benefit. This exclusion also will not apply to the Cash Benefit if received under the Global Coverage Benefit.

The exclusion regarding confinement, care or services received outside the fifty (50) United States and District of Columbia, or Canada will not apply to the Global Coverage Benefit.

NONDUPLICATION OF COVERAGE

This Policy will not pay benefits when confinement, care or services are:
(1) provided in a government facility (unless otherwise required by law);
(2) paid or payable under Medicare. This includes any amounts that would be covered under Medicare, except that they are subject to a Medicare deductible or coinsurance of some kind. This does not apply when expenses are reimbursable under Medicare solely as a secondary payer;
(3) provided under any governmental programs (except Medicaid);
(4) for services or items available or paid under another long term care insurance or health insurance policy; or
(5) paid or payable under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

except to the extent that Your Out of Pocket Expenses exceed the amount covered by one of these entities, policies or programs.

A government facility includes a facility administered, covered or reimbursed by the Veteran's Administration.

OTHER INSURANCE WITH US

We may reduce benefits payable under this Policy for long term care confinement, care and services if We also pay benefits for such confinement, care and services under another individual long term care insurance policy issued by Us. This includes policies providing nursing home, assisted living facility and/or home health care coverage, regardless of the actual terminology. It also applies whether benefits are payable on an expense reimbursement, indemnity or any other basis.

Benefits, including the Cash Benefit, will be reduced under this Policy only when payment under this Policy and all other Transamerica Life Insurance Company policies combined would exceed the Out of Pocket Expenses You incur for long term care confinement and services. Under this Policy, We will not pay more than the difference between Your actual Out of Pocket Expenses and the amount payable by Your other long term care insurance policies with Us.

In addition, if You are insured under more than one individual long term care insurance policy issued by Us with a similar coordination provision, the policy with the earliest effective date of coverage will be deemed primary coverage and pay first. Thereafter, payment will be made under any additional policy (deemed secondary coverage) in order of effective date, from the earliest to the latest.

Any policy without a similar coordination provision will pay first without any reduction in its benefits.

CLAIMS INFORMATION

This section informs You of: when to notify Us of a claim; what to send to Us; where to send it; how We pay benefits; and other claims-related rights and obligations under this Policy.

Notifying Us of a Claim

Notice of Claim: Early notification to Our Claims Department will help Us make a timely review of Your claim. Please let Us know immediately, or in advance whenever possible, when You need care or services covered by this Policy. Please see Your Schedule page for the toll-free number for the Claims Department. You may choose to send Us written notice instead.

Notice must be received by Us at Our Administrative Office within 60 days of the date the covered loss starts or as soon as is reasonably possible. The notice should include at least: Your name, Policy Number, and the address to which the claim form should be sent. You may authorize someone else to act for You in filing a claim.

How to File a Claim

Claim Forms: When We receive notice of a claim, We will send out a claim form to be used to file Proof of Loss. We will send the claim form to You within 15 days of notice of a claim.

The claim form has instructions on how to fill it out and where to send it. Please read the form carefully. Answer all questions and send all required information to the address on the form. You may choose to have someone else complete the information for You as Your representative.

If You do not get the claim form within 15 days, Proof of Loss can be filed without it by sending Us a letter. The letter needs to describe the occurrence, the nature, and the extent of the loss for which claim is being made. That letter must be sent to Us within the time period stated in the Proof of Loss section. At a minimum, the description should tell Us such things as:

- Your name, address, social security number, and policy number;
- the type of benefits for which claim is being made;
- the names and addresses of the medical professionals and care providers who are aware of Your condition or have provided care covered by this Policy;

- the diagnosis; and
- the time periods for which benefits are being claimed.

Assessment of Your Condition: Before We approve a claim for benefits under this Policy, an assessment may be performed by a Licensed Health Care Practitioner We select. This assessment may be performed in person. The Licensed Health Care Practitioner will assess Your condition and prognosis for recovery.

To continue payments, We may require a Licensed Health Care Practitioner We select to reassess Your condition and to update the prognosis for recovery. We will pay the costs of the initial assessment and all reassessments. We may require a reassessment at least once every 12 months while benefits are being paid. We may require a reassessment more often, but not more often than every 90 days.

When to File a Claim

Proof of Loss: You must give Us written Proof of Loss within 90 days after the end of the Elimination Period in order to satisfy the Elimination Period requirements. You must send the Proof of Loss to Our Administrative Office. We will require a certification by a Licensed Health Care Practitioner that You were a Chronically Ill Individual during the Elimination Period. It must include documentation that during the Elimination Period, You received services from covered providers for which You incurred a charge.

In order to help Us determine Your eligibility for the payment of benefits, We may require that You provide Us with any combination of documents, such as, but not limited to:

(1) claim forms and authorizations to obtain Proof of Loss;
(2) Physician's orders;
(3) medical records;
(4) copies of licensure of any facility, provider or for any bed to which You are assigned;
(5) itemized daily or monthly billing statements;
(6) records of the care or services You received;
(7) Explanation of Benefits (EOBs) that You have received from other sources for the same services. This includes: other health insurance or long term care insurance policies; the Veteran's Administration; and Medicare;
(8) provider's Plan of Care or provider assessment/reassessment records or similar documents; and
(9) provider's residence agreements, disclosures, life care contracts or similar documents.

In addition, We reserve the right to conduct an Assessment of Your Condition before We approve a claim for benefits under this Policy.

We must receive written Proof of Loss within 90 days after the end of each month for which benefits may be paid. If it is not reasonably possible to give Us written proof in the time required, We will not reduce or deny a claim for being late if the Proof of Loss is sent to Us as soon as is reasonably possible. Unless You are not legally capable, the required Proof of Loss must always be given to Us no later than one year from the time specified.

How and When Claims are Paid

Time of Payment of Claim: Benefits under this Policy are payable after services have been rendered and charges have been incurred for such services. We will not pay benefits based on Advance Bills.

A. Within 30 business days after We receive notice of claim and Proof of Loss, We will either: pay the claim, if We have received all of the required information and determine that the claim is payable; or send You a written notice acknowledging the date of receipt of the claim. If We do not pay the claim, We will let You know: We are declining to pay all or part of the claim and the specific reason(s) for denial; or that additional information is necessary to determine if all or any part of the claim is payable and the specific additional information that is necessary.

B. Within 30 business days after We receive the requested additional information, We will either: pay the claim; or We will let You know that We are declining to pay all or part of the claim and the specific reason(s) for denial.

If We fail to follow the process outlined above, We will pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after:
(1) the receipt of the claim with respect to subsection A above; or
(2) all requested additional information is received with respect to subsection B above.

The interest payable will be included in a late claim payment without the requirement to file an additional claim for such interest.

Payment of Claims: All benefits will be paid in U.S. dollars.

You may request that the payment of benefits to be made to someone other than You. This assignment of benefits must be sent to Us in writing. You should make this assignment of benefits no later than at the time Proof of Loss is filed. We will assume no liability for the payment of benefits to an assigned party that was paid based on the assignment of benefits in Our file at the time of payment.

Benefits unpaid at Your death will be paid to Your estate. We may pay such benefits to any relative by blood or marriage that we deem to be entitled to the benefits if they would otherwise be paid to Your estate. We may pay such benefits to any other person who has cared for or looked after Your affairs and who is deemed by Us to be justly entitled to the benefits. We may pay up to $1,000 under this provision. We will be discharged to the extent of any such payment made in good faith.

How to Appeal a Claim

Claims Appeal Process: We evaluate a claim based on the provisions of this Policy and the information We obtain or that is given to Us. If You do not agree with a claim decision, You may ask for an appeal. Your request must be in writing to Us. It needs to include all of the following information: the names, addresses and phone numbers of the providers who You think We should contact to learn more about Your health and the care received; the Physicians and other health care professionals who treated You; and the facilities that provided the care or services. No special form is needed. Your request must be sent to Our Administrative Office within 1 year of the time of filing written Proof of Loss. You may authorize someone else to act for You under this appeal process. You or Your authorized representative may submit additional information of any kind that You think will help with Your appeal.

After We receive Your appeal and the necessary supporting documents, We will reexamine the information regarding Your claim and any additional information provided to Us. Within 30 days after We receive all of the necessary information, We will complete Our review. We will send You and Your authorized representative, if any, Our decision in writing. If Our decision is to pay the claim, We will pay it promptly. If the appeal is denied, We will clearly state Our reasons and make information directly relating to the denial available to You.

Right of Recovery

We have the right to recover any overpayment made because of an error in the processing of a claim. We may offset any amounts that have not been previously recovered from any future benefit payment.

Subrogation: If You become a Chronically Ill Individual as a result of an act or omission of someone else and receive covered care or services, We shall provide benefits to You, subject to the terms of this Policy. Acceptance of such benefits will mean You consent to the provisions of this section.

If We make any payments for benefits under this Policy, We shall be subrogated, to the extent of such payments, to all rights of recovery You have against any person or entity. You shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to Us.

We shall have a lien on all funds received by You up to the amount of benefits provided to You. We may give notice of that lien to any party who may have caused or contributed to the loss. All funds received shall be deemed to be for benefits paid by Us to or for Your account, regardless of the characterization of such funds. In the event that You receive funds on which We have a lien, such funds shall be held in trust by You until paid over to Us.

If We so decide, We may be subrogated to Your rights to the extent of the benefits received under this Policy. This includes Our right to bring suit against a third party in Your name. After giving You 30 days written notice, We or Our designee shall have the right to bring suit and take such action as necessary in Your name to recover the amount of benefits paid under this Policy. We can only do this if You or anyone acting on Your behalf has not taken action against such third party to obtain a judgment, settlement, or other recovery. Any action taken without Your consent shall be without prejudice to You.

You must take all actions, provide such information and assistance, and execute all instruments as We may require to help in the enforcement of Our rights under this provision. You shall take no action prejudicing Our rights and interests under this provision.

GENERAL PROVISIONS

This section describes: the documents that form this contract; the importance of a truthful application; and other basic rights and obligations.

The Contract

Entire Contract: The entire contract between You and Us will consist of:
(1) this Policy;
(2) the application; and
(3) any riders, endorsements or amendments made a part of this Policy.

No agent/insurance producer has authority to change or waive any part of this Policy. To be valid, any change or waiver must be:
(1) in writing;
(2) approved by one of Our executive officers; and
(3) endorsed on or attached to this Policy.

Misstatement of Age

If Your age has been misstated, the benefits payable will be those that the premium paid would have purchased at Your correct age. If Your correct age is greater than the maximum age at which We would have issued this Policy, Our liability will be limited to the refund of all premiums paid for this Policy.

Contesting Coverage

Time Limit on Certain Defenses: When Your coverage has been in force less than 6 months, We may rescind the coverage or deny an otherwise valid claim upon a showing of misrepresentation that is material to Our decision to issue You the coverage.

When Your coverage has been in force for at least 6 months but less than 2 years, We may rescind the coverage or deny an otherwise valid claim upon a showing of misrepresentation that is both material to Our decision to issue You the coverage and which pertains to the condition for which benefits are sought.

After Your coverage has been in force for 2 years or more, We may only rescind the coverage upon a showing that You knowingly and intentionally misrepresented relevant facts relating to Your health.

Correction of Mistakes
When We discover a mistake or You bring one to Our attention, We reserve the right to correct it. We reserve the right to correct any mistakes We make whether: in the premium calculation and collection process; in the policy issue process; in the benefit payment process; or in some other part of Our contractual relationship. The benefit selections You made on the application and the premiums You have paid will be used to determine the coverage of Your Policy.

Other Provisions
Nonparticipating: This Policy does not participate in Our profits or surplus earnings.

No Cash Values, Borrowing, or Use as Collateral: This Policy does not provide for a cash surrender value, or other money that can be: borrowed; or paid, assigned or pledged as collateral for a loan.

Conformity with Law: If anything in this Policy does not comply with a law to which it is subject on its Effective Date, that provision is amended to conform to such law.

Time Periods: All time periods begin and end at 12:01 A.M. Standard time at Your Home.

Legal Actions: You cannot bring suit against Us until at least 60 days after written Proof of Loss has been given to Us. You cannot bring suit against Us after 3 years from the time written Proof of Loss is required to be given.

EFFECTIVE DATE, PREMIUM AND TERMINATION PROVISIONS

The Policy Taking Effect
Effective Date and Consideration: This Policy is issued based on Your answers to the questions on the application and payment of the Initial Modal Premium. It takes effect on the Effective Date shown on the Schedule, provided the Initial Modal Premium is paid. The Schedule will show only the benefits and benefit amounts We initially issued. Any benefits You delete or add later will be shown by endorsement to this Policy. All policy and benefit provisions and the Elimination Period will be calculated from the effective date of any increase in benefits.

Paying Premiums
After payment of the initial premium, each additional premium, if any, is due at the end of the period for which the prior premium was paid. Premiums for this Policy must be paid when due in order for the coverage to remain in force. The Premium Paying Mode shown on the Schedule states how often premiums are to be paid per year. The Premium Paying Period shown on the Schedule states how long premiums are to be paid. Premiums are to be paid to Us at Our Administrative Office. The Premium Paying Mode You selected will impact Your overall cost of insurance.

Rate Guarantee
Premium rates for this Policy are guaranteed from the Policy's Effective Date for the period of time shown on the Schedule. When the Rate Guarantee ends, Your premium will be adjusted by any premium increases that may occur during the Rate Guarantee period. Increases in premium may occur only after the Rate Guarantee has expired. Only the benefits You originally purchased are covered by this Rate Guarantee. Any benefits added after the Effective Date will not be covered by the Rate Guarantee. However, if there are any remaining years in the Rate Guarantee, the new benefits will be covered for those years.

What Happens When Premiums Are Not Paid

Grace Period: This Policy has a 65-day Grace Period. If a premium other than the initial premium is not paid within 30 days from the Premium Due Date, We will send written notice of the nonpayment of the premium to You and the person or persons You named to receive such notice. We will send the notice to the addresses You provided to Us. You have an additional 35 days to pay the premium after We have mailed this notice. You may choose to change Your benefits as described below in **Your Right to Reduce Benefits** in order to reduce Your premium. During the Grace Period, this Policy will stay in effect. If We do not receive the premium payment before the end of the Grace Period, this Policy will Lapse.

You may have named a person or persons to receive notice of nonpayment of premium on Your application. The person or persons You named are not responsible for paying the premium. You may change the person or persons named at any time while this Policy is in effect. Please note that You must tell Us if any of the addresses change. You must send the information in writing to Our Administrative Office. We will provide You with a reminder of Your right to change the person or persons named at least every two years.

Your Right to Reduce Benefits

You may request that We reduce Your benefits at any time while this Policy is in force. This request must be in writing.

You may choose to:
(1) reduce only the Policy Maximum Amount;
(2) reduce the Maximum Daily Benefit resulting in a reduced Policy Maximum Amount; or
(3) reduce other benefits consistent with Our administrative processes.

The premium for the Policy containing the reduced benefits will be based on: the age used to determine the premium for the coverage then currently in force; and the reduced amount of coverage elected. You may not reduce Your coverage below the minimum requirements set by Your state.

If Your Policy is about to Lapse, We will advise You of Your right to lower Your premium by reducing Your coverage. Notice will be sent 30 days after the premium is due. You will have 35 days to consider the offer. It will be Your responsibility to continue to pay Your premium before the end of each Grace Period.

Putting This Policy Back In Force

Reinstatement: Once this Policy Lapses, We may or may not put it back in force (reinstate) at Our option. Within 90 days of Your last Premium Due Date, You may request that We reinstate this Policy. We will require an application for reinstatement, but We will not require any premium at that time. If the application is approved by Us, You must then pay all past-due premiums. This Policy will be put back in force as of the Lapse date.

Your reinstated Policy will cover only losses that begin after the date of reinstatement. In all other respects, Your rights and Our rights will be the same as before this Policy Lapsed. If there are any new provisions that apply to the reinstatement, they will be endorsed on or attached to the reinstated Policy.

Unintentional Lapse: If Your Policy Lapses unintentionally, We will reinstate Your coverage only if:
(1) We receive the request for reinstatement in Our Administrative Office within 180 days of the last Premium Due Date; and
(2) We receive a Licensed Health Care Practitioner's written certification that You were diagnosed, using generally accepted medical diagnostic methods and tests, as being a Chronically Ill Individual at the time this Policy Lapsed; and
(3) We receive all past-due premiums for the benefits that were in force at the time this Policy Lapsed.

Any claim incurred during the 180-day period will be considered for benefits subject to all other Policy provisions.

When the Policy Terminates

We will not cancel or otherwise end this Policy because of Your age or a change in Your mental or physical health.

Termination: This Policy and all benefits will end on the earliest of the following:

(1) the date this Policy Lapses;
(2) the date of Your death;
(3) the date the Policy Maximum Amount has been exhausted; or
(4) Our receipt of Your written request to cancel this Policy. If You do not specify a date to cancel this Policy, it will end on the next Policy monthly anniversary following Our receipt of the request. If You name a future cancellation date in Your written request, it will end on Your requested future cancellation date.

If You send Us a written notice to cancel Your Policy and You have named a person or persons in addition to Yourself to be notified regarding premium payments, We will send a notice to that person or persons that You have requested that We cancel Your Policy.

Payment of benefits for covered charges incurred before this Policy ends will not be affected.

Refund of Premiums

If this Policy terminates due to Your death, We will refund the portion of the modal premium paid for the period after the monthly anniversary following Your death up to the next Premium Due Date. This refund will be made only if Your Policy is still in its Premium Paying Period and is in force at the time of Your death. Any premiums paid for the time following the next Policy monthly anniversary after Your death will be refunded. The refund will be made within 30 days of Our receipt of written notice of Your death. It will be paid to Your estate.

If We receive a written request from You to cancel this Policy, We will refund any premiums paid for the period after Your cancellation. This refund will be made only if Your Policy is still in its Premium Paying Period and in force at the time We receive Your written cancellation. If You do not specify a date to cancel this Policy, We will refund any premiums paid from the next Policy monthly anniversary following Our receipt of the request. If You name a future date to cancel this Policy, We will refund any premiums paid from Your requested future cancellation date forward. The refund will be made within 30 days of Our receipt of written notice of cancellation. It will be paid to You.

New Coverage Offer

We will notify You if a new long term care policy series that provides coverage for new long term care services or providers not included in this Policy becomes available. If it does and it is material to Your coverage and **has not been previously available from Our Company to the general public**, We will give You the opportunity to apply for it.

New long term care services or providers that are material in nature shall not include changes to policy structure; or benefits or provisions that are minor in nature. Examples of when notification will not be provided include, but are not limited to: changes in elimination periods; benefit periods; and benefit amounts. We will decide, in Our sole discretion, if a new policy feature is material.

We will give You the opportunity to apply for the new coverage, unless You would not be eligible due to issue age limitations under the new coverage.

It will not be available to You if:
(1) You are eligible for benefits;
(2) You are receiving benefits;
(3) You are in the process of satisfying Your Elimination Period; or
(4) You previously have been in claim status under this Policy.

The coverage for the new services or providers will be available in one of the following ways. The choice of which one of these ways to make such coverage available will be solely at Our discretion.
(1) By adding a rider to this Policy containing the new benefits, which may require the payment of a separate premium based on Your attained age; or
(2) By exchanging this Policy with a new Policy based on Your age at the time of exchange, and recognizing past insured status by granting a premium credit as determined by Us toward the new Policy; or
(3) By exchanging this Policy with a new Policy, and recognizing past insured status on this Policy by basing premium for the new Policy on Your age when this Policy was issued; or
(4) By any alternative program developed by Us that has been approved by Your state.

You must apply for coverage for the new services or providers and provide the information We need at that time so We can determine whether You qualify for additional coverage. You must be eligible for the new coverage based on Our underwriting requirements in effect at the time the request is received by Us.

GENERAL DEFINITIONS

Adult Day Care
A program for six (6) or more individuals of social and health-related services provided during the day in a community group setting. The purpose of the program is to support frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the home.

Adult Day Care Center
A facility or organization that is licensed, registered or certified to provide Adult Day Care, if required by the state in which it is located.

If licensure, registration, or certification is not required by the state, it is that part (or separate center) of a facility that provides Adult Day Care and meets all of the following requirements:
(1) it operates at least 5 days a week for a minimum of 4 hours per day and is not an overnight facility;
(2) it maintains a daily written record for each client, which includes a Plan of Care and a record of all services provided;
(3) it has established procedures for obtaining appropriate aid in the event of a medical emergency;
(4) it has formal arrangements for providing for the services of: (a) a dietitian; (b) a licensed physical therapist; (c) a licensed speech therapist; and (d) a licensed occupational therapist; and
(5) its staff includes all of the following: (a) a full-time director; (b) one or more nurses in attendance during operating hours; and (c) not less than 3 full-time staff members.

Advance Bill(s)
Bills for services that are prebilled or billed prior to the services actually being provided. Benefits under this Policy are not eligible for payment until after covered services are received. For example: A bill or invoice may be created one month by a Long Term Care Facility for residency or services that it anticipates will be provided in the next month. This is considered an Advance Bill. It will not be accepted as Proof of Loss and is not eligible for payment. Only services that have been provided and received are eligible for payment.

Calendar Month
A period beginning on the first day through and including the last day of any of the 12 months of a year. For example: January 1st through January 31st.

Care Coordination
Services of a Care Coordinator who may work with You, Your family and/or Your Physician to assess Your care needs and establish an individualized Plan of Care. Care Coordination may include help in arranging for services to assist You in remaining at Home. Care Coordination also may include the scheduling of a comprehensive, face-to-face assessment of Your functional and cognitive capacity by a Licensed Health Care Practitioner. The Care Coordinator may or may not meet with You in person.

Care Coordination includes coordinating:
(1) development of the Plan of Care;
(2) implementation and coordination of services provided under the Plan of Care;
(3) completion of a comprehensive reassessment of the Plan of Care as needed; and
(4) revisions to the Plan of Care as appropriate.

Care Coordination Agency
An organization which is appropriately licensed or is state or federally certified/approved in the United States to provide Care Coordination services with a staff of at least one full-time registered nurse and one full-time medical social worker or case manager and which maintains a written record for each client. If such licensing or certification is not required in the state in which You reside, the organization must:
(1) operate at least 5 days a week for a minimum of 8 hours per day;
(2) operate under policies and procedures established by a group of professionals, including at least one registered nurse and one social worker;
(3) have someone on call to provide emergency coverage during nonoperating hours; and
(4) have a quality assurance program.

A Care Coordination Agency does not include an organization that provides Home Health Care Services, Home Care Services, Adult Day Care or Hospice Care or stands to gain direct financial benefit for services it recommends.

Care Coordinator
A person who is a Licensed Health Care Practitioner and is: (1) provided to You by Us from Our list; or (2) one of Your own choosing. If You choose a Care Coordinator who is not from Our list, the Licensed Health Care Practitioner must be employed by a Care Coordination Agency and must provide Care Coordination services. The Care Coordinator may gather objective information specific to Your circumstances; use the information gathered to help develop the Plan of Care; and identify providers that can deliver the needed care and services. He or she may assist You in identifying Your long term care needs and matching those needs with available service providers and resources.

Care Coordinators are normally familiar with care providers in Your area. There usually is a wide range of providers available. They vary greatly from skilled professionals to unskilled caregivers, based on the type of care needed. The Care Coordinator may help find providers to work with You and Your family. You are responsible for choosing the actual providers to be used. You may ask for another provider to be identified if for any reason You are not satisfied with a Care Coordinator or a care provider.

A Care Coordinator does not include anyone who: (1) has an ownership interest in; (2) is on contract with; or (3) is an employee of any provider of the services received. A Care Coordinator cannot be a member of Your Immediate Family.

Caregiver Training
Appropriate training and instruction provided by a person approved by the Care Coordinator to provide the knowledge and skills necessary for:
(1) the proper use and care of a Therapeutic Device and/or disposable medical aids, including but not limited to catheters; ostomy bags; or suctioning tubes; or
(2) the performance of appropriate caregiving procedures, such as changing of wound dressings; repositioning a patient in bed; or giving injections.

Elimination Period
The number of days that You must be confined as an overnight bed patient or receiving care or services before We will pay benefits for those services that are subject to the Elimination Period. The care or services must be for which benefits would be payable under this Policy if there were no Elimination Period. No such benefits will be paid until You have: (1) satisfied the Eligibility for the Payment of Benefits; and (2) incurred Out of Pocket Expenses for the number of days shown on the Schedule. You will be responsible for the expenses for those days. Days used to satisfy the Elimination Period do not have to be consecutive. Once satisfied, You will not have to satisfy the Elimination Period again.

The Elimination Period is shown on the Schedule.

Only confinement, care and services received that are subject to the Elimination Period can be used to satisfy the Elimination Period. If You are confined as an overnight bed patient in a facility and receiving the Cash Benefit, those days of confinement while receiving the Cash Benefit cannot be used to satisfy the Elimination Period.

We will give You credit toward the Elimination Period for days of confinement, care or services covered under this Policy, even though they are paid or payable by Medicare. Credit toward the Elimination Period is given only for those services that are subject to the Elimination Period under this Policy.

Days of confinement in a hospital or rehabilitation hospital/facility cannot be used to satisfy the Elimination Period, even if they are paid or payable by Medicare.

Home
Any place where You reside other than: a Long Term Care Facility; a rehabilitation hospital/facility; a hospital; or other acute care facility.

Home Care Agency
An entity that provides care and services in Your Home and meets all of the following criteria:
(1) it is, where required, licensed, certified or accredited as a Home Health Care Agency, Home Care Agency, or Nurse Registry (in states where Nurse Registries exist);
(2) it provides Home Health Care Services or Home Care Services;
(3) it is, where required by its licensure, certification or accreditation, supervised by a Registered Nurse or a licensed social worker;
(4) it keeps written Plan of Care records on all patients. This includes Physician's orders where appropriate; and
(5) if providing Home Health Care Services, it also keeps daily written clinical records on all patients.

Placement agencies, employment agencies and similar entities do not qualify as Home Care Agencies.

Home Care Services
Services that are provided by skilled or unskilled persons who work under the supervision of a Home Care Agency. These services are provided in Your Home. Home Care Services include the following:
(1) Personal Care Attendant Services;

(2) reporting changes in Your condition and needs, and completing appropriate records; and
(3) Homemaker Services.

Home Health Care Services
A program of part-time or intermittent professional, para-professional or skilled care provided through a Home Care Agency to You in Your Home. Home Health Care Services include nursing services provided by a: Nurse; physical therapist; respiratory therapist; speech therapist; occupational therapist; infusion therapist; or nutritional specialist.

Homemaker Services
Support services that are secondary to assistance with the Activities of Daily Living or because of a Severe Cognitive Impairment. These services must be included in Your Plan of Care. They include one or more of the following, required so that You can remain at Home: meal preparation; laundry; and light housekeeping. Light housekeeping means: vacuuming; dusting; dry mopping; dishwashing; cleaning the kitchen and bathroom; and changing beds.

Home Modification
Modifications to Your Home that are being made to improve Your ability to perform the Activities of Daily Living and allow You to live safely and independently in Your Home. Examples of Home Modification include: installing a lift system; installing a ramp for wheelchair access; widening doorways; installing grab bars in Your bathroom; and similar changes to improve accessibility.

Home Modification does not include things such as: home maintenance or repair; cosmetic changes; elevators; exercise rooms; remodeling; installation of a hot tub or swimming pool; or any similar modification. We will not pay for the purchase of any tools. We will not pay for the removal or reversal of any Home Modification that was previously covered under this Policy.

Hospice Care
A coordinated, interdisciplinary program for meeting the special needs of Terminally Ill individuals. This includes the physical, emotional, social and spiritual needs of such individuals. Hospice Care provides palliative and supportive services during the terminal illness to individuals who have no reasonable prospect of cure.

Hospice Care Facility
A facility that is licensed or certified by the state in which it is located to provide Hospice Care.

Hospice Care Provider
A Long Term Care Facility, Home Care Agency, Hospice Care Facility or other provider that is licensed to provide Hospice Care. It does not include a hospital.

Immediate Family
Your Spouse/Partner and anyone who is related to You or Your Spouse/Partner (including adopted, in-law and step-relatives). This includes a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

Lapse
The termination of Your Policy as of the last Premium Due Date if Your premium is not paid before the end of the Grace Period.

Licensed Health Care Practitioner
A Physician, registered professional nurse (RN), licensed social worker, or other individual who meets such requirements as may be prescribed by the U.S. Secretary of the Treasury. A Licensed Health Care Practitioner may not be a member of Your Immediate Family.

Long Term Care Facility
A health care facility that is licensed, certified, or registered by the appropriate authority in the state in which it is located to provide inpatient care for persons who are in need of assistance with Activities of Daily Living or are Severely Cognitively Impaired. The facility must charge a fee for the inpatient care at the time the care is provided.

A Long Term Care Facility must:
(1) provide personal care by on-site facility staff. It must also provide 3 meals a day, including special diets;
(2) have procedures in place establishing appropriate protocol for medication management and the handling and administration of drugs and biologicals;
(3) provide an emergency call system and on-site facility staff able to respond to and meet both scheduled and unpredictable needs of residents on a 24-hour-a-day basis. The staff's duties must include supervision of safety, security and awareness of the whereabouts of the residents at all times; and
(4) have a Physician or Registered Nurse on site or on contract to provide nursing services specified in case of an emergency.

Regardless of name, any properly licensed, certified, or registered facility providing the services shown above will qualify as a Long Term Care Facility. This includes, for example: nursing homes; skilled nursing facilities; nursing care facilities; assisted living facilities; adult foster care facilities; congregate care facilities; basic care facilities; residential care facilities; family and group assisted living facilities; boarding care homes; domiciliary care homes; personal care homes; and hospice care facilities.

In those states where there is no facility that is licensed, certified or registered to provide inpatient care for persons who are in need of assistance with Activities of Daily Living or are Severely Cognitively Impaired, a facility must meet all of the requirements in items # 1-4 listed above. In addition, it must meet all of the following requirements in order to qualify as a Long Term Care Facility:
(5) the following information must be provided in writing to each resident:
   a) a tenant services contract or agreement in place for each resident; and
   b) admission and transfer/discharge requirements;
(6) provides a minimum of 10 beds; and
(7) has staff on site 24-hours-a-day to provide personal care.

Long Term Care Facility does not mean a facility or part of a facility that is operated mainly for the treatment and care of: mental, nervous, psychotic or psychoneurotic deficiencies or disorders; tuberculosis; drug addiction; or rehabilitation or occupational therapy. A Long Term Care Facility is not a rehabilitation hospital/facility.

A Long Term Care Facility is not a hospital. It may be a separate and distinct wing or section of such an institution, if such wing or section, including Your assigned bed, is appropriately licensed, certified, or registered to provide the level of care defined above. Also, a Long Term Care Facility is not: an independent living apartment or unit; hotel; motel; retirement home; or any dwelling similar to these.

Medical Alert System
A communication system installed in Your Home that is used solely for the purpose of calling for assistance in the event of a medical emergency. We will not pay for any charges for: normal telephone service; a home security system; or any other similar service or device.

Medicare
The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.

Nurse
A person who is duly licensed as either:
(1) a Registered Nurse (RN);
(2) a Licensed Practical Nurse (LPN); or
(3) a Licensed Vocational Nurse (LVN).

The term Nurse does NOT include:
(1) You; or
(2) a member of Your Immediate Family.

Our Administrative Office
The Long Term Care Division located at the address shown on the front of Your Policy.

Out of Pocket Expenses
This Policy will pay You for the actual charges You incur and are legally obligated to pay for covered services after You receive those covered services. Benefits are payable up to the policy maximums shown on the Schedule. Advance Bills are not eligible for payment. Only covered services that have been provided and received are eligible for payment.

As a condition to receiving benefits, You must submit the care provider's bill or invoice showing all of the following:
(1) Your name;
(2) the name, address and tax identification number of the provider who rendered the covered service(s);
(3) the date(s) of each covered service including the month, day and year;
(4) each type of covered service rendered each day; and
(5) the actual charge for which You are legally obligated to pay for each covered service.

The covered service(s) must have been included in Your current written Plan of Care and must be provided within the frequency specified in the Plan of Care.

As part of Our review of Your claim, We reserve the right to require that You provide Us with documentation demonstrating to Our satisfaction that You have paid and fully satisfied the Out of Pocket Expenses for each covered service. Such documentation may include cancelled checks or bank statements and, if requested, must be provided before any benefits will be paid to You.

Partner
An adult who is not related to You by blood or marriage under the laws of the state in which this Policy was delivered; who has resided with You continuously for at least 2 years prior to the Policy's Effective Date; and both of You hold Yourselves out to the public as life partners. Partner is used to describe these relationships, which may include domestic partners and/or civil union partners, regardless of the term used by Your state or jurisdiction.

Partner does not include any person who is married to anyone else (whether by civil or religious ceremony or common-law marriage), nor any roommate or friend of Yours.

Personal Care Attendant Services
Care or assistance that is necessary to protect Your health and safety while allowing You to remain at Home. This includes services such as assistance with Activities of Daily Living, medication management, mobility, and personal hygiene. Personal Care Attendant Services are not services that are primarily for personal convenience or companionship, nor do they include transportation services.

Physician
A person who is legally qualified and licensed by a jurisdiction within the 50 United States and District of Columbia, or Canada as a Medical Doctor (M.D.) or a Doctor of Osteopathy (D.O.) and who is operating within the scope of that license.

The term Physician does not include:
(1) You;
(2) a member of Your Immediate Family; or
(3) anyone who has a financial interest in, or is an employee of, a facility, agency, or center administering the Plan of Care.

Plan of Care
A written, face-to-face, systematic, standardized and comprehensive assessment of Your physical and cognitive abilities by a Licensed Health Care Practitioner. The Plan of Care must specify the type, frequency and providers of all the services that You require. The services also must be consistent with the assessment done to develop the Plan of Care. The Plan of Care may include services not covered by Your Policy. No more than one Plan of Care may be in effect at a time.

The Plan of Care must include the date, if any, by which You are expected to recover from Your illness or injury. The Plan of Care must be prescribed, approved and signed by a Licensed Health Care Practitioner. Unless otherwise stated in this Policy, it must be updated or confirmed in writing at least once every 12 months or more frequently at the discretion of the Company. We will not require an update or written confirmation more frequently than once each 90 days except under the Global Coverage Benefit. We reserve the right to discuss the Plan of Care with the Licensed Health Care Practitioner to verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual.

If possible, a copy of the Plan of Care should be sent to Us before the care and services are received. Otherwise, it must be provided to Us at the time the first claim under the Plan of Care is submitted. Unless otherwise stated in this Policy, the Plan of Care must be submitted no later than 90 days after the care and services begin. It must document by assessment that You met the requirements in the Eligibility for the Payment of Benefits provision during that 90-day period.

A Plan of Care must be approved by a Licensed Health Care Practitioner who: (1) does not have a financial interest in; (2) is not on contract with; and (3) is not an employee of the facility, agency, center or provider administering all or any part of such Plan of Care.

Policy
This contract between You and Us.

Policy Maximum Amount
The total dollar amount payable for all benefits of this Policy, except for the Optional Care Coordination Benefit. The Policy Maximum Amount is shown on the Schedule. When the Policy Maximum Amount has been exhausted, no further benefits will be payable.

Premium Due Date
After the initial premium, each date a premium is due, subject to the terms of this Policy.

Premium Paying Mode
As shown on the Schedule, how often premiums are to be paid.

Proof of Loss
Information or documents satisfactory to Us that We require to determine whether benefits are payable under Your Policy. We are able to pay benefits only after We have received all necessary Proofs of Loss. You must either provide Us with this information or authorize its release to Us.

Qualified Long Term Care Services
Necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which:
(1) are required by a Chronically Ill Individual; and
(2) are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Only Qualified Long Term Care Services are covered under this Policy.

Please Note: To be eligible for payment under this Policy, it is not enough for services simply to be Qualified Long Term Care Services. These services must also:
(1) be services that are otherwise eligible to be paid under this Policy; and
(2) satisfy all other requirements of this Policy.

Qualified Long Term Care Services do not include charges for items or services unrelated to assistance with the Activities of Daily Living or Severe Cognitive Impairment. The following are examples of items or services that are not covered. These include, but are not limited to: dry cleaning; personal care items such as toothbrushes, toothpaste, mouthwash, deodorant, hair brushes, denture cleaning materials, tissues, razors, etc.; beauty and barber shop services; tobacco and smoking supplies; newspapers and periodicals; stationery, postage and writing implements; radio, telephone, television, cable, satellite and internet services; dental services and dentures; glasses; and hearing aids.

Rate Guarantee
As shown on the Schedule, the number of years during which We cannot increase Your premium. The Rate Guarantee only applies to the premium for the benefits originally elected when Your Policy was issued. Any benefits added after the Effective Date will not be covered by the Rate Guarantee. However, if there are any remaining years in the Rate Guarantee, the new benefits will be covered for those years. Increases in premium may occur only after the Rate Guarantee has expired.

Respite Care
Respite or relief for Your Volunteer Caregiver. Respite Care is provided so that the Volunteer Caregiver who normally provides Your care may take short-term leave or take a rest to provide him or her with temporary relief from the responsibilities of caregiving. Respite Care covers short-term care provided: in a Long Term Care Facility; in a community-based program such as Adult Day Care; or care received in Your Home.

Spouse
A legal spouse.

Terminally Ill
A person who has been certified in writing by his or her Physician as having a life expectancy of 6 months or less.

Therapeutic Device or Technology
Equipment or technology that is designed to assist You in performing the Activities of Daily Living or help with Your Severe Cognitive Impairment. It must be appropriate for Your condition and used in Your Home. Examples of a Therapeutic Device or Technology include:
(1) hospital-style beds;
(2) crutches;
(3) wheelchairs;
(4) infusion pumps;
(5) walkers;
(6) smart home monitoring or "wander mats"; or
(7) tracking systems like "smart shoes" with GPS (global positioning system).

Therapeutic Device does not mean any drug or medical equipment implanted in Your body, temporarily or permanently. It also does not include: CPAP machines; backup generators; oxygen; hearing aids; artificial limbs; teeth; medical supplies; motorized scooters; sporting, protective, athletic or exercise equipment.

Volunteer Caregiver
The unpaid person who has the primary responsibility of caring for You in Your Home. A person who is paid to care for You is not a Volunteer Caregiver.

We, Us, Our, the Company
Transamerica Life Insurance Company.

You, Your, Yours, Yourself
The Insured named on the Schedule.

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

ACCIDENT BENEFIT ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of the Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy as shown on the Schedule.

NOTE: If You are younger than age 67 at the time of an Injury, this Benefit is available to You. Any Accident Benefits being paid will end on Your 67th birthday.

DEFINITION

An Accidental Injury (herein called "Injury") is an unexpected and unintentional physical event. It is independent of and unrelated to any and all existing medical conditions.

A medical event such as a Stroke, Heart Attack or Seizure is not an Injury. This is true whether there was a diagnosis of an underlying medical condition or not.

BENEFIT

We will pay You for the Out of Pocket Expenses for Qualified Long Term Care Services needed as a result of an Injury. We will pay up to two times the Maximum Daily Benefit shown on the Schedule. The following conditions must be met:

(1) Your Injury must occur after the Effective Date of Your Policy;
(2) Your Injury must occur before Your 67th birthday; and
(3) prior to this Injury, You were not eligible for the payment of any benefits under the Policy.

All of the requirements of the Policy must be met. You must become eligible for benefits due to this Injury. A Licensed Health Care Practitioner must certify that You are a Chronically Ill Individual as a result of this Injury. This certification must take place within 90 days of the date of this Injury. You must satisfy the Elimination Period, if it applies to the type of benefits You are receiving.

All of the benefits of the Policy are available to You through the Accident Benefit except for: the Cash Benefit; the Global Coverage Benefit; the Remain At Home Benefit; and the Extension of the Long Term Care Facility Benefit. We will not make payments under both this Accident Benefit and the Policy. We will not pay more than Your Out of Pocket Expenses for covered care and services. Even though We will pay up to two times the Maximum Daily Benefit, We will not subtract more than one times the Maximum Daily Benefit from Your Policy Maximum Amount.

We will stop paying this benefit when:

(1) You are no longer eligible for benefits;
(2) You reach Your 67th birthday; or
(3) You exhaust the Policy Maximum Amount.

This Endorsement ends on the earliest of:

(1) the date the Policy ends; or
(2) on Your 67th birthday.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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CONTINGENT NONFORFEITURE BENEFIT ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy. If this Endorsement is added after Your Policy was issued, the Effective Date is shown below.

After the expiration of the rate guarantee:

- if We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of Your initial annual premium in the chart below; and
- You are unable to afford the increased premium; then

You may choose one of the two Options below.

We will give You at least 60 days written notice prior to the due date of the premium rate increase.

Options

We will notify You that You may elect to:

(1) reduce Your current Policy benefits so that the required premium payments are not increased. You may not reduce Your benefits to less than an amount that is currently available; or

(2) change Your coverage as shown below under the Shortened Benefit Period. You have 120 days after the due date for the rate increase to choose this option. If Your Policy Lapses during this 120-day period, the Shortened Benefit Period will automatically take effect.

No underwriting is required.

Your initial annual premium is based on Your age when the Policy was issued. Please note that if the cumulative increase is less than the percentage set forth below, the Shortened Benefit Period option is not available to You.

Issue Age	% Increase Over Initial Annual Premium	Issue Age	% Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 - 34	190%	73	34%
35 - 39	170%	74	32%
40 - 44	150%	75	30%
45 - 49	130%	76	28%
50 - 54	110%	77	26%
55 - 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%

67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

Shortened Benefit Period

Your coverage will continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums.

The daily benefit amounts available will be the same amounts in effect at the time Your Policy would have Lapsed. The maximum benefit amount in force will be equal to all of the premiums paid for all of Your coverage combined. This amount will exclude any waived premiums.

The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. Combined benefits under Your Policy and this Endorsement will not be more than the maximum amount payable for each benefit. Nor will they be more than the total benefits that would have been payable under Your Policy if You had continued to pay the premiums.

All of the requirements of the Policy that applied in order for You to be eligible for the payment of benefits at the time Your coverage would have Lapsed will continue to apply. To the extent that any of the requirements were satisfied under Your Policy at the time it would have Lapsed, they will also be satisfied under this Endorsement.

All optional coverage, including any riders, will end when Your coverage is continued under this Endorsement. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

At the time Your coverage would have Lapsed, if You have a benefit in force that allows coverage to become paid-up or premium to be waived for life at some future date, this Endorsement will only apply if: (1) Your coverage would have Lapsed before the date when coverage would otherwise have become paid-up; or (2) Your coverage would have Lapsed before the date when the waiver of premium for life would have applied. This Endorsement will end on the date coverage becomes paid-up or premium is waived for life under any such provision.

At the time Your coverage would have Lapsed, if You had a return of premium benefit that was in force: (1) the return of premium benefit will end; and (2) no return of premium benefit will be paid under this Endorsement.

Once the maximum benefit amount in force under this Endorsement has been paid, no further benefits will be payable and all coverage will end.

Endorsement Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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Long Term Care Division
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LIMITED PREMIUM PAYMENT PERIOD CONTINGENT NONFORFEITURE BENEFIT ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy. If this Endorsement is added after Your Policy was issued, the Effective Date is shown below.

After the expiration of the rate guarantee:

- if We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of Your initial annual premium in either of the charts below; and
- You are unable to afford the increased premium; then

You may choose one of the Options below.

We will give You at least 60 days written notice prior to the due date of the premium rate increase.

Options

We will notify You that You may elect to:

(1) reduce Your current Policy benefits so that the required premium payments are not increased. You may not reduce Your benefits to less than an amount that is currently available; or

(2) change Your coverage as shown under the Reduced Paid-Up Benefit shown below. You have 120 days after the due date for the rate increase to choose this option. If Your Policy Lapses during this 120-day period, the Reduced Paid-Up Benefit will automatically take effect; or

(3) change Your coverage as shown under the Shortened Benefit Period shown below. You have 120 days after the due date for the rate increase to choose this option.

No underwriting is required. If You meet the conditions for both Options (2) and (3) above, You may choose which one You would like.

Reduced Paid-Up Benefit

You are eligible for the Reduced Paid-Up Benefit when all three conditions below are met:

(1) the premium You are required to pay after the increase exceeds Your original premium by the percentage shown below or more:

Issue Age	% Increase Over Initial Annual Premium
Under 65	50%
65 - 80	30%
Over 80	10%

(2) You stop paying Your premiums within 120 days of when the premium increase took effect; and

(3) the ratio of the number of months You have already paid premiums is 40% or more of the number of months You originally agreed to pay.

If You choose this option, Your coverage will be changed to reduced "paid-up" status. This means that there will be no more premium payments required. Your benefits will change in the following ways:

(a) the total maximum amount of benefits Your reduced paid-up Policy will provide is determined by:
- multiplying Your Policy Maximum Amount at the time the Policy becomes paid-up times 90%; then
- multiplying that number by the ratio of the number of months You have already paid premiums to the number of months You agreed to pay them; and

(b) the daily benefit amounts You purchased will be adjusted by the same ratio.

If You purchased lifetime benefits, only the daily benefit amounts You purchased will be adjusted by the applicable ratio.

For Example:

You bought the Policy at age 65 with an annual premium payable for 10 years.

In the sixth year, You receive a rate increase of 35% and You decide to stop paying premiums.

You have already paid 50% of Your total premium payments and that is more than the 40% ratio. Your "paid-up" Policy benefits are: Your Policy Maximum Amount that was in effect when You stopped paying Your premiums times .90, then that number times .50. That equals 45%. So that means 45% of Your Policy benefits are paid-up.

Shortened Benefit Period

You are eligible for the Shortened Benefit Period when the conditions below are met:

(1) the premium You are required to pay after the increase exceeds Your original premium by the percentage shown below or more; and

Issue Age	% Increase Over Initial Annual Premium	Issue Age	% Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 - 34	190%	73	34%
35 - 39	170%	74	32%
40 - 44	150%	75	30%
45 - 49	130%	76	28%
50 - 54	110%	77	26%
55 - 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

(2) You stop paying Your premiums within 120 days of when the premium increase took effect.

Your coverage will continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums.

The daily benefit amounts available will be the same amounts in effect at the time Your Policy would have Lapsed. The maximum benefit amount in force will be equal to all of the premiums paid for all of Your coverage combined. This amount will exclude any waived premiums.

The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed.

For Options (2) and (3) above:
Combined benefits under Your Policy and this Endorsement will not be more than the maximum amount payable for each benefit. Nor will they be more than the total benefits that would have been payable under Your Policy if You had continued to pay the premiums.

All of the requirements of the Policy that applied in order for You to be eligible for the payment of benefits at the time Your coverage would have Lapsed will continue to apply. To the extent that any of the requirements were satisfied under Your Policy at the time it would have Lapsed, they will also be satisfied under this Endorsement.

All optional coverage, including any riders, will end when Your coverage is continued under this Endorsement. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

At the time Your coverage would have Lapsed, if You have a benefit in force that allows coverage to become paid-up or premium to be waived for life at some future date, this Endorsement will only apply if: (1) Your coverage would have Lapsed before the date when coverage would otherwise have become paid-up; or (2) Your coverage would have Lapsed before the date when the waiver of premium for life would have applied. This Endorsement will end on the date coverage becomes paid-up or premium is waived for life under any such provision.

At the time Your coverage would have Lapsed, if You had a return of premium benefit that was in force: (1) the return of premium benefit will end; and (2) no return of premium benefit will be paid under this Endorsement.

Once the maximum benefit amount in force under this Endorsement has been paid, no further benefits will be payable and all coverage will end.

Endorsement Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

RETURN OF PREMIUM TO AGE 67 ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of the Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy as shown on the Schedule.

NOTE: If You are younger than age 67 at the time of Your death, this Benefit is available to You.

BENEFIT

Subject to any provision to the contrary, if this Endorsement has been continuously in force, a benefit will be paid if You die when You are younger than age 67. No benefit will be paid if You are age 67 or older.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid pursuant to the terms of the Policy, from the Effective Date of the Policy up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest.

Payment of the benefit will be made in one lump sum to Your beneficiary. Your beneficiary will be the person listed in Your application unless later changed by You.

You may change Your beneficiary at any time by sending written notice to Us. The effective date of the beneficiary change will be the date the change is received and recorded by Us. If You die before We receive the request, the change will not be effective.

If there is no named or living beneficiary on the date of Your death, this benefit will be paid to Your estate.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

TRANSAMERICA
® LIFE INSURANCE COMPANY

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RELOCATION BENEFIT ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of the Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy as shown on the Schedule.

RELOCATION BENEFIT

We will pay You for the Out of Pocket Expenses for the transportation costs of moving You 100 miles or more. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Relocation Maximum Benefit; and
(3) the Policy Maximum Amount.

This benefit is available one time during the lifetime of Your Policy. This benefit is intended to help pay the transportation costs to move You 100 miles or more to another city or state where You will receive care. It may be where You have a child or other family member who will care for You or be involved in Your care. This benefit helps pay for the transportation costs associated with Your move. It will not pay for other costs such as (but not limited to): costs associated with selling, buying or renting a place of residence; costs associated with establishing residency, such as any required deposits; or costs for putting items in storage. In addition, it will not pay for an Immediate Family member's time to help You move.

The Relocation Benefit is available even if You are receiving other benefits under the Policy. If the Relocation Benefit is paid under Global Coverage, it is subject to the Global Coverage Maximum Benefit Amount.

No Relocation Benefit will be paid under the Accident Benefit Endorsement, if You have that Endorsement attached to Your Policy. If You have the Full Restoration of Benefits Rider attached to Your Policy, the Relocation Benefit will not be restored.

The Relocation Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

All of the requirements of the Policy must be met.

This Endorsement ends: (1) on the date the Policy ends; or (2) once You have received the Relocation Benefit.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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SHARED CARE BENEFIT RIDER

This Rider allows Your Spouse/Partner to access the available benefits under Your Policy once the Policy Maximum Amount under his/her own policy has been exhausted.

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

Eligibility

You have named Your Spouse/Partner as the Shared Care covered person under Your Policy. This will allow Your Spouse/Partner to access benefits under Your Policy if, and only if:

- You and Your Spouse/Partner both purchase and maintain identical Long Term Care Insurance Policies issued by Transamerica Life Insurance Company; and
- You and Your Spouse/Partner both have identical Shared Care Benefit Riders attached to Your Policies; and
- the Policy Maximum Amount of Your Spouse/Partner's own Transamerica Life Insurance Company policy has been exhausted; and
- Your Policy has at least some of its Policy Maximum Amount still available; and
- We receive a signed consent form from You allowing Your Spouse/Partner to receive benefits under Your Policy Maximum Amount.

Definition

Spouse/Partner means the Spouse/Partner who is named in the application for this Rider.

Benefit

If Your Spouse/Partner exhausts the Policy Maximum Amount under his/her own Transamerica Life Insurance Company policy, We will continue Your Spouse/Partner's coverage under Your Policy. Your Spouse/Partner's coverage is subject to all of the terms and the Policy Maximum Amount of Your Policy as long as You keep Your Policy and this Rider in force. You may keep this Rider in force by the timely payment of the Rider premium.

In order for Your Spouse/Partner to access benefits under Your Policy:

- Your Spouse/Partner must have already exhausted the Policy Maximum Amount under his/her own policy; and
- Your Policy must have at least some of its Policy Maximum Amount still available; and
- Your Spouse/Partner must have already satisfied the Elimination Period under his/her own policy, if the benefits used under his/her policy were subject to the Elimination Period; **or**
- Your Spouse/Partner must satisfy the Elimination Period under Your Policy, if the benefits he/she receives are subject to the Elimination Period.

You and Your Spouse/Partner both may receive benefits under Your Policy at the same time. We will not pay benefits that exceed the Policy Maximum Amount of both policies combined.

All of the benefits of Your Policy are available for Your Spouse/Partner to access through this Rider, except as noted below.

Waiver of Premium

The Waiver of Premium Benefit contained in Your Policy or in any Rider attached to it will apply only if You are receiving benefits under Your Policy. We will not waive Your Policy's premiums because Your Spouse/Partner is receiving benefits under Your Policy.

Restoration of Benefits

The Full Restoration of Benefits Rider, if it is attached to Your Policy, only applies to benefits that You have used under Your Policy. No benefits used by Your Spouse/Partner will be restored under Your Policy.

Global Coverage

The Global Coverage Benefit under Your Policy is only available to You. Your Spouse/Partner cannot receive Global Coverage under Your Policy.

Your Right to Purchase Additional Coverage

If Your Spouse/Partner exhausts the Policy Maximum Amount of Your Policy, We will offer You the option to purchase 2 more years of coverage. This means Your new Policy Maximum Amount will be equal to the Long Term Care Facility Maximum Daily Benefit then in effect times 730 days. Any other benefit amounts will be at the same level that they were on the date Your Policy Maximum Amount was exhausted. Except for this Rider, all other optional riders will be restored as well. Your Spouse/Partner will no longer have access to Your Policy's benefits.

This right to purchase additional coverage will not be available to You if:

- Your Policy Maximum Amount is exhausted on or after Your 91st birthday;
- You have met the Eligibility for the Payment of Benefits requirements of Your Policy within the 2-year period prior to the date Your Policy Maximum Amount was exhausted; or
- You are the one who exhausted the Policy Maximum Amount of Your Policy.

We will notify You when the Policy Maximum Amount of Your Policy has been exhausted. We will explain Your right to purchase additional coverage. You will have 60 days from the date of the notice to decide if You want to take advantage of Your right to purchase additional coverage. You must notify Us in writing if You choose to increase Your Policy Maximum Amount as shown above. No underwriting will be required. The premium for the additional coverage will be at Our table of rates in effect on the date of purchase. It will be based on Your attained age on the date of purchase.

Death of Your Spouse/Partner

If Your Spouse/Partner dies while this Rider is in effect, We will increase Your Policy Maximum Amount by the amount of the remaining Policy Maximum Amount under Your deceased Spouse/Partner's Policy, if any. We must receive written proof of the death of Your Spouse/Partner. We will provide You with written notice of the new Policy Maximum Amount and Your new premium. No further premiums for this Rider will be required.

Termination

Termination of this Rider will not affect the Policy to which it is attached. Any benefits paid under this Rider will be subtracted from the Policy Maximum Amount.

This Rider ends on the earliest of:

(1) the date the Policy ends;
(2) the date the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit;
(3) the date the Shared Care Benefit Rider on Your Spouse/Partner's policy ends for any reason other than because benefits under that policy were exhausted;
(4) the date the Policy Maximum Amount is exhausted under both Your Policy and Your Spouse/Partner's policy;
(5) the date You or Your Spouse/Partner elects to change either of Your policies so that the policies are no longer identical; or
(6) the date We receive written request from You to cancel this Rider or Your Policy.

Rider Effective Date:_____

Craig S. Vernon
SECRETARY

Brenda Clancy
PRESIDENT

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Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
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MONTHLY BENEFIT RIDER

This Rider is made part of Your Policy. It is subject to all provisions, definitions, conditions, maximums, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

Benefits payable under this Rider are based on Your Out of Pocket Expenses. We will not pay benefits based on Advance Bills. In order for benefits to be payable, all of the requirements of the Policy must be met. The Global Coverage Benefit is not available under this Rider.

LONG TERM CARE FACILITY MAXIMUM MONTHLY BENEFIT

Instead of paying the Long Term Care Facility Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Long Term Care Facility confinement based on services received during each Calendar Month. This means that the daily limit for the benefits listed no longer applies. Instead, benefits are paid based on the total services received during the month.

The Maximum Monthly Benefit for Long Term Care Facilities can also be used for: Bed Reservation; Respite Care; or Hospice Care. You must be confined in a Long Term Care Facility (or in a Hospice Care Facility, in the case of Hospice Care).

The maximum benefit payable during each Calendar Month will be calculated by multiplying the Long Term Care Facility Maximum Daily Benefit by the number of actual days in the month. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

Prorate: If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of Care for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. Prorate means We will divide the Maximum Monthly Benefit by the actual number of days in the month, then multiply by the number of days in that month that You meet the Eligibility for the Payment of Benefits requirements and for which We receive a Plan of Care.

HOME CARE AND ADULT DAY CARE MAXIMUM MONTHLY BENEFIT

Instead of paying the Home Care and Adult Day Care Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Home Care Services, Home Health Care Services and Adult Day Care based on services received during each Calendar Month. This means that the daily limit for these benefits no longer applies. Instead, benefits are paid based on the total services received during the month. This may allow You to receive multiple services on the same day that would otherwise exceed your Home Care and Adult Day Care Maximum Daily Benefit.

The Maximum Monthly Benefit for Home Care and Adult Day Care can also be used for Respite Care or Hospice Care received in Your Home.

The maximum benefit payable during each Calendar Month will be calculated by multiplying the Home Care and Adult Day Care Maximum Daily Benefit shown on the Schedule by the number of actual days in the month. If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of

Care for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. See the Prorate paragraph above for details. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

This Rider ends on the date that the Policy ends.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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FULL RESTORATION OF BENEFITS RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Effective Date shown on the Schedule.

When We have paid claims under the Policy, those Policy benefits can be restored under this Rider. This Rider is subject to the Requirements below. The Eligibility for the Payment of Benefits provision does not apply to this Rider. If You have completely exhausted Your benefits under the Policy, this Rider will not apply.

We will restore the Policy Maximum Amount to the amount that it would have been if no benefits had been paid under the Policy. We will restore the Remain At Home Maximum Benefit in the same way. If You have a Benefit Increase Option Rider attached to Your Policy, this includes any increases that have occurred as a result of that rider. The restored amount can be used only for confinement or care that is subject to the Policy Maximum Amount. The Global Coverage Benefit will not be restored.

The Policy Maximum Amount will be restored only one time during the life of the Policy. We will restore the Remain At Home Maximum Benefit one time during the life of the Policy as well.

Requirements For Full Restoration of Benefits

- You must not meet the definition of a Chronically Ill Individual for 180 consecutive days.
- You may not receive any Qualified Long Term Care Services during that time.
- You must notify Us that a Licensed Health Care Practitioner has certified that You are no longer a Chronically Ill Individual.
- You must file that certification with Us.

The 180 consecutive day period begins when Your condition is verified by Us through an Assessment of Your Condition.

We will not accept a back-dated certification. The Policy and this Rider must remain in force during this period.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

SIMPLE BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT

On each anniversary of the effective date of this Rider, We will increase Your original Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount shown on the Schedule minus any claims paid. The Policy Maximum Amount will increase by the Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

For example:

Original Policy Maximum Amount:	$300,000	
Total Prior Benefit Increases:	$100,000	
Claims Paid:	$ 50,000	
Benefit Increase for Current Year:	$ 12,500	(= [$300,000 - $50,000] x 5%)
Remaining Policy Maximum Amount:	$362,500	(= $300,000 + $100,000 - $50,000 + $12,500)

These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

TRANSAMERICA
® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

COMPOUND BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule of Your Policy. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on Your last Policy anniversary, minus any claims paid since the last Policy anniversary. The Policy Maximum Amount will increase by the Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

For example:

Previous Anniversary's Policy Maximum Amount:	$400,000	
Claims Paid During Last Policy Year:	$ 50,000	
Benefit Increase for Current Year:	$ 17,500	(= [$400,000 - $50,000] x 5%)
Remaining Policy Maximum Amount:	$367,500	(= $400,000 - $50,000 + $17,500)

These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

STEP-RATED COMPOUND BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Benefit Increase Percentage shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on the last anniversary of Your Policy, minus any claims paid since the last anniversary of Your Policy. The Policy Maximum Amount will be increased by the Benefit Increase Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

For example:

Previous Anniversary's Policy Maximum Amount:	$400,000	
Claims Paid During Last Policy Year:	$ 50,000	
Benefit Increase for Current Year:	$ 17,500	(= [$400,000 - $50,000] x 5%)
Remaining Policy Maximum Amount:	$367,500	(= $400,000 - $50,000 + $17,500)

These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

On each anniversary of the effective date of this Rider, Your current premium will be increased by the Premium Increase Percentage shown on the Schedule.

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

You can write to Us and tell Us You want to end the increases under this Rider at any time. The increases in dollar benefit amounts and premium increases that result will then stop. They will end on the next anniversary of the effective date of this Rider after We receive Your written notice to end the increases. Your dollar benefit amounts and premium amount will remain at the then current attained level. Your premiums remain subject to Our right to increase premiums.

After You have ended the increases under this Rider, You can write to Us and tell Us that You want to restart them. If You do that, We will restart the increase in dollar benefit amounts and premium amount on Your next anniversary of the effective date of this Rider after We receive Your written notice to start them again.

There is no limit to the number of times You can stop and restart the increases under this Rider. However, if You choose not to increase Your benefits for three consecutive years, the option to restart the increases under this Rider will end.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date: _____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

TAILORED BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule page of Your Policy. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

Compound Benefit Increases Prior to Age 61

On each anniversary of the effective date of this Rider up to and including the one prior to Your 61st birthday, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage Under Age 61 shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on the last anniversary of Your Policy, minus any claims paid since the last anniversary of Your Policy. It will increase by the Percentage Under Age 61 shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

For example:

Previous Anniversary's Policy Maximum Amount:	$400,000	
Claims Paid During Last Policy Year:	$ 50,000	
Benefit Increase for Current Year:	$ 17,500	(= [$400,000 - $50,000] x 5%)
Remaining Policy Maximum Amount:	$367,500	(= $400,000 - $50,000 + $17,500)

Compound Benefit Increases Beginning at Age 61 and Prior to Age 76

Starting with the anniversary of the effective date of this Rider on or after Your 61st birthday, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage Age 61-75 shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on the last anniversary of Your Policy, minus any claims paid since the last anniversary of Your Policy. It will increase by the Percentage Age 61-75 shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue on each anniversary of this Rider up to and including the one prior to Your 76th birthday.

No Benefit Increases Starting at Age 76

Beginning with the anniversary of the effective date of this Rider on or after Your 76th birthday, there will be no more benefit increases under this Rider.

General Information

The increases prior to age 76 will continue as long as this Rider and Your Policy are in force, even if You are receiving benefits on the date of the increase.

Your premium will not increase as a result of the benefit increases under this Rider. However, Your premium does remain subject to Our right to change premiums.

Changes in Benefits After Issue

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date: _____

Craig S. Vermes
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

FULL COMPOUND BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule page of Your Policy. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT
On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage shown on the Schedule. The Policy Maximum Amount will be increased by the same Percentage as the increase in the Maximum Daily Benefits. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

FULL SIMPLE BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule page of Your Policy. The effective date of this Rider also is shown on the Schedule page. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT
On each anniversary of the effective date of this Rider, We will increase Your original Maximum Daily Benefits. Those benefits will increase by the Percentage shown on the Schedule. The Policy Maximum Amount will be increased by the same Percentage as the increase in the Maximum Daily Benefits. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

FULL STEP-RATED COMPOUND BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule page of Your Policy. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Benefit Increase Percentage shown on the Schedule.

We will increase the Policy Maximum Amount of Your Policy as well. The Policy Maximum Amount will be increased by the Benefit Increase Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

On each anniversary of the effective date of this Rider, Your current premium will be increased by the Premium Increase Percentage shown on the Schedule.

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

You can write to Us and tell Us You want to end the increases under this Rider at any time. The increases in dollar benefit amounts and premium increases that resulted will then stop. They will end on the next anniversary of the effective date of this Rider after We receive Your notice to end the increases. Your dollar benefit amounts and premium amount will remain at the then current attained level. Your premiums remain subject to Our right to increase premiums.

After You have ended the increases under this Rider, You can write to Us and tell Us that You want to restart them. If You do that, We will restart the increase in dollar benefit amounts and premium amount on Your next anniversary of the effective date of this Rider after We receive Your written notice to start them again.

There is no limit to the number of times You can stop and restart the increases under this Rider. However, if You choose not to increase Your benefits for three consecutive years, the increases under this Rider will end.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date:_____

SECRETARY

PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

FULL TAILORED BENEFIT INCREASE OPTION RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule page of Your Policy. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

Compound Benefit Increases Prior to Age 61

On each anniversary of the effective date of this Rider up to and including the one prior to Your 61st birthday, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage Under Age 61 shown on the Schedule. The Policy Maximum Amount will be increased by the Percentage Under Age 61 shown on the Schedule as well. The Remain At Home Maximum Benefit will increase in the same way.

Compound Benefit Increases Beginning at Age 61 and Prior to Age 76

Starting with the anniversary of the effective date of this Rider on or after Your 61st birthday, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage Age 61-75 shown on the Schedule. The Policy Maximum Amount will be increased by the Percentage Age 61-75 shown on the Schedule as well. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue on each anniversary of this Rider up to and including the one prior to Your 76th birthday.

No Benefit Increases Starting at Age 76

Beginning with the anniversary of the effective date of this Rider on or after Your 76th birthday, there will be no more benefit increases under this Rider.

General Information

The increases prior to age 76 will continue as long as this Rider and Your Policy are in force, even if You are receiving benefits on the date of the increase.

Your premium will not increase as a result of the benefit increases under this Rider. However, Your premium does remain subject to Our right to change premiums.

Changes in Benefits After Issue

If You add to Your benefits after the effective date of this Rider, those added benefits will not increase until the amount of the additional coverage has been in effect one full year.

If You increase or decrease Your Policy's benefits after Your Policy was issued, the above calculations will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Rider ends on the earliest of:

(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date: _____

SECRETARY

PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

DEFERRED BENEFIT INCREASE OPTION ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy.

As shown on the Schedule, You have elected not to add a Benefit Increase Option Rider at the time of Your application for the Policy.

OPTION
You will be able to add a Compound Benefit Increase Option Rider to Your Policy. You must add it within the 90-day period prior to the first, the third, or the fifth anniversary dates of the Policy. In order to add a Compound Benefit Increase Option Rider, You must not have incurred any claims under the Policy prior to the time that You add the Rider. No additional underwriting will be required.

A Compound Benefit Increase Rider can only be added for an additional premium. The additional premium required will be based on Your age on the anniversary date of the Policy when You exercise this Option.

This Option ends on the fifth anniversary of Your Policy.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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Long Term Care Division
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[1-800-227-3740]

GUARANTEED PURCHASE OPTION ENDORSEMENT

This Endorsement is made a part of the Policy to which it is attached. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy. The Effective Date of this Endorsement will be the Effective Date of Your Policy. If this Endorsement is added after Your Policy was issued, the Effective Date is shown below.

OPTION

You have the option to purchase additional coverage on the Purchase Option Dates. You will be able to purchase additional coverage every three years on the Purchase Option Dates. The Purchase Option Dates start on the third anniversary of the effective date of this Endorsement. You will not have to give Us evidence of insurability. You will have this option until You reach age 85, subject to the following:

- If You are under age 70; and
- You do not purchase additional amounts of coverage on any two Purchase Option Dates; future options will not be available.

- On and after the age of 70: If You do not purchase additional amounts of coverage on any Purchase Option Date, future options will not be available.

CONDITIONS

Your Option is subject to the following conditions:

(1) the Policy must be in force on the Purchase Option Dates;
(2) We will notify You when a Purchase Option Date is coming up. You must tell Us within 31 days of the Purchase Option Date if You are going to purchase the additional coverage. Your notice must be in writing;
(3) the amount of additional coverage that can be purchased on each Purchase Option Date is calculated by taking the amounts originally issued times 16%;
(4) amounts greater than or less than 16% may not be purchased under this Option. If You purchase additional coverage, We will send You an endorsement to the Policy that shows the new benefit amounts;
(5) the premium for the additional coverage will be at Our table of rates in effect on the date of purchase. It will be based on Your attained age on the date of purchase; and
(6) the additional coverage will be subject to all of the provisions of the Policy, from the effective date of the increase.

If coverage becomes paid-up or premium is being waived due to a death, additional coverage purchased under this Option will be available only at a premium charge. The premium must continue to be paid for those benefits, even if Your Policy is otherwise paid-up.

The calculation in number (3) will be different if: (1) You increase or decrease Your Policy's benefits after Your Policy was issued; and (2) the increase in coverage is not related to this Option. If that occurs, the calculation in number (3) will be based on the new benefit amounts. Those new benefit amounts will be shown on an endorsement to Your Policy.

This Endorsement ends on the earliest of:
(1) the date Your Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Endorsement Effective Date:_____

SECRETARY

PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

WAIVER OF PREMIUM RIDER – CASH BENEFIT

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

Waiver of Premium Benefit
We will automatically change Your Premium Paying Mode to monthly and not require the payment of Your monthly premium when You qualify for this benefit. Any unearned premiums paid which apply to the period that premiums are being waived will be refunded to You following the Policy monthly anniversary on which the Waiver of Premium began.

To qualify for this Waiver of Premium Benefit, You must:
(1) meet the requirements in the Eligibility for the Payment of Benefits provision; and
(2) be receiving the Cash Benefit.

We will stop waiving the premium when You no longer qualify for this Waiver of Premium Benefit. We will stop waiving the premium on the date the Policy Maximum Amount has been exhausted.

To keep Your Policy in force when We stop waiving the premium, premiums must be paid as they become due.

If benefits are added while the premium is being waived, the premium for those added benefits must continue to be paid.

If You are receiving any benefits other than the Cash Benefit, this Waiver of Premium Benefit will not apply. If You are receiving the Global Monthly Cash Benefit, this Waiver of Premium Benefit will not apply.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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Long Term Care Division
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[Hurst, Texas 76053-5302]
[1-800-227-3740]

WAIVER OF PREMIUM RIDER – HOME CARE AND ADULT DAY CARE

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

Waiver of Premium Benefit

We will automatically change Your Premium Paying Mode to monthly and not require the payment of Your monthly premium when You qualify for this benefit. Any unearned premiums paid which apply to the period that premiums are being waived will be refunded to You. They will be refunded following the Policy monthly anniversary on which the Waiver of Premium began.

To qualify for this Waiver of Premium Benefit, You must:

(1) meet the requirements in the Eligibility for the Payment of Benefits provision;
(2) satisfy the Elimination Period, if it applies to the type of benefits You are receiving; and
(3) be receiving the Home Care and Adult Day Care Benefit; or
(4) be receiving Home Care Services, Home Health Care Services or Adult Day Care Services under the Accident Benefit Endorsement, if You have it attached to Your Policy.

We will stop waiving the premium when You no longer qualify for this Waiver of Premium Benefit. We will stop waiving the premium on the date the Policy Maximum Amount has been exhausted.

To keep Your Policy in force when We stop waiving the premium, premiums must be paid as they become due.

If benefits are added while the premium is being waived, the premium for those added benefits must continue to be paid.

If You are receiving the Cash Benefit or the Global Coverage Benefit, this Waiver of Premium Benefit will not apply.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

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Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

JOINT WAIVER OF PREMIUM RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider also is shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. The premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT
We will waive all premiums for Your Policy for the same months that We are waiving the premiums for Your Spouse/Partner's policy under the Waiver of Premium Benefit. We will stop waiving the premiums for Your Policy under this Rider when We are no longer waiving the premiums for Your Spouse/Partner's policy.

Eligibility for Joint Waiver of Premium: This benefit is only available if:
(1) both You and Your Spouse/Partner have identical individual long term care policies in force with Us under the same policy form series which includes this Joint Waiver of Premium Rider; and
(2) Your Spouse/Partner qualifies for and receives the Waiver of Premium Benefit under the same policy form series.

To keep Your Policy in force when Your Joint Waiver of Premium Rider ends or when We are no longer waiving the premium, premiums must be paid as they become due. Any unearned premiums paid which apply to the period that premiums are being waived will be refunded to You following the Policy monthly anniversary on which the Waiver of Premium began.

This Joint Waiver of Premium Rider ends when:
(1) the Policy Maximum Amount has been exhausted under either Your Policy or Your Spouse/Partner's policy;
(2) Your Policy or Your Spouse/Partner's Policy is continued under any nonforfeiture or contingent nonforfeiture benefit; or
(3) Your Policy or Your Spouse/Partner's Policy ends.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

FULL SURVIVORSHIP RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider and the effective date of this Rider are shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. In addition, the premium for this Rider is then shown in the endorsement attached to this Rider.

BENEFIT
If You and Your Spouse/Partner both have identical individual long term care policies in force with Us under the same policy form series and Your Spouse/Partner dies while both policies are in force, We will waive Your premiums for life following the later of:
(1) the date of death of Your Spouse/Partner; or
(2) the tenth anniversary of the effective date of this Rider.

Any benefit added or increased must be in effect for at least 10 years for both You and Your Spouse/Partner before the premium will be waived for such benefit.

The premium for any benefit added after the death of Your Spouse/Partner will not ever be waived under this provision.

You must notify Us of the death of Your Spouse/Partner within 180 days of the date of death.

This Rider ends on the earliest of:
(1) the date the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

SURVIVORSHIP RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider and the effective date of this Rider are shown on the Schedule. If this Rider has been added after Your Policy was issued, the effective date of this Rider is shown below. In addition, the premium for this Rider is shown in the endorsement attached to this Rider.

BENEFIT

We will waive all future premiums for Your Policy and no further premium payments will be required if all of the following conditions are met:

(1) Your Spouse/Partner dies 10 years or more after the effective date of this Rider;
(2) no claims have been paid to You or Your Spouse/Partner under either of Your policies during the first 10 years these policies were in force;
(3) on the date of Your Spouse/Partner's death, both You and Your Spouse/Partner have identical individual long term care policies in force with Us under the same policy form series. These policies must have been in force for at least 10 consecutive years. They cannot have been continued under any nonforfeiture or contingent nonforfeiture benefit; and
(4) on the date of Your Spouse/Partner's death, this Rider has been in force for at least 10 years.

Any benefit added or increased must be in effect for at least 10 years for both You and Your Spouse/Partner without any claims incurred and for at least 10 years from the date of such increase or addition before the premium will be waived for such benefit.

The premium for any benefit added after the death of Your Spouse/Partner will not ever be waived under this provision.

You must notify Us of the death of Your Spouse/Partner within 180 days of the date of death.

This rider ends on the earliest of:

(1) the date the Policy ends;
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit; or
(3) when Your Spouse/Partner dies and You have not met the conditions necessary to qualify for benefits under this Rider. If You notify Us that this happens, We will remove this Rider and its associated premium from future premium notices.

Rider Effective Date:_____

Craig D. Vermeer
SECRETARY

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PRESIDENT

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Long Term Care Division
[P.O. Box 95302]
[Hurst, Texas 76053-5302]
[1-800-227-3740]

RETURN OF PREMIUM UPON DEATH RIDER

This Rider is made part of Your Policy. It is subject to all provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

BENEFIT
Subject to any provision to the contrary, if this Rider has been continuously in force from its Effective Date, a benefit will be paid after You die. We will also pay this benefit if the Policy has been continuously in force, then it lapses and Your death occurs within 90 days of the date the last premium payment was due.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid pursuant to the terms of the Policy, from the Effective Date of this Rider up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest.

Payment of benefits will be made in one lump sum to Your beneficiary. Your beneficiary will be the person listed in Your application unless later changed by You.

You may change Your beneficiary at any time by sending written notice to Us. The effective date of the beneficiary change will be the date the change is received and recorded by Us. If You die before We receive the request, the change will not be effective.

If there is no named or living beneficiary on the date of Your death, this benefit will be paid to Your estate.

If You have another return of premium provision in force at the time of Your death, We will only pay the return of premium under this Rider. We will not make return of premium payments under both provisions.

Termination
This Rider ends on the earliest of:
(1) the date that the Policy ends; or
(2) when the Policy is continued under any nonforfeiture or contingent nonforfeiture benefit.

Craig D. Vermeer
SECRETARY

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Long Term Care Division
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[1-800-227-3740]

NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER

This Rider is made a part of Your Policy. It is subject to all of the provisions, definitions, conditions, exceptions and limitations of Your Policy which do not conflict with this Rider. In case of conflict between the Policy and this Rider, the provisions of this Rider will control.

The additional premium amount for this Rider is shown on the Schedule. The effective date of this Rider is the Policy's Effective Date shown on the Schedule.

BENEFIT
This Rider provides for Your coverage to continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums. Your Policy must have been in effect for at least 3 full years before this Rider will pay benefits.

The daily benefit amounts available will be the same amounts in effect at the time the coverage would have Lapsed. The total benefit amount in force under this Rider will be equal to all of the premium paid for all coverage combined, including this Rider. It does not include any waived premiums.

The minimum Policy Maximum Amount under this Rider will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. Combined benefits under Your Policy and this Rider will not be more than the maximum amount payable for each benefit. Nor will they be more than the total benefits that would have been payable under Your Policy if You had continued to pay the premiums. All of the eligibility requirements and any elimination period that applied in order for You to be eligible for the payment of benefits at the time Your coverage would have Lapsed will continue to apply. To the extent that any of the eligibility requirements or the elimination period was satisfied under Your Policy at the time it would have Lapsed, it will also be satisfied under this Rider.

All optional coverage, including any other riders, will end when Your coverage is continued under this Rider. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

At the time Your coverage would have Lapsed, if You have a benefit in force that allows coverage to become paid-up or premium to be waived for life at some future date, this Rider will only apply if: (1) Your coverage would have Lapsed before the date when coverage would otherwise have become paid-up; or (2) Your coverage would have Lapsed before the date when the waiver of premium for life would have applied. This Rider will end on the date coverage becomes paid-up or premium is waived for life under any such provision.

At the time Your coverage would have Lapsed, if You had a return of premium benefit that was in force: (1) the return of premium benefit will end; and (2) no return of premium benefit will be paid.

Craig D. Vermeer
SECRETARY

Brenda Clancy
PRESIDENT

TRANSAMERICA LIFE INSURANCE COMPANY
LONG TERM CARE DIVISION
[P.O. BOX 95302], [HURST, TEXAS 76053-5302]
[1-800-227-3740]

LONG TERM CARE OUTLINE OF COVERAGE FOR INDIVIDUAL POLICY FORM TLC 2-P AR 0410

RETAIN THIS OUTLINE FOR YOUR RECORDS

("We," "Us," or "Our" means the Company. "You" or "Your" means the Insured.)

NOTICE TO BUYER: The Policy may not cover all of the costs associated with long term care incurred during the period of coverage. The buyer is advised to review carefully all Policy limitations.

CAUTION

The issuance of this long term care insurance coverage is based upon the answers to the questions on the application. A copy of the application will be included in Your Policy. If any answers are incorrect or untrue, We may have the right to deny benefits or rescind the Policy. The best time to clear up any question is now, before a claim arises! If, for any reason, any of the answers are incorrect or untrue, contact Us at Our Administrative Office: Transamerica Life Insurance Company, [P.O. Box 95302], [Hurst, Texas 76053-5302]. Our toll-free number is shown above.

1. **POLICY DESIGNATION**
   The Policy is an individual policy of insurance.

2. **PURPOSE OF OUTLINE OF COVERAGE**
   This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to Outlines of Coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY.

3. **FEDERAL TAX CONSEQUENCES**
   The Policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. **TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED**
   RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of Your Policy, to continue the Policy as long as You pay Your premiums on time. Transamerica Life Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

   Waiver of Premium Benefit: We will automatically change Your Premium Paying Mode to monthly. We will not require the payment of Your monthly premium when You qualify for the Waiver of Premium Benefit.

   To qualify for the Waiver of Premium Benefit, You must:
   (1) meet the requirements in the Eligibility for the Payment of Benefits provision;
   (2) satisfy the Elimination Period, if it applies to the benefits You are receiving; and
   (3) be confined as an overnight bed patient and receiving either: (a) the Long Term Care Facility Benefit or (b) the Accident Benefit, if the Accident Benefit Endorsement is attached to Your Policy; or
   (4) be receiving the Hospice Care Benefit.

   We will stop waiving the premium when You no longer qualify for the Waiver of Premium Benefit.

   Termination: The Policy will end on the earliest of the following:
   (1) the date the Policy Lapses;
   (2) the date of Your death;
   (3) the date the Policy Maximum Amount has been exhausted; or

(4) Our receipt of Your written request to cancel the Policy. If You do not specify a date to cancel the Policy, it will end on the next Policy monthly anniversary following Our receipt of the request. If You name a date, it will end on Your requested future cancellation date.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS**

Right to Change Rates: We can change Your premiums based on Your premium class, subject to approval by the Department of Insurance, if such approval is required under state regulations. Any change in premium may occur only after the Rate Guarantee has expired. Any change in premium can occur only during the Premium Paying Period shown on the Schedule. We must give You at least 60 days written notice before We change Your premiums. Your premiums will not increase due to a change in Your age or health.

6. **TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED**

You have 30 days from the day You receive the Policy to review it and return it to Us if You decide not to keep it. You do not have to tell Us why You are returning the Policy. Within 30 days of when You receive it, simply return it to Us at Our Administrative Office or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any premium paid within 30 days after Our receipt of the returned Policy. The Policy will be void as if it had never been issued.

If the Policy terminates due to Your death, We will refund the portion of the modal premium paid for the period after the monthly anniversary following Your death up to the next Premium Due Date.

If We receive a written request from You to cancel Your Policy, We will refund any premiums paid for the period after Your cancellation.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

If You are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the Company. That booklet is called the "Guide to Health Insurance for People with Medicare." Neither Transamerica Life Insurance Company nor its agents/insurance producers represent Medicare, the federal government or any state government.

8. **LONG TERM CARE COVERAGE**

Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services provided in a setting other than an acute care unit of a hospital, such as: (1) in a long term care facility; (2) in the community; or (3) in Your Home.

The Policy provides coverage for Out of Pocket Expenses for Qualified Long Term Care Services. Coverage is subject to policy limitations, an elimination period and other requirements.

9. **BENEFITS PROVIDED BY THE POLICY**

BENEFIT DESCRIPTIONS

This Outline of Coverage gives a brief description of the benefits available for purchase under the Policy. You and Your agent/insurance producer must decide which options are best suited to Your personal needs and finances. Your application and the actual policy issued to You will determine Your insurance coverage. The benefits You select and their maximums will be shown on Your application and on the Schedule of Your Policy.

In order for benefits to be payable under the Policy:

(1) You must satisfy the Eligibility for the Payment of Benefits provision;
(2) all Qualified Long-Term Care Services must begin while Your coverage is in force;
(3) all charges must be incurred for services rendered or goods provided while the applicable benefit is in force;
(4) You must satisfy the Elimination Period if it applies to the benefits You are receiving;
(5) all care and services must be in accordance with accepted medical and nursing standards of practice; and
(6) all care and services must be consistent with Your current Plan of Care. You must provide Us with both an acceptable Plan of Care and Proof of Loss documentation.

If more than one type of covered care or service is received on the same day, only the daily benefit providing the largest payment will be payable, unless otherwise stated in a benefit section.

Please Note: To be eligible for payment under the Policy, it is not enough for services simply to be Qualified Long Term Care Services. These services must also:
(1) be services that are otherwise eligible to be paid under the Policy; and
(2) satisfy all other requirements of the Policy.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any benefits provided under the Policy and any rider(s) or endorsement(s) attached, We must receive a Plan of Care that specifies what Qualified Long Term Care Services are needed. The Services must be needed because You have been certified within the last 12 months by a Licensed Health Care Practitioner as:
(1) being unable to perform, without Substantial Assistance from another individual, at least 2 out of the 6 Activities of Daily Living (ADLs) for an expected period of at least 90 days due to a loss of functional capacity; or
(2) requiring Substantial Supervision to protect You from threats to health and safety due to Severe Cognitive Impairment.

Activities of Daily Living (ADLs) - Each of the following six (6) functional areas is considered an Activity of Daily Living (ADL):
(1) Bathing: The ability to wash oneself by sponge bath; or in either a tub or shower, including the task of getting into and out of the tub or shower.
(2) Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
(3) Dressing: The ability to put on and take off all items of clothing and any necessary braces, fasteners or artificial limbs.
(4) Eating: The ability to feed oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by a feeding tube or intravenously.
(5) Toileting: The ability to get to and from the toilet, to get on and off the toilet, and to perform associated personal hygiene.
(6) Transferring: The ability to move into and out of a bed, chair or wheelchair.

Severe Cognitive Impairment (including the term "Severely Cognitively Impaired")
A severe loss or deterioration in intellectual capacity that is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in Your:
(1) short-term or long-term memory;
(2) orientation as to people, places or time;
(3) deductive or abstract reasoning; and
(4) judgment as it relates to safety awareness.

The evaluation shall include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

BENEFITS

CASH BENEFIT

We will pay You the Monthly Cash Benefit shown on the Schedule, subject to:
(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) Our receipt of a Plan of Care; and
(3) the Policy Maximum Amount.

We will pay You for each Calendar Month You continue to meet those requirements. We will pay this benefit instead of all other benefits under the Policy, except for the Optional Care Coordination Benefit.

We must receive a Plan of Care at least once each 90 days. Bills to show Out of Pocket Expenses are not required for this benefit to be payable. If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of Care for only part of a Calendar Month, We will prorate the Monthly Cash Benefit payment.

Payment of this benefit will end when You no longer meet the requirements in the Eligibility for the Payment of Benefits provision. We will stop paying this benefit if We do not receive a Plan of Care as required. We will also stop paying this benefit when You choose to receive other benefits for care and services that are covered under the Policy. Simply call or write to tell Us that You want to switch to other benefits payable under the Policy and We will let You know what You need to do.

If You are confined as an overnight bed patient in a facility and are receiving the Cash Benefit, those days of confinement while receiving the Cash Benefit cannot be applied toward satisfaction of the Elimination Period. The Cash Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period. This benefit does not entitle You to a waiver of premium.

HOME CARE AND ADULT DAY CARE BENEFIT

We will pay You for the Out of Pocket Expenses for each day You receive Home Care Services, Home Health Care Services, or Adult Day Care. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Home Care and Adult Day Care Maximum Daily Benefit;
(3) the Policy Maximum Amount; and
(4) the Elimination Period, if Your Schedule indicates that it applies to this benefit.

Home Care Services or Home Health Care Services must be provided by or through a Home Care Agency in Your Home under a Plan of Care. Adult Day Care must be received for at least 4 hours during any day for which benefits are payable. Adult Day Care must be provided by and at an Adult Day Care Center. Home Care Services, Home Health Care Services and/or Adult Day Care will not be payable on any day that You are confined as an inpatient in a hospital or Long Term Care Facility.

OPTIONAL CARE COORDINATION BENEFIT

We will pay for the Care Coordinator to facilitate an assessment of Your care needs and the development of a Plan of Care. This is in addition to any other benefits paid under the Policy. We will pay for the Care Coordinator to provide Care Coordination services as long as You are certified as meeting the requirements in the Eligibility for the Payment of Benefits provision.

While working with You, Your family, and Your Physician, the Care Coordinator will help to establish an individualized Plan of Care. Upon Your request, the Care Coordinator will provide You with a list of care providers and services in Your area for You to consider. Neither the Care Coordinator nor We will suggest or recommend providers or guarantee the quality of care by any of the providers or services listed. However, it will be a starting point for You to use when seeking care providers. If You desire, the Care Coordinator will assist You in obtaining the services recommended in the Plan of Care. This assistance will be limited to referring You to providers and help in coordinating such referrals.

You may choose to use a Care Coordinator from Our list or one of Your own choosing. In order to obtain a Care Coordinator from Our list, You may need to contact Us at the Claims Department's toll-free number shown on the Schedule. For a Care Coordinator who is selected from Our list, there is no charge to You for the covered services of a Care Coordinator. No amount will be subtracted from the Policy Maximum Amount. For a Care Coordinator who is not selected from Our list, the Optional Care Coordination Benefit is limited to the Maximum Lifetime Optional Care Coordination Benefit shown on the Schedule, and any amount paid for such covered Care Coordination services will be deducted from the Policy Maximum Amount.

REMAIN AT HOME BENEFIT

If You are receiving the Optional Care Coordination Benefit and using a Care Coordinator from Our list, this benefit is available. The Care Coordinator from Our list must approve the provider selected by You, as well as the labor, equipment and/or supplies in advance.

While You are living in Your Home, the Remain At Home Benefit can be used to pay for the following Qualified Long Term Care Services: (1) Home Modification; (2) Caregiver Training for a Volunteer Caregiver; (3) Therapeutic Device or Technology; and (4) Medical Alert System.

We will pay You for the Out of Pocket Expenses for care or services You receive under the Remain At Home Benefit. Payment is subject to: (1) satisfaction of the Eligibility for the Payment of Benefits provision; (2) the Remain At Home Maximum Benefit; and (3) the Policy Maximum Amount.

The care or services provided under the Remain At Home Benefit must be consistent with Your care needs. They also must be provided according to a Plan of Care approved by the Care Coordinator from Our list. The Remain At Home Benefit is available even if You are receiving the Home Care and Adult Day Care Benefit at the same time. The Remain At Home Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

RESPITE CARE BENEFIT

If You are being cared for by Your Volunteer Caregiver on a continuous basis, We will pay You for the Out of Pocket Expenses for Respite Care. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Respite Care Maximum Daily Benefit;
(3) the Policy Maximum Amount; and
(4) Respite Care must be provided in a Long Term Care Facility or in Your Home.

Benefits for Respite Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period. Benefits for Respite Care are available for up to the Number of Days Per Calendar Year shown on the Schedule.

LONG TERM CARE FACILITY BENEFIT

We will pay You for the Out of Pocket Expenses for each day You are confined as an overnight bed patient in a Long Term Care Facility. This includes room and board and Qualified Long Term Care Services. We will not pay more than the charge for a one-bedroom unit. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Elimination Period;
(3) the Long Term Care Facility Maximum Daily Benefit;
(4) the Policy Maximum Amount; and
(5) care and services must be provided while confined as an overnight bed patient in a Long Term Care Facility as defined in the Policy.

EXTENSION OF THE LONG TERM CARE FACILITY BENEFIT

If Your Policy Lapses while You are receiving the Long Term Care Facility Benefit, benefits will be continued until the earliest of the following: (1) You no longer qualify for benefits; (2) You are discharged from the Long Term Care Facility; (3) You exhaust the Policy Maximum Amount of the Policy; or (4) You die. No other Policy benefits or benefits added by rider or endorsement to the Policy will be continued under this benefit.

LONG TERM CARE FACILITY BED RESERVATION BENEFIT

When You are absent for any reason (except discharge) during a Long Term Care Facility confinement, We will pay You for the Out of Pocket Expenses while the room in the Long Term Care Facility is being reserved. We will pay You for each day of Your absence, up to the Long Term Care Facility Maximum Daily Benefit. You must have satisfied the Elimination Period before the Bed Reservation Benefit is available. The Bed Reservation Benefit is available for up to the Number of Days Per Calendar Year shown on the Schedule. It is subject to satisfaction of the Eligibility for the Payment of Benefits provision and the Policy Maximum Amount.

GLOBAL COVERAGE BENEFIT

If You are outside of the fifty (50) United States and the District of Columbia, or Canada, We will pay You for the Out of Pocket Expenses for care or services that otherwise would be covered under the Policy. Payment is subject to:

(1) the Elimination Period;
(2) the Global Coverage Maximum Daily Benefit;
(3) the Global Monthly Cash Benefit, if You are receiving the Cash Benefit under Global Coverage;
(4) the Global Coverage Maximum Benefit Amount; and
(5) the Policy Maximum Amount.

If You receive the Cash Benefit under Global Coverage, it is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

Benefits that are available under this Global Coverage Benefit are limited to: (1) the Long Term Care Facility Benefit; (2) the Home Care and Adult Day Care Benefit; (3) the Cash Benefit; and (4) the Hospice Care Benefit. All of the terms of the Policy apply to this benefit. The Global Coverage Benefit will pay benefits in lieu of all other benefits under the Policy. Premiums will not be waived while You are receiving the Global Coverage Benefit.

The following requirements must be satisfied:

(1) You must provide Us with a written certification that is acceptable to Us that You meet the requirements of the Eligibility for the Payment of Benefits provision; and
(2) You must provide Us with written proof that is acceptable to Us that You meet the requirements of the Conditions section; and
(3) You must provide Us with written proof that is acceptable to Us that You have satisfied the Elimination Period; and
(4) You must provide Us with a current written Plan of Care. You must also provide Us with any updates to it; and
(5) You must provide Us with properly completed claim forms; and
(6) You must provide Us with proof that is acceptable to Us that You are receiving covered care or services. This means that all care and services must be Qualified Long Term Care Services according to the Policy. No proof of receipt of services is required for the Cash Benefit to be payable under Global Coverage; and
(7) You must provide Us with a copy of proof acceptable to Us that You are outside of the fifty (50) United States and the District of Columbia, or Canada; and
(8) all documentation must be provided to Us in English at Your own expense.

If You have a restoration of benefits provision or rider attached to Your Policy, no benefits paid under the Global Coverage Benefit will be restored under that rider.

HOSPICE CARE BENEFIT

We will pay You for the Out of Pocket Expenses for each day You receive Hospice Care. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) a certification that You are Terminally Ill;
(3) the Hospice Care Maximum Daily Benefit;
(4) the Policy Maximum Amount; and
(5) Hospice Care must be provided by a Hospice Care Provider.

Benefits for Hospice Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period. We will not pay for more than 180 days of Hospice Care. Benefits for Hospice Care will not be payable when other benefits are payable under the Policy except for: the Optional Care Coordination Benefit; and the Global Coverage Benefit

ALTERNATE PLAN OF CARE BENEFIT

Your Policy provides coverage for a wide range of long term care services. Because there may be new and evolving long term care services that We cannot anticipate at the time Your Policy was issued, the Alternate Plan of Care Benefit gives Us the discretion to consider whether We may want to cover alternate Qualified Long Term Care Services not otherwise expressly covered by the Policy.

We will consider paying benefits to You based on the Out of Pocket Expenses You incur for services requested under an Alternate Plan of Care only if:

(1) You are currently receiving benefits under the Policy; and
(2) You request in writing, prior to receipt of such alternative services, that We consider payment for services not identified in the Policy; and
(3) We determine that You satisfy and continue to satisfy the requirements under the Eligibility for the Payment of Benefits provision of the Policy; and
(4) the cost of services under the Alternate Plan of Care You request is less expensive than the amount We would otherwise pay for Qualified Long Term Care Services; and
   - the services are clearly specified in Your Plan of Care; and
   - the Alternate Plan of Care Benefit amount is agreed to in a written Alternate Plan of Care agreement that is signed by You and Us.

We have the absolute discretion to determine the amount, if any, We are willing to pay toward the cost of such services. Any benefits paid under this provision will reduce Your Policy Maximum Amount. We will not pay this benefit until Your Elimination Period has been satisfied.

[**ACCIDENT BENEFIT ENDORSEMENT** – Only issued if You are younger than age 67 at the time You purchase the Policy

We will pay You for the Out of Pocket Expenses for Qualified Long Term Care Services needed as a result of an Injury. We will pay up to two times the Maximum Daily Benefit shown on the Schedule. The following conditions must be met:

(1) Your Injury must occur after the Effective Date of Your Policy;
(2) Your Injury must occur before Your 67th birthday; and
(3) prior to this Injury, You were not eligible for the payment of any benefits under the Policy.

All of the requirements of the Policy must be met. You must become eligible for benefits due to this Injury. A Licensed Health Care Practitioner must certify that You are a Chronically Ill Individual as a result of this Injury. This must take place within 90 days of the date of this Injury. You must satisfy the Elimination Period, if it applies to the type of benefits You are receiving.

All of the benefits of the Policy are available to You through the Accident Benefit except for: the Cash Benefit; the Global Coverage Benefit; the Remain At Home Benefit; and the Extension of the Long Term Care Facility Benefit. We will not pay more than Your Out of Pocket Expenses for covered care and services. Even though We will pay up to two times the Maximum Daily Benefit, We will not subtract more than one times the Maximum Daily Benefit from Your Policy Maximum Amount.

If You are age 67 or older at the time of an Injury, this benefit will not be available to You. Any benefits being paid under this Endorsement will end on Your 67th birthday.]

CONTINGENT NONFORFEITURE BENEFIT ENDORSEMENT [– Only issued if You choose a Lifetime Premium Paying Period]

After the expiration of the rate guarantee:

- if We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of Your initial annual premium in the chart below; and
- You are unable to afford the increased premium; then

You may choose one of the two Options below. No underwriting is required. We will give You at least 60 days written notice prior to the due date of the premium rate increase.

Issue Age	% Increase Over Initial Annual Premium	Issue Age	% Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 - 34	190%	73	34%
35 - 39	170%	74	32%
40 - 44	150%	75	30%
45 - 49	130%	76	28%
50 - 54	110%	77	26%
55 - 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

Options

We will notify You that You may elect to:

(1) reduce Your current Policy benefits so that the required premium payments are not increased. You may not reduce Your benefits to less than an amount that is currently available; or

(2) change Your coverage to a shortened benefit period. You have 120 days after the due date for the rate increase to choose this option. If Your Policy Lapses during this 120-day period, the shortened benefit period will automatically take effect.

The daily benefit amounts available will be the same amounts in effect at the time the coverage would have Lapsed. The maximum benefit amount in force will be equal to all of the premium paid for all coverage combined. This amount will exclude any waived premiums. The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. All optional coverage, including any riders, will end when Your coverage is continued under this Endorsement. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

[LIMITED PAYMENT PERIOD CONTINGENT NONFORFEITURE BENEFIT ENDORSEMENT – Only issued if You choose a Premium Paying Period other than Lifetime

After the expiration of the rate guarantee:

- if We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of Your initial annual premium in either of the charts below; and
- You are unable to afford the increased premium; then

You may choose one of the Options below. No underwriting is required. We will give You at least 60 days written notice prior to the due date of the premium rate increase.

Options

We will notify You that You may elect to:

(1) reduce Your current Policy benefits so that the required premium payments are not increased. You may not reduce Your benefits to less than an amount that is currently available; or

(2) change Your coverage to a Reduced Paid-up Benefit. You have 120 days after the due date for the rate increase to choose this option. If Your Policy Lapses during the 120-day period, the Reduced Paid-Up Benefit will automatically take effect; or

(3) change Your coverage to a Shortened Benefit Period. You have 120 days after the due date for the rate increase to choose this option.

Reduced Paid-Up Benefit: If You choose this option, Your coverage will be changed to reduced "paid-up" status. This means that there will be no more premium payments required. Your benefits will change in the following ways:

(1) The total maximum amount of benefits Your reduced paid-up Policy will provide is determined by:
- multiplying Your Policy Maximum Amount at the time the Policy becomes paid up times 90%; then
- multiplying that number by the ratio of the number of months You have already paid premiums to the number of months You agreed to pay them; and

(2) The daily benefit amounts You purchased will be adjusted by the same ratio.

Issue Age	% Increase Over Initial Annual Premium
Under 65	50%
65 - 80	30%
Over 80	10%

If You purchased lifetime benefits, only the daily benefit amounts You purchased will be adjusted by the applicable ratio.

Shortened Benefit Period: The daily benefit amounts available will be the same amounts in effect at the time Your Policy would have Lapsed. The maximum benefit amount in force will be equal to all of the premiums paid for all of Your coverage combined. This amount will exclude any waived premiums. The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed.

Issue Age	% Increase Over Initial Annual Premium	Issue Age	% Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 - 34	190%	73	34%
35 - 39	170%	74	32%
40 - 44	150%	75	30%
45 - 49	130%	76	28%
50 - 54	110%	77	26%
55 - 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and over	10%

If You meet the conditions for both Options (2) and (3) above, You may choose which one You would like.

All optional coverage, including any riders, will end when Your coverage is continued under this Endorsement. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.]

[RELOCATION BENEFIT ENDORSEMENT

We will pay You for the Out of Pocket Expenses for the transportation costs of moving You 100 miles or more. Payment is subject to:

(1) satisfaction of the Eligibility for the Payment of Benefits provision;
(2) the Relocation Maximum Benefit shown on the Schedule; and
(3) the Policy Maximum Amount.

This benefit is available one time during the lifetime of Your Policy. This benefit is intended to help pay the transportation costs to move You 100 miles or more to another city or state where You will receive care. It may be where You have a child or other family member who will care for You or be involved in Your care. This benefit helps pay for the transportation costs associated with Your move. It will not pay for other costs such as (but not limited to): (1) costs associated with selling, buying or renting a place of residence; (2) costs associated with establishing residency, such as any required deposits; or (3) costs for putting items in storage.

In addition, it will not pay for an Immediate Family member's time to help You move. The Relocation Benefit is available even if You are receiving other benefits under the Policy. No Relocation Benefit will be paid under the Accident Benefit Endorsement, if You have that Endorsement attached to Your Policy. If You have the Full Restoration of Benefits Rider attached to Your Policy, the Relocation Benefit will not be restored. The Relocation Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.]

[**RETURN OF PREMIUM TO AGE 67 ENDORSEMENT**

Subject to any provision to the contrary, if this Endorsement has been continuously in force, a benefit will be paid if You die when You are younger than age 67. No benefit will be paid if You are 67 or older.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid pursuant to the terms of the Policy, from the Effective Date of the Policy up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest. Payment of the benefit will be made in one lump sum to Your beneficiary. Your beneficiary will be the person listed in Your application unless later changed by You.]

OPTIONAL RIDERS – Additional Premium Required

NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER

This Rider provides for the Policy to continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums. Your Policy must have been in effect for at least 3 full years before this Rider will pay benefits. The daily benefit amounts available will be the same amounts in effect at the time the coverage would have Lapsed. The total benefit amount in force will be equal to all of the premium paid for all coverage combined, including this Rider. This amount will exclude any waived premiums. The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. All optional coverage, including any other riders, will end when Your coverage is continued under this Rider. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

[SHARED CARE BENEFIT RIDER

If Your Spouse/Partner exhausts the Policy Maximum Amount under his/her own Transamerica Life Insurance Company policy, We will continue Your Spouse/Partner's coverage under Your Policy. Your Spouse/Partner's coverage is subject to all of the terms and the Policy Maximum Amount of Your Policy as long as You keep Your Policy and this Rider in force.

This will allow Your Spouse/Partner to access benefits under Your Policy if:

(1) You and Your Spouse/Partner both purchase and maintain identical Long Term Care Insurance Policies issued by Transamerica Life Insurance Company; and
(2) You and Your Spouse/Partner both have identical Shared Care Benefit Riders attached to Your Policies; and
(3) the Policy Maximum Amount of Your Spouse/Partner's own Transamerica Life Insurance Company policy has been exhausted; and
(4) Your Policy has at least some of its Policy Maximum Amount still available; and
(5) We receive a signed consent form from You allowing Your Spouse/Partner to receive benefits under Your Policy Maximum Amount.

In order for Your Spouse/Partner to access benefits under Your Policy:

(1) Your Spouse/Partner must have already exhausted the Policy Maximum Amount under his/her own policy; and
(2) Your Policy must have at least some of its Policy Maximum Amount still available; and
(3) Your Spouse/Partner must have already satisfied the Elimination Period under his/her own policy, if the benefits used under his/her policy were subject to the Elimination Period; **or**
(4) Your Spouse/Partner must satisfy the Elimination Period under Your Policy, if the benefits he/she receives are subject to the Elimination Period.

You and Your Spouse/Partner both may receive benefits under Your Policy at the same time. We will not pay benefits that exceed the Policy Maximum Amount of both policies combined.

The Waiver of Premium Benefit contained in Your Policy or in any Rider attached to it will only apply if You are receiving benefits under Your Policy. We will not waive Your Policy's premiums because Your Spouse/Partner is receiving benefits under Your Policy.

The Full Restoration of Benefits Rider, if it is attached to Your Policy, only applies to benefits that You have used under Your Policy. No benefits used by Your Spouse/Partner will be restored under Your Policy.

The Global Coverage Benefit contained in Your Policy is only available to You. Your Spouse/Partner cannot receive the Global Coverage Benefit under Your Policy.

If Your Spouse/Partner dies while this Rider is in effect, We will increase Your Policy Maximum Amount by the amount of the remaining Policy Maximum Amount under Your deceased Spouse/Partner's policy, if any.]

[MONTHLY BENEFIT RIDER

Long Term Care Facility Maximum Monthly Benefit

Instead of paying the Long Term Care Facility Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Long Term Care Facility confinement based on services received during each Calendar Month. This means that the daily limit for the benefits listed no longer applies. Instead, benefits are paid based on the total services received during the month.

The Maximum Monthly Benefit can also be used for: Bed Reservation; Respite Care; or Hospice Care. You must be confined in a Long Term Care Facility (or in a Hospice Care Facility, in the case of Hospice Care).

The maximum benefit payable during each Calendar Month will be the Long Term Care Facility Maximum Daily Benefit shown on the Schedule times the actual number of days in the month. If You meet the requirements for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

Home Care Maximum Monthly Benefit

Instead of paying the Home Care and Adult Day Care Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Home Care Services, Home Health Care Services and Adult Day Care based on services received during each Calendar Month. This means that the daily limit for these benefits no longer applies. Instead, benefits are paid based on the total services received during the month. This may allow You to receive multiple services on the same day that would otherwise exceed Your Home Care and Adult Day Care Maximum Daily Benefit. The Maximum Monthly Benefit can also be used for Respite Care or Hospice Care received in Your Home.

The maximum benefit payable during each Calendar Month will be the Home Care and Adult Day Care Maximum Daily Benefit shown on the Schedule times the actual number of days in the month. If You meet the requirements for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.]

[FULL RESTORATION OF BENEFITS RIDER

When We have paid claims under the Policy, those Policy benefits can be restored under this Rider. We will restore the Policy Maximum Amount to the amount that it would have been if no benefits had been paid under the Policy. We will restore the Remain At Home Maximum Benefit in the same way. The Global Coverage Benefit will not be restored. The Policy Maximum Amount will be restored only one time during the life of the Policy. We will restore the Remain At Home Maximum Benefit one time during the life of the Policy as well. If You have completely exhausted Your benefits under the Policy, this Rider will not apply.

Requirements For Full Restoration of Benefits

(1) You must not meet the definition of a Chronically Ill Individual for 180 consecutive days.
(2) You may not receive any Qualified Long Term Care Services during that time.
(3) You must notify Us that a Licensed Health Care Practitioner has certified that You are no longer a Chronically Ill Individual.
(4) You must file that certification with Us.

The 180 consecutive day period begins when Your condition is verified by Us through an Assessment of Your Condition. We will not accept a back-dated certification. The Policy and this Rider must remain in force during this period.]

[WAIVER OF PREMIUM RIDER – HOME CARE AND ADULT DAY CARE

We will automatically change Your Premium Paying Mode to monthly and We will not require the payment of Your monthly premium when You qualify for this benefit.

To qualify for this Waiver of Premium Benefit, You must:

(1) meet the requirements in the Eligibility for the Payment of Benefits provision;
(2) satisfy the Elimination Period, if it applies to the type of benefits You are receiving; and
(3) be receiving the Home Care and Adult Day Care Benefit; or
(4) be receiving Home Care Services, Home Health Care Services or Adult Day Care Services under the Accident Benefit Endorsement, if it is attached to Your Policy.

We will stop waiving the premium when You no longer qualify for this Waiver of Premium Benefit. We will stop waiving the premium on the date the Policy Maximum Amount has been exhausted. This Waiver of Premium does not apply if You are receiving the Global Coverage Benefit.]

[WAIVER OF PREMIUM RIDER – CASH BENEFIT

We will automatically change Your Premium Paying Mode to monthly and We will not require the payment of Your monthly premium when You qualify for this benefit.

To qualify for this Waiver of Premium Benefit, You must:

(1) meet the requirements in the Eligibility for the Payment of Benefits provision; and
(2) be receiving the Cash Benefit.

We will stop waiving the premium when You no longer qualify for this Waiver of Premium Benefit. We will stop waiving the premium on the date the Policy Maximum Amount has been exhausted. This Waiver of Premium does not apply if You are receiving the Global Coverage Benefit.]

[JOINT WAIVER OF PREMIUM RIDER

We will waive all premiums for Your Policy for the same months that We are waiving the premiums for Your Spouse/Partner's policy under the Waiver of Premium Benefit. We will stop waiving the premiums for Your Policy under this Rider when We are no longer waiving the premiums for Your Spouse/Partner's policy.

Eligibility for Joint Waiver of Premium: This benefit is only available if:

(1) both You and Your Spouse/Partner have identical individual long term care policies in force with Us under the same policy form series which includes the Joint Waiver of Premium Rider; and
(2) Your Spouse/Partner qualifies for and receives the Waiver of Premium Benefit under the same policy form series.]

[SURVIVORSHIP RIDER

We will waive all future premiums for Your Policy and no further premium payments will be required if all of the following conditions are met:

(1) Your Spouse/Partner dies 10 years or more after the effective date of this Rider;
(2) no claims have been paid to You or Your Spouse/Partner under either of Your policies during the first 10 years these policies were in force;
(3) on the date of Your Spouse/Partner's death, both You and Your Spouse/Partner have identical individual long term care policies in force with Us under the same policy form series. These policies must have been in force for at least 10 consecutive years. They cannot have been in force only under a nonforfeiture benefit; and
(4) on the date of Your Spouse/Partner's death, this Rider has been in force for at least 10 years.]

[FULL SURVIVORSHIP RIDER

If You and Your Spouse/Partner both have identical individual long term care policies in force with Us under the same policy form series and Your Spouse/Partner dies while both policies are in force, We will waive Your premiums for life following the later of:

(1) the date of death of Your Spouse/Partner; or
(2) the tenth anniversary of the effective date of this Rider.

You must notify Us of the death of Your Spouse/Partner within 180 days of the date of death.]

[RETURN OF PREMIUM UPON DEATH RIDER

Subject to any provision to the contrary, if this Rider has been continuously in force from its Effective Date, a benefit will be paid after You die. We will also pay this benefit if the Policy has been continuously in force, then it lapses and Your death occurs within 90 days of the date the last premium payment was due.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid under the Policy, from the Effective Date of this Rider up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest.

The benefit payment will be made in one lump sum to Your beneficiary. If You have another return of premium provision in force at the time of Your death, We will only pay the return of premium under this Rider. We will not make return of premium payments under both provisions.]

10. GENERAL EXCLUSIONS AND LIMITATIONS

The Policy and any rider(s) or endorsement(s) attached to it will not pay benefits when You are eligible for confinement, care or services:

(1) resulting from alcoholism, drug addiction or chemical dependency, unless as a result of medication prescribed by a Physician;
(2) resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
(3) due to participation in a felony, riot or insurrection;
(4) for which no charge is normally made in the absence of insurance;
(5) received outside the fifty (50) United States and the District of Columbia, or Canada; or
(6) performed by a member of Your Immediate Family. Your Immediate Family member can provide covered care or services if he or she is a regular employee of an organization that is engaged in providing the Qualified Long Term Care Services. The organization he or she works for must receive the payment for the care or service. Your Immediate Family member must receive no compensation other than the normal compensation for employees in his or her job category.

We will not pay for any confinement, care or service that is not included in Your Plan of Care. We will not pay for anything that is prohibited by state or federal law, including any law governing economic and trade sanctions.

The exclusion regarding a member of Your Immediate Family will not apply to the Cash Benefit. This exclusion also will not apply to the Cash Benefit if received under the Global Coverage Benefit.

The exclusion regarding confinement, care or services received outside the fifty (50) United States and District of Columbia, or Canada will not apply to the Global Coverage Benefit.

NONDUPLICATION OF COVERAGE

The Policy and any rider(s) or endorsement(s) attached to it will not pay benefits when confinement, care or services are:

(1) provided in a government facility (unless otherwise required by law);
(2) paid or payable under Medicare. This includes any amounts that would be covered under Medicare, except that they are subject to a Medicare deductible or coinsurance of some kind. This does not apply when expenses are reimbursable under Medicare solely as a secondary payer;
(3) provided under any governmental programs (except Medicaid);
(4) for services or items available or paid under another long-term care insurance or health insurance policy; or
(5) paid or payable under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

except to the extent that Your Out of Pocket Expenses exceed the amount covered by one of these entities, policies or programs.

A government facility includes a facility administered, covered or reimbursed by the Veteran's Administration.

OTHER INSURANCE WITH US

We may reduce benefits payable under the Policy for long term care confinement, care and services if We also pay benefits for such confinement, care and services under another individual long term care insurance policy issued by Us. This includes policies providing nursing home, assisted living facility and/or home health care coverage, regardless of actual terminology. It also applies whether benefits are payable on an expense reimbursement, indemnity or any other basis.

LIMITATIONS

We will not pay for: Physician's charges; hospital or laboratory charges; prescription or non-prescription medications; medical supplies; durable medical equipment (except as provided under the Remain At Home Benefit); payments in-kind; transportation; and personal expenses, such as items and services furnished at Your request for comfort, convenience, beautification or entertainment.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, You should consider whether and how the benefits of the Policy may be adjusted.

The following Benefit Increase Option Riders are available for an additional premium. Your premiums will be higher than for a policy without a Benefit Increase Option Rider attached to it. Under the Compound Benefit Increase Option Rider [or the Simple Benefit Increase Option Rider], premiums will not increase due to Your age or the amount of the benefit increase. Below is a graph that shows the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graph shows the premiums for those types of policies.

[FULL COMPOUND BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage shown on the Schedule. The Policy Maximum Amount will be increased by the same Percentage as the Maximum Daily Benefits. The Remain At Home Maximum Benefit will increase in the same way. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.]

[COMPOUND BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on Your last Policy anniversary, minus any claims paid since the last Policy anniversary. The Policy Maximum Amount will increase by the Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.]

[FULL SIMPLE BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your original Maximum Daily Benefits. Those benefits will increase by the Percentage shown on the Schedule. The Policy Maximum Amount will be increased by the same Percentage as the Maximum Daily Benefits. The Remain At Home Maximum Benefit will increase in the same way. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.]

[SIMPLE BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your original Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount shown on the Schedule minus any claims paid. The Policy Maximum Amount will increase by the Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.]

[FULL STEP-RATED COMPOUND BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Benefit Increase Percentage shown on the Schedule. We will increase Your Policy Maximum Amount and the Remain At Home Maximum Benefit by the same Percentage. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase. On each anniversary of the effective date of this Rider, Your current premium will be increased by the Premium Increase Percentage shown on the Schedule.]

[STEP-RATED COMPOUND BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Benefit Increase Percentage shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on the last anniversary of Your Policy, minus any claims paid since the last anniversary of Your Policy. The Policy Maximum Amount will be increased by the Benefit Increase Percentage shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

On each anniversary of the effective date of this Rider, Your current premium will be increased by the Premium Increase Percentage shown on the Schedule.]

[FULL TAILORED BENEFIT INCREASE OPTION RIDER

Compound Benefit Increases Prior to Age 61

On each anniversary of the effective date of this Rider up to and including the one prior to Your 61st birthday, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage Under Age 61 shown on the Schedule. The Policy Maximum Amount will be increased by the Percentage Under Age 61 shown on the Schedule as well. The Remain At Home Maximum Benefit will increase in the same way.

Compound Benefit Increases Beginning at Age 61 and Prior to Age 76

Starting with the anniversary of the effective date of this Rider on or after Your 61st birthday, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage Age 61-75 shown on the Schedule. The Policy Maximum Amount will be increased by the Percentage Age 61-75 shown on the Schedule as well. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue on each anniversary of this Rider up to and including the one prior to Your 76th birthday. Beginning with the anniversary of the effective date of this Rider on or after Your 76th birthday, there will be no more benefit increases under this Rider.

The increases prior to age 76 will continue as long as this Rider and Your Policy are in force, even if You are receiving benefits on the date of the increase. Your premium will not increase as a result of the benefit increases under this Rider. However, Your premium does remain subject to Our right to change premiums.]

[TAILORED BENEFIT INCREASE OPTION RIDER

Compound Benefit Increases Prior to Age 61

On each anniversary of the effective date of this Rider up to and including the one prior to Your 61st birthday, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage Under Age 61 shown on the Schedule.

We will also increase the Policy Maximum Amount. It is calculated based on the Policy Maximum Amount on the last anniversary of Your Policy, minus any claims paid since the last anniversary of Your Policy. It will increase by the Percentage Under Age 61 shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

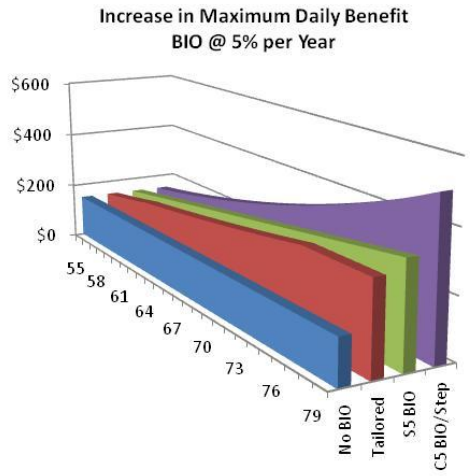
Compound Benefit Increases Beginning at Age 61 and Prior to Age 76

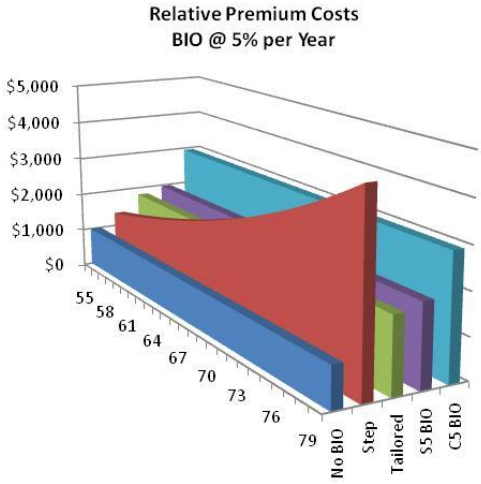
Starting with the anniversary of the effective date of this Rider on or after Your 61st birthday, We will increase Your current Maximum Daily Benefits. They will increase without regard to claims paid. Those benefits will increase by the Percentage Age 61-75 shown on the Schedule.

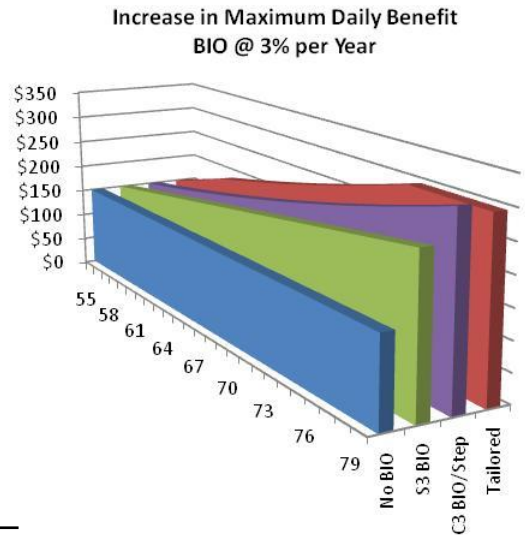
We will also increase the Policy Maximum Amount, less the amount of any claims We have paid to You. It is calculated based on the Policy Maximum Amount on the last anniversary of Your Policy, minus any claims paid since the last anniversary of Your Policy. It will increase by the Percentage Age 61-75 shown on the Schedule. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue on each anniversary of this Rider up to and including the one prior to Your 76th birthday. Beginning with the anniversary of the effective date of this Rider on or after Your 76th birthday, there will be no more benefit increases under this Rider.

The increases prior to age 76 will continue as long as this Rider and Your Policy are in force, even if You are receiving benefits on the date of the increase. Your premium will not increase as a result of the benefit increases under this Rider. However, Your premium does remain subject to Our right to change premiums.]






Increase in Maximum Daily Benefit
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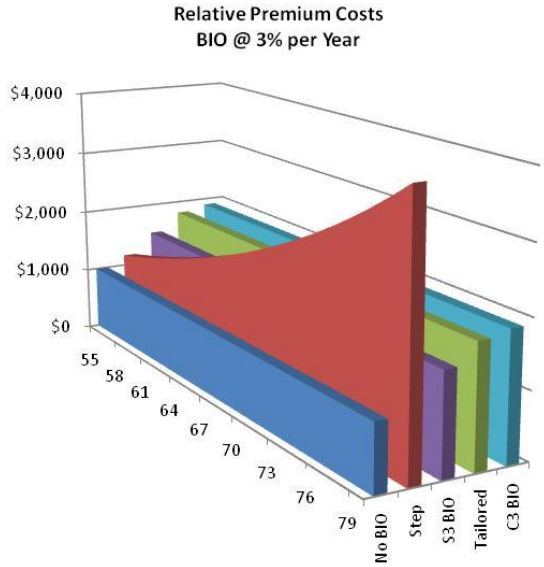
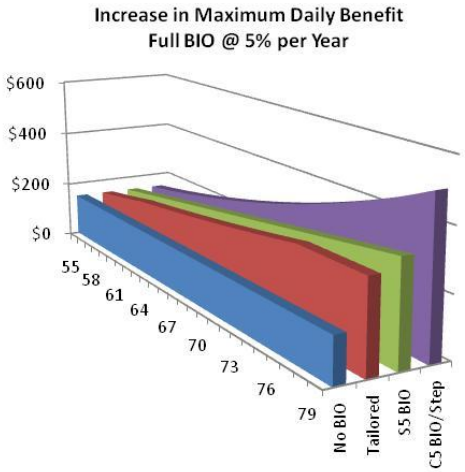
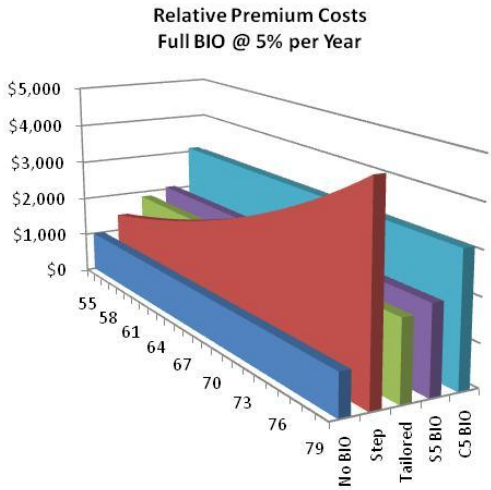
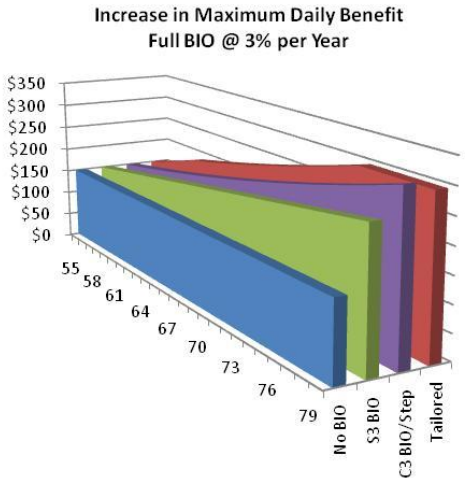
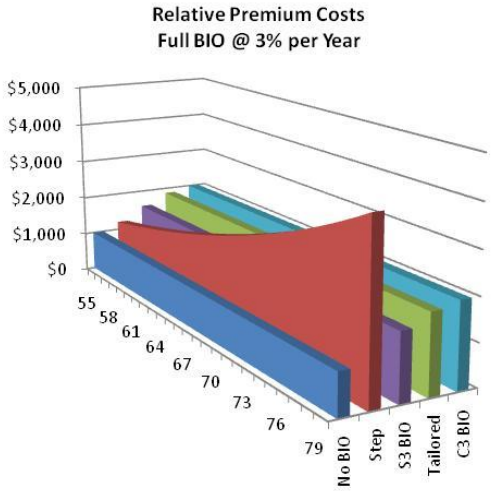
Tailored


Relative Premium Costs
BIO @ 3% per Year
$4,000
$3,000
$2,000
$1,000
$0
55
58
61
64
67
70
73
76
79
No BIO
Step
S3 BIO
Tailored
C3 BIO


Increase in Maximum Daily Benefit
Full BIO @ 5% per Year
$600
$400
$200
$0
55
58
61
64
67
70
73
76
79
No BIO
Tailored
S5 BIO
C5 BIO/Step


Relative Premium Costs
Full BIO @ 5% per Year
$5,000
$4,000
$3,000
$2,000
$1,000
$0
55
58
61
64
67
70
73
76
79
No BIO
Step
Tailored
S5 BIO
C5 BIO


Increase in Maximum Daily Benefit
Full BIO @ 3% per Year
$350
$300
$250
$200
$150
$100
$50
$0
55
58
61
64
67
70
73
76
79
No BIO
S3 BIO
C3 BIO/Step
Tailored


Relative Premium Costs
Full BIO @ 3% per Year
$5,000
$4,000
$3,000
$2,000
$1,000
$0
55
58
61
64
67
70
73
76
79
No BIO
Step
S3 BIO
Tailored
C3 BIO

[DEFERRED BENEFIT INCREASE OPTION ENDORSEMENT

This Endorsement is available if You do not add a Benefit Increase Option Rider at the time of Your application for the Policy. You will have the opportunity to add a Compound Benefit Increase Option Rider within the 90-day period prior to the first, the third, or the fifth anniversary dates of the Policy. No additional underwriting will be required. In order to add the Rider, You must not have incurred any claims under the Policy prior to when You add the Rider. The additional premium required to add the Rider will be based on Your age on the anniversary date of the Policy when You exercise this Option.]

[GUARANTEED PURCHASE OPTION ENDORSEMENT

You have the option to purchase additional coverage on the Purchase Option Dates. You will be able to purchase additional coverage every three years on the Purchase Option Dates. The Purchase Option Dates start on the third anniversary of the effective date of this Endorsement. You will not have to give Us evidence of insurability. You will have this Option until You reach age 85, subject to the following:

- If You are under age 70; and
- You do not purchase additional amounts of coverage on any two Purchase Option Dates;

future options will not be available.

- On and after the age of 70: If You do not purchase additional amounts of coverage on any Purchase Option Date, future options will not be available.

The amount of additional coverage that can be purchased on each Purchase Option Date is calculated by taking the amounts originally issued times 16%. The premium for the additional coverage will be at Our table of rates in effect on the date of purchase. It will be based on Your attained age on the date of purchase.]

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS**

The Policy provides coverage for mental and nervous conditions as long as You are certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in the Policy. This includes coverage for: Alzheimer's disease; Parkinson's disease; senile dementia; and related degenerative and dementing illnesses.

13. **PREMIUM**

Your total annual premium is $_____. This includes $_____ for the Included Benefits and $_____ for the Optional Riders You selected.

The Premium Paying Mode You choose will impact Your overall cost of insurance. Please note that the more often You pay, the higher Your total premium amount will be per year. You should compare all of the Premium Paying Modes available. Choose the one that works best for Your personal needs and finances.

14. **ADDITIONAL FEATURES**

This coverage is medically underwritten.

15. CONTACT THE ARKANSAS SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM (SHIIP) AT [800-224-6330] OR [501-371-2782] IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT TRANSAMERICA LIFE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

TRANSAMERICA® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. BOX 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Application for Long Term Care Insurance (ABC)

ID Number	Application No. (Home Office Use)

APPLICANT INFORMATION - PLEASE PRINT

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade Please provide policy #:_____

BUSINESS INFORMATION (to be completed by the Agent/Insurance Producer)

SERVICE GROUP NAME (includes employers/association):

SERVICE GROUP # (from implementation memo):

☐ Employee: Date of Hire _____ ☐ Employee's Spouse/Partner ☐ Family Member

PERSONAL INFORMATION

Name: First MI Last

Date of Birth: / /

State of Birth:

Social Security No.: / /

Sex: ☐ Male ☐ Female

Height: _____ Feet _____ Inches

Weight:_____ lbs.

APPLICANT STATUS:

☐ COUPLE, and Spouse/Partner is also applying for (or has) Transamerica Life coverage. Spouse's/Partner's name _____

☐ INDIVIDUAL who is part of a couple, but Spouse/Partner is not applying. Why is Spouse/Partner not applying?_____

_____

☐ INDIVIDUAL who is single, divorced or widowed.

TOBACCO STATUS:

Do you currently use any form of tobacco products?..... ☐ Yes ☐ No

If no, have you ever used any tobacco products?..... ☐ Yes ☐ No

If yes, have you used within the last..... [☐ 2 yrs.] [☐ 3 yrs.] [☐ 3+ yrs.]

CONTACT INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT & COMPLETE PHONE NUMBER AND E-MAIL ADDRESS

☐ Home Phone: ☐ Work Phone: ☐ Cell Phone:

[☐] E-Mail Address: BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.

ADDRESS/Apt No.: _____ **CITY:** _____

_____ **STATE:** _____ **ZIP:**_____

OCCUPATION, PROFESSION OR BUSINESS (If retired, give year retired and from what occupation)

_____

_____

DRIVER'S LICENSE NO. AND STATE (If applicant does not have a driver's license, please give passport number instead)

☐ Driver's License No.

#_____ State:_____

☐ Passport No.

#_____ State:_____

OTHER INSURANCE INFORMATION

	Yes	No
1. Are you covered by Medicaid (not Medicare)?.....	☐	☐
2. Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits?.....	☐	☐

OTHER INSURANCE INFORMATION

	Yes	No
3. In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?……. If Yes, give company name, when and why:	☐	☐

_____

_____

_____

_____

	Yes	No
4. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)?…….. If Yes, please give details in the chart below question 9.	☐	☐
5. Do you currently have a rider in force that provides long term care benefits attached to a life insurance policy or an annuity contract?…….. If Yes, please give details in the chart below question 9.	☐	☐
6. Did you have a long term care insurance policy or certificate in force in the last twelve (12) months?……. If Yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in the chart below question 9.	☐	☐
7. Have you currently applied for, or do you intend to apply for any other long term care insurance?……. If Yes, please provide details in the chart below question 9.	☐	☐
8. Do you intend to replace any in force medical or long term care insurance with this policy?……. If Yes, please provide details in the chart below question 9 and complete the required replacement form.	☐	☐
9. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse?……. If Yes, please provide details below.	☐	☐

Name	Name of Company	Company Address	Policy #	Type of Plan	Lapse Date

☐ Check here if more space is needed, attach a signed and dated additional sheet.

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A Only.
SIMPLIFIED ISSUE – Answer Questions in SECTIONS A & B.
FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

A

	Yes	No
1. During the last 6 MONTHS, with the exception of vacation, have you been continuously and actively working for your current employer for a minimum of 30 hours per week? If NO, please give the number of hours you work per week. _____ hrs..…….	☐	☐
2. During the last 6 MONTHS, have you missed more than 5 consecutive days of work due to accidents, injury, sickness or any physical or cognitive impairment?…….	☐	☐
3. During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting?…….	☐	☐

Please provide details if question 1 is answered 'NO' or if question 2 or 3 are answered 'YES'.

_____

_____

_____

_____

_____

If any question B 1-4 is answered Yes, You are not eligible for coverage.

B

	Yes	No
1. Have you EVER had, or been diagnosed or treated by a member of the medical profession, or had symptoms of any of the following conditions?.....	☐	☐

If Yes, please check the applicable condition(s):

- ☐ AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV
- ☐ Alzheimer's disease or Dementia
- ☐ Amputation due to disease
- ☐ ALS (Lou Gehrig's disease)
- ☐ Arthritis with narcotic pain medication
- ☐ Multiple Strokes/CVA's/TIA's*
- ☐ Organ Transplant (other than Corneal)
- ☐ Multiple Sclerosis
- ☐ Huntington's Chorea
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Organic Brain Syndrome
- ☐ Osteoporosis with fractures
- ☐ Parkinson's disease
- ☐ Polymyositis
- ☐ Scleroderma
- ☐ Memory loss
- ☐ Unplanned weight loss greater than 15 pounds within last 2 years
- ☐ Polycystic Kidney Disease

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete Sections B & C.

	Yes	No
2. During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), alcohol abuse, drug or prescription drug addiction?.....	☐	☐
3. During the last 12 MONTHS:		
• Have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?.....	☐	☐
• Have you been advised to enter, do you reside in or are you confined to a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), rehabilitation facility, attended an adult day care facility, or required home health care?.....	☐	☐
4. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease?.....	☐	☐

PRIMARY PHYSICIAN'S NAME:	**TELEPHONE NUMBER:**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE LAST CONSULTED:	**[YOUR HEALTH INSURANCE OR PPO MEDICAL ID#]** (if known):

REASON LAST SEEN: _____

B

List All Medications Prescribed Or Taken Within The Last 12 Months

If question C 1 or 2 is answered Yes, You are not eligible for coverage. For any other Yes answer, check the applicable box & provide details in question 7.

C

	Yes	No
1. In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?	☐	☐
2. Within the last 3 MONTHS, have you had:		
• Heart Attack (MI) or Chest Pain	☐	☐
• Uncontrolled Blood Pressure	☐	☐
• Cancer	☐	☐
• Hip or Back Surgery	☐	☐

Please answer each question in number 3 below by checking Yes or No. Each condition should have a separate answer.

3. In the last 5 YEARS, have you been diagnosed by or received treatment from a member of the medical profession for, or had symptoms of:

Y	N		Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Cardiomyopathy	☐	☐	Epilepsy
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Peripheral Vascular Disease	☐	☐	COPD
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Congestive Heart Failure (CHF)	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Thyroid disease	☐	☐	Stroke	☐	☐	Dizziness
☐	☐	Anemia	☐	☐	Aneurysm	☐	☐	Disorientation
☐	☐	Macular Degeneration	☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Emphysema
☐	☐	Arthritis	☐	☐	Irregular Heartbeat	☐	☐	Paralysis
☐	☐	Rheumatoid Arthritis	☐	☐	Carotid Artery Stenosis	☐	☐	Fainting
☐	☐	Osteoporosis	☐	☐	Transient Ischemic Attack (TIA)	☐	☐	Falls
☐	☐	Fractures	☐	☐	Mental or Cognitive Disorder including Memory Loss	☐	☐	Blurred Vision
☐	☐	Fibromyalgia	☐	☐	Heart Surgery	☐	☐	Loss of Balance
☐	☐	Heart Attack	☐	☐	Confusion	☐	☐	Loss of Strength
☐	☐	Joint Replacement	☐	☐	Asthma	☐	☐	Convulsions
☐	☐	Used a Straight Cane	☐	☐	Mental Retardation	☐	☐	Diabetes
☐	☐	Chest Pain	☐	☐	Depression	☐	☐	Ulcerative Colitis
☐	☐	High Blood Pressure				☐	☐	Crohn's Disease
☐	☐	Heart Murmur				☐	☐	Chronic Hepatitis
☐	☐	Heart Disease				☐	☐	Cirrhosis
						☐	☐	Sarcoidosis
						☐	☐	Systemic Lupus (SLE)

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Pancreas	☐	☐	Lungs
☐	☐	Liver	☐	☐	Bone and Joint			
☐	☐	Small or Large Intestine	☐	☐	Gastrointestinal Tract			

	Yes	No
4. Do you have a handicap sticker, handicap placard, or handicap license plate?	☐	☐
5. In the last 24 MONTHS, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?	☐	☐
6. In the last 12 MONTHS, have you had unplanned weight loss; or has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed?	☐	☐

7. **Give details for all Yes answers to C 1 - 6.**

☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

PLAN SELECTION

Rate Class Applying For:
[☐ Preferred] [☐ Standard] [☐ Class 1] [☐ Class 2] [☐ Class 3] [☐ Class 4]

Daily Benefit: [Facility] [Facility/Home Care] $_____ [Home Care $_____]

Policy Maximum Amount: $_____

Elimination Period: [☐ 0] [☐ 20] [☐ 30] [☐ 50] [☐ 60] [☐ 90] [☐ 100] [☐ 120] [☐ 150] [☐ 180] [☐ 365] Days

Benefit Increase Option: ☐ Compound 5%
[☐ Compound 3%] [☐ Simple 3%] [☐ Simple 5%] [☐ Step Rated 3%] [☐ Step Rated 5%] [☐ Tailored 5%/3%] [☐ Deferred]
[☐ Guaranteed Purchase Option]

If not selecting the 5% Compound Benefit Increase Option, you must check and sign the Rejection of 5% Compound Benefit Increase Option statement below.

☐ **Rejection of 5% Compound Benefit Increase Option:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of my coverage with and without inflation protection. Specifically, I have reviewed the features of the 5% Compound Benefit Increase Option and I reject the option.

Signature:_____

Nonforfeiture Benefit:
☐ Shortened Benefit Period
If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture Benefit statement below.

☐ **Rejection of Nonforfeiture Benefit:** I understand that if I fail to pay my premium when due or prior to the end of the grace period, my policy will lapse and I will not be eligible for any future benefits because I have chosen not to purchase the Nonforfeiture Benefit. Nevertheless, I reject the option.

Signature:_____

Other Benefits:

[☐ Shared Care Rider –
Spouse/Partner's name:_____]
[☐ Full Restoration of Benefits Rider]
[☐ Monthly Benefit Rider]
[☐ Waiver of Premium Rider - Cash Benefit]
[☐ Waiver of Premium Rider - Home Care and Adult Day Care]
[☐ Return of Premium Rider]
[☐ Survivorship Rider]
[☐ 0/10] [☐ 10/10]
[☐ Joint Waiver of Premium Rider]
[☐ Rate Guarantee _____ years]

BENEFICIARY NAME:	**RELATIONSHIP:**
ADDRESS (Street, City, State, Zip Code)	

PREMIUM PAYMENT (total premium cost may vary depending on mode of payment selected)

Initial Premium Payment:
[☐ Check] [☐ EFT] [☐ Credit Card]

Premium Payment Mode:
[☐ Annual] [☐ Semi-Annual] [☐ Quarterly]
[☐ Monthly (available only with [EFT][and][List Bill])]

Recurring Payment Method:
[☐ Direct Bill] [☐ List Bill] [☐ EFT]
[☐ Credit Card] [☐ Payroll Deduction]

Premium Paying Period:
[☐ Lifetime] [☐ 5 years] [☐ 10 years] [☐ 15 years]
[☐ 20 years] [☐ Paid-Up to Age 65] [☐ Single Pay]

Annual Premium:	Mode Premium:	Payment w/ Application
$	$	$

FAMILY HISTORY PROFILE – Please answer with biological parent information, if known

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

AGREEMENT: I understand that I am applying for an individual long term care insurance policy and not for coverage under a group policy. I understand and agree that no agent/insurance producer or other person except an officer of Transamerica Life Insurance Company has the authority to alter or waive any of the above conditions or any questions in the application, or to determine insurability. I understand and agree that the policy will not take effect unless it is issued by the company.

STATEMENT OF RECEIPT: I certify that I have received the Outline of Coverage, "A Shopper's Guide to Long Term Care Insurance," HIPAA Privacy Notice, the Potential Rate Increase disclosure form, "Things You Should Know Before You Buy Long Term Care Insurance," the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

APPLICANT'S ACKNOWLEDGMENT OF SUITABILITY: I acknowledge that the agent/insurance producer identified in this application made the necessary inquiries concerning my insurance needs, and proposed a program of insurance that is suitable for my needs.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY, SUBJECT TO THE TIME LIMIT ON CERTAIN DEFENSES PROVISION IN THE POLICY.

ACKNOWLEDGMENT: I, the undersigned applicant, acknowledge and represent that I have read, or had read to me, the complete application. I, the applicant, represent to the best of my knowledge and belief, that I am competent and the answers contained in this application are true, complete and correctly recorded. This application will be part of the policy for which I am applying.

Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive information or statements is guilty of insurance fraud.

SIGNATURE: **DATE**
X

PLACE SIGNED (City/State)

EFFECTIVE DATE (if not date of application)

SPECIAL INSTRUCTIONS:_____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGMENT OF COMPLIANCE: I certify that I personally discussed with the applicant and followed the Company's written guidelines provided to me concerning comparisons of coverage and suitability in the marketing of this insurance coverage. I also certify, to the best of my knowledge and belief, that the answers contained in this application are true, complete, and correctly recorded.

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

FOR THE AGENT/INSURANCE PRODUCER

	Yes	No
1. Did you interview the applicant in person, ask all questions, and witness signatures?.....	☐	☐
If No, please give details:_____		
2. Did you see, hear, or were you advised of any physical or cognitive impairments of the applicant including but not limited to walking, speaking, any form of tremor, or any signs of confusion?	☐	☐
If Yes, please give details:_____		
3. To the best of your knowledge, is the information provided in this application true and complete?.....	☐	☐

LIST ANY OTHER HEALTH INSURANCE POLICIES YOU HAVE SOLD TO THE APPLICANT

(1) List policies sold that are still in force; and

(2) List policies sold within the last five (5) years that are no longer in force.

COMPANY	POLICY #	TYPE OF COVERAGE	IN FORCE	LAPSE DATE
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

TRANSAMERICA® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. BOX 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Application for Long Term Care Insurance (JABC)

ID Number	Application No. (Home Office Use)

APPLICANT INFORMATION - PLEASE PRINT

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade Please provide policy #:_____

BUSINESS INFORMATION (to be completed by the Agent/Insurance Producer)

SERVICE GROUP NAME (includes employers/association):

SERVICE GROUP # (from implementation memo):

☐ Employee: Date of Hire _____ ☐ Employee's Spouse/Partner ☐ Family Member

PERSONAL INFORMATION

APPLICANT 1		APPLICANT 2	
Name: First MI Last		**Name:** First MI Last	
Date of Birth: / /	**State of Birth:**	**Date of Birth:** / /	**State of Birth:**
Social Security No.: / /		**Social Security No.:** / /	
Sex: ☐ Male ☐ Female		**Sex:** ☐ Male ☐ Female	
Height: _____ Feet _____ Inches	**Weight:** _____ lbs.	**Height:** _____ Feet _____ Inches	**Weight:** _____ lbs.

APPLICANT STATUS:

☐ COUPLE, and Spouse/Partner is also applying for (or has) Transamerica Life coverage. Spouse's/Partner's name _____

☐ INDIVIDUAL who is part of a couple, but Spouse/Partner is not applying. Why is Spouse/Partner not applying?_____

_____

☐ INDIVIDUAL who is single, divorced or widowed.

TOBACCO STATUS:	**APPLICANT 1**	**APPLICANT 2**
Do you currently use any form of tobacco products?.....	☐ Yes ☐ No	☐ Yes ☐ No
If no, have you ever used any tobacco products?.....	☐ Yes ☐ No	☐ Yes ☐ No
If yes, have you used within the last.....	[☐ 2 yrs.] [☐ 3 yrs.] [☐ 3+ yrs.]	[☐ 2 yrs.] [☐ 3 yrs.] [☐ 3+ yrs.]

CONTACT INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT & COMPLETE PHONE NUMBER AND E-MAIL ADDRESS

APPLICANT 1	APPLICANT 2
☐ Home Phone:	☐ Home Phone:
☐ Work Phone:	☐ Work Phone:
☐ Cell Phone:	☐ Cell Phone:
[☐] E-Mail Address:	[☐] E-Mail Address:
BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.	BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.

ADDRESS/Apt No.: _____ **CITY:** _____

_____ **STATE:** _____ **ZIP:** _____

OCCUPATION, PROFESSION OR BUSINESS (If retired, give year retired and from what occupation)

Applicant 1: _____ Applicant 2: _____

DRIVER'S LICENSE NO. AND STATE (If applicant does not have a driver's license, please give passport number instead)

Applicant 1: _____ State:_____
☐ Driver's License No.
☐ Passport No.

Applicant 2: _____ State:_____
☐ Driver's License No.
☐ Passport No.

OTHER INSURANCE INFORMATION

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
1. Are you covered by Medicaid (not Medicare)?……	☐	☐	☐	☐
2. Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits?	☐	☐	☐	☐
3. In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?……	☐	☐	☐	☐

If Yes, give company name, when and why:

Applicant 1:	Applicant 2:

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
4. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)?…… If Yes, please give details in the chart below question 9.	☐	☐	☐	☐
5. Do you currently have a rider in force that provides long term care benefits attached to a life insurance policy or an annuity contract?…… If Yes, please give details in the chart below question 9.	☐	☐	☐	☐
6. Did you have a long term care insurance policy or certificate in force in the last twelve (12) months?…… If Yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in the chart below question 9.	☐	☐	☐	☐
7. Have you currently applied for, or do you intend to apply for any other long term care insurance?…… If Yes, please provide details in the chart below question 9.	☐	☐	☐	☐
8. Do you intend to replace any in force medical or long term care insurance with this policy?…… If Yes, please provide details in the chart below question 9 and complete the required replacement form.	☐	☐	☐	☐
9. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse?…… If Yes, please provide details below.	☐	☐	☐	☐

Name	Name of Company	Company Address	Policy #	Type of Plan	Lapse Date

☐ Check here if more space is needed, attach a signed and dated additional sheet.

MODIFIED GUARANTEE ISSUE – Answer Questions in SECTION A Only.
SIMPLIFIED ISSUE – Answer Questions in SECTIONS A & B.
FULL UNDERWRITING - Answer Questions in SECTIONS A, B & C.

A

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
1. During the last 6 MONTHS, with the exception of vacation, have you been continuously and actively working for your current employer for a minimum of 30 hours per week? If NO, please give the number of hours you work per week. _____ hrs.……	☐	☐	☐	☐
2. During the last 6 MONTHS, have you missed more than 5 consecutive days of work due to accidents, injury, sickness or any physical or cognitive impairment?……	☐	☐	☐	☐
3. During the last 12 MONTHS, have you ever required assistance or supervision of any kind to perform any everyday activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring, or toileting?……	☐	☐	☐	☐

Please provide details if question 1 is answered 'NO' or if question 2 or 3 are answered 'YES'.

Applicant 1:	Applicant 2:

If any question B 1-4 is answered Yes, You are not eligible for coverage.

B

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
1. Have you EVER had, or been diagnosed or treated by a member of the medical profession, or had symptoms of any of the following conditions?.....	☐	☐	☐	☐

If Yes, please check the applicable condition(s):

Applicant 1	Applicant 2		Applicant 1	Applicant 2		Applicant 1	Applicant 2	
☐	☐	AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV	☐	☐	Organ Transplant (other than Corneal)	☐	☐	Polymyositis
☐	☐	Alzheimer's disease or Dementia	☐	☐	Multiple Sclerosis	☐	☐	Scleroderma
☐	☐	Amputation due to disease	☐	☐	Huntington's Chorea	☐	☐	Memory loss
☐	☐	ALS (Lou Gehrig's disease)	☐	☐	Muscular Dystrophy	☐	☐	Unplanned weight loss greater than 15 pounds within last 2 years
☐	☐	Arthritis with narcotic pain medication	☐	☐	Myasthenia Gravis	☐	☐	Polycystic Kidney Disease
☐	☐	Stroke/CVA/TIA*	☐	☐	Organic Brain Syndrome			
			☐	☐	Osteoporosis w/fractures			
			☐	☐	Parkinson's disease			

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete Sections B & C.

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
2. During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), alcohol abuse, drug or prescription drug addiction?.....	☐	☐	☐	☐
3. During the last 12 MONTHS:				
• Have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?.....	☐	☐	☐	☐
• Have you been advised to enter, do you reside in or are you confined to a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), rehabilitation facility, attended an adult day care facility, or required home health care?.....	☐	☐	☐	☐
4. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease?	☐	☐	☐	☐

B

Applicant 1:	Applicant 2:
PRIMARY PHYSICIAN'S NAME:	**PRIMARY PHYSICIAN'S NAME:**
TELEPHONE NUMBER:	**TELEPHONE NUMBER:**
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____	**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
DATE LAST CONSULTED:	**DATE LAST CONSULTED:**
REASON LAST SEEN: _____	**REASON LAST SEEN:** _____
[YOUR HEALTH INSURANCE OR PPO MEDICAL ID#] (if known):	**[YOUR HEALTH INSURANCE OR PPO MEDICAL ID#]** (if known):

Applicant 1	List All Medications Prescribed Or Taken Within The Last 12 Months	Applicant 2

If question C 1 or 2 is answered Yes, You are not eligible for coverage. For any other Yes answer, check the applicable box & provide details in question 7.

C

Applicant 1:	Y	N
1. In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?	☐	☐
2. Within the last 3 MONTHS, have you had:		
• Heart Attack (MI) or Chest Pain	☐	☐
• Uncontrolled Blood Pressure	☐	☐
• Cancer	☐	☐
• Hip or Back Surgery	☐	☐

Applicant 2:	Y	N
1. In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?	☐	☐
2. Within the last 3 MONTHS, have you had:		
• Heart Attack (MI) or Chest Pain	☐	☐
• Uncontrolled Blood Pressure	☐	☐
• Cancer	☐	☐
• Hip or Back Surgery	☐	☐

Please answer each question in number 3 below by checking Yes or No. Each condition should have a separate answer.

3. In the last 5 YEARS, have you been diagnosed by or received treatment from a member of the medical profession for, or had symptoms of:

Applicant 1:

Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Transient Ischemic Attack (TIA)
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Mental or Cognitive Disorder including Memory Loss
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Heart Surgery
☐	☐	Thyroid disease	☐	☐	Confusion
☐	☐	Anemia	☐	☐	Asthma
☐	☐	Macular Degeneration	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Rheumatoid Arthritis	☐	☐	Epilepsy
☐	☐	Osteoporosis	☐	☐	COPD
☐	☐	Fractures	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Fibromyalgia	☐	☐	Dizziness
☐	☐	Heart Attack	☐	☐	Disorientation
☐	☐	Joint Replacement	☐	☐	Emphysema
☐	☐	Used a Straight Cane	☐	☐	Paralysis
☐	☐	Chest Pain	☐	☐	Fainting
☐	☐	High Blood Pressure	☐	☐	Falls
☐	☐	Heart Murmur	☐	☐	Blurred Vision
☐	☐	Heart Disease	☐	☐	Loss of Balance
☐	☐	Cardiomyopathy	☐	☐	Loss of Strength
☐	☐	Peripheral Vascular Disease	☐	☐	Convulsions
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Diabetes
☐	☐	Stroke	☐	☐	Ulcerative Colitis
☐	☐	Aneurysm	☐	☐	Crohn's Disease
☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Chronic Hepatitis
☐	☐	Irregular Heartbeat	☐	☐	Cirrhosis
☐	☐	Carotid Artery Stenosis	☐	☐	Sarcoidosis
			☐	☐	Systemic Lupus (SLE)

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Liver
☐	☐	Small or Large Intestine	☐	☐	Pancreas
☐	☐	Bone and Joint	☐	☐	Gastrointestinal Tract
☐	☐	Lungs			

Applicant 2:

Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Transient Ischemic Attack (TIA)
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Mental or Cognitive Disorder including Memory Loss
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Heart Surgery
☐	☐	Thyroid disease	☐	☐	Confusion
☐	☐	Anemia	☐	☐	Asthma
☐	☐	Macular Degeneration	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Rheumatoid Arthritis	☐	☐	Epilepsy
☐	☐	Osteoporosis	☐	☐	COPD
☐	☐	Fractures	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Fibromyalgia	☐	☐	Dizziness
☐	☐	Heart Attack	☐	☐	Disorientation
☐	☐	Joint Replacement	☐	☐	Emphysema
☐	☐	Used a Straight Cane	☐	☐	Paralysis
☐	☐	Chest Pain	☐	☐	Fainting
☐	☐	High Blood Pressure	☐	☐	Falls
☐	☐	Heart Murmur	☐	☐	Blurred Vision
☐	☐	Heart Disease	☐	☐	Loss of Balance
☐	☐	Cardiomyopathy	☐	☐	Loss of Strength
☐	☐	Peripheral Vascular Disease	☐	☐	Convulsions
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Diabetes
☐	☐	Stroke	☐	☐	Ulcerative Colitis
☐	☐	Aneurysm	☐	☐	Crohn's Disease
☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Chronic Hepatitis
☐	☐	Irregular Heartbeat	☐	☐	Cirrhosis
☐	☐	Carotid Artery Stenosis	☐	☐	Sarcoidosis
			☐	☐	Systemic Lupus (SLE)

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Liver
☐	☐	Small or Large Intestine	☐	☐	Pancreas
☐	☐	Bone and Joint	☐	☐	Gastrointestinal Tract
☐	☐	Lungs			

	Applicant 1		Applicant 2	
	Yes	No	Yes	No
4. Do you have a handicap sticker, handicap placard, or handicap license plate?	☐	☐	☐	☐
5. In the last 24 MONTHS, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?	☐	☐	☐	☐
6. In the last 12 MONTHS, have you had unplanned weight loss; or has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed?	☐	☐	☐	☐

Section C - Continued

C

7. **Give details for all Yes answers to C 3 - 6.**

Applicant 1: ☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

Applicant 2: ☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

PLAN SELECTION

Rate Class Applying For:
[☐ Preferred] [☐ Standard] [☐ Class 1] [☐ Class 2] [☐ Class 3] [☐ Class 4]

Daily Benefit: [Facility] [Facility/Home Care] $_____ [Home Care $_____]
Policy Maximum Amount: $_____
Elimination Period: [☐ 0] [☐ 20] [☐ 30] [☐ 50] [☐ 60] [☐ 90] [☐ 100] [☐ 120] [☐ 150] [☐ 180] [☐ 365] Days

Benefit Increase Option: ☐ Compound 5%
[☐ Compound 3%] [☐ Simple 3%] [☐ Simple 5%] [☐ Step Rated 3%] [☐ Step Rated 5%] [☐ Tailored 5%/3%] [☐ Deferred]
[☐ Guaranteed Purchase Option]

If not selecting the 5% Compound Benefit Increase Option, you must check and sign the Rejection of 5% Compound Benefit Increase Option statement below.

☐ **Rejection of 5% Compound Benefit Increase Option:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of my coverage with and without inflation protection. Specifically, I have reviewed the features of the 5% Compound Benefit Increase Option and I reject the option.

Signature of Applicant 1:_____ Signature of Applicant 2:_____

Nonforfeiture Benefit:
☐ Shortened Benefit Period

If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture Benefit statement below.

☐ **Rejection of Nonforfeiture Benefit:** I understand that if I fail to pay my premium when due or prior to the end of the grace period, my policy will lapse and I will not be eligible for any future benefits because I have chosen not to purchase the Nonforfeiture Benefit. Nevertheless, I reject the option.

Signature of Applicant 1:_____ Signature of Applicant 2:_____

Other Benefits:
[☐ Shared Care Rider – Spouse/Partner only]
[☐ Full Restoration of Benefits Rider]
[☐ Monthly Benefit Rider]
[☐ Waiver of Premium Rider - Cash Benefit]
[☐ Waiver of Premium Rider - Home Care and Adult Day Care]
[☐ Return of Premium Rider]
[☐ Survivorship Rider]
[☐ 0/10] [☐ 10/10]
[☐ Joint Waiver of Premium Rider]
[☐ Rate Guarantee _____ years]

Applicant 1:		Applicant 2:	
BENEFICIARY NAME:	**RELATIONSHIP:**	**BENEFICIARY NAME:**	**RELATIONSHIP:**
ADDRESS (Street, City, State, Zip Code)		**ADDRESS (Street, City, State, Zip Code)**	

PREMIUM PAYMENT (total premium cost may vary depending on mode of payment selected)

Applicant 1:	Applicant 2:
Initial Premium Payment: [☐ Check] [☐ EFT] [☐ Credit Card]	Initial Premium Payment: [☐ Check] [☐ EFT] [☐ Credit Card]
Recurring Payment Method: [☐ Direct Bill] [☐ List Bill] [☐ EFT] [☐ Credit Card] [☐ Payroll Deduction]	Recurring Payment Method: [☐ Direct Bill] [☐ List Bill] [☐ EFT] [☐ Credit Card] [☐ Payroll Deduction]
Premium Payment Mode: [☐ Annual] [☐ Semi-Annual] [☐ Quarterly] [☐ Monthly (available only with [EFT][and][List Bill])]	Premium Payment Mode: [☐ Annual] [☐ Semi-Annual] [☐ Quarterly] [☐ Monthly (available only with [EFT][and][List Bill])]
Premium Paying Period: [☐ Lifetime] [☐ 5 years] [☐ 10 years] [☐ 15 years] [☐ 20 years] [☐ Paid-Up to Age 65] [☐ Single Pay]	Premium Paying Period: [☐ Lifetime] [☐ 5 years] [☐ 10 years] [☐ 15 years] [☐ 20 years] [☐ Paid-Up to Age 65] [☐ Single Pay]

Applicant 1:		Applicant 2:	
Annual Premium: $	Mode Premium: $	Annual Premium: $	Mode Premium: $
Payment w/ Application: $		Payment w/ Application: $	

FAMILY HISTORY PROFILE – Please answer with biological parent information, if known

Applicant 1:

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Applicant 2:

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

PROTECTION AGAINST UNINTENDED LAPSE

Applicant 1:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

Applicant 2:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

AGREEMENT: I understand that I am applying for an individual long term care insurance policy and not for coverage under a group policy. I understand and agree that no agent/insurance producer or other person except an officer of Transamerica Life Insurance Company has the authority to alter or waive any of the above conditions or any questions in the application, or to determine insurability. I understand and agree that the policy will not take effect unless it is issued by the company.

STATEMENT OF RECEIPT: I certify that I have received the Outline of Coverage, "A Shopper's Guide to Long Term Care Insurance," HIPAA Privacy Notice, the Potential Rate Increase disclosure form, "Things You Should Know Before You Buy Long Term Care Insurance," the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

APPLICANT'S ACKNOWLEDGMENT OF SUITABILITY: I acknowledge that the agent/insurance producer identified in this application made the necessary inquiries concerning my insurance needs, and proposed a program of insurance that is suitable for my needs.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY, SUBJECT TO THE TIME LIMIT ON CERTAIN DEFENSES PROVISION IN THE POLICY.

ACKNOWLEDGMENT: I, the undersigned applicant, acknowledge and represent that I have read, or had read to me, the complete application. I, the applicant, represent to the best of my knowledge and belief, that I am competent and the answers contained in this application are true, complete and correctly recorded. This application will be part of the policy for which I am applying.

Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive information or statements is guilty of insurance fraud.

Applicant 1:		Applicant 2:	
SIGNATURE: X	DATE	SIGNATURE: X	DATE
PLACE SIGNED (City/State)		PLACE SIGNED (City/State)	
EFFECTIVE DATE (if not date of application)		EFFECTIVE DATE (if not date of application)	

SPECIAL INSTRUCTIONS: _____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGMENT OF COMPLIANCE: I certify that I personally discussed with the applicant(s) and followed the Company's written guidelines provided to me concerning comparisons of coverage and suitability in the marketing of this insurance coverage. I also certify, to the best of my knowledge and belief, that the answers contained in this application are true, complete, and correctly recorded.

AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	
AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	
AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	
AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	

FOR THE AGENT/INSURANCE PRODUCER

	Yes	No
1. Did you interview the applicant(s) in person, ask all questions, and witness signatures?.....	☐	☐
If No, please give details:_____		
2. Did you see, hear, or were you advised of any physical or cognitive impairments of the applicant(s) including but not limited to walking, speaking, any form of tremor, or any signs of confusion?	☐	☐
If Yes, please give details, including which applicant:_____		
3. To the best of your knowledge, is the information provided in this application true and complete?.....	☐	☐

LIST ANY OTHER HEALTH INSURANCE POLICIES YOU HAVE SOLD TO THE APPLICANT(S)

(1) List policies sold that are still in force; and

(2) List policies sold within the last five (5) years that are no longer in force.

APPLICANT #	COMPANY	POLICY #	TYPE OF COVERAGE	IN FORCE	LAPSE DATE
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	

TRANSAMERICA® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. BOX 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Application for Long Term Care Insurance (Full Underwriting)

ID Number	Application No. (Home Office Use)

APPLICANT INFORMATION - PLEASE PRINT

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade Please provide policy #:_____

BUSINESS INFORMATION (to be completed by the Agent/Insurance Producer)

SERVICE GROUP NAME (includes employers/association):

SERVICE GROUP # (from implementation memo):

☐ Employee: Date of Hire _____ ☐ Employee's Spouse/Partner ☐ Family Member

PERSONAL INFORMATION

Name: First MI Last

Date of Birth: / /

State of Birth:

Social Security No.: / /

Sex: ☐ Male ☐ Female

Height: _____ Feet _____ Inches

Weight:_____ lbs.

APPLICANT STATUS:

☐ COUPLE, and Spouse/Partner is also applying for (or has) Transamerica Life coverage. Spouse's/Partner's name _____

☐ INDIVIDUAL who is part of a couple, but Spouse/Partner is not applying. Why is Spouse/Partner not applying?_____

_____

☐ INDIVIDUAL who is single, divorced or widowed.

TOBACCO STATUS:

Do you currently use any form of tobacco products?..... ☐ Yes ☐ No

If no, have you ever used any tobacco products?..... ☐ Yes ☐ No

If yes, have you used within the last..... [☐ 2 yrs.] [☐ 3 yrs.] [☐ 3+ yrs.]

CONTACT INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT & COMPLETE PHONE NUMBER AND E-MAIL ADDRESS

☐ Home Phone: ☐ Work Phone: ☐ Cell Phone:

[☐] E-Mail Address: BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.

ADDRESS/Apt No.: _____ **CITY:** _____

_____ **STATE:** _____ **ZIP:**_____

OCCUPATION, PROFESSION OR BUSINESS (If retired, give year retired and from what occupation)

_____

_____

DRIVER'S LICENSE NO. AND STATE (If applicant does not have a driver's license, please give passport number instead)

☐ Driver's License No.

#_____ State:_____

☐ Passport No.

#_____ State:_____

OTHER INSURANCE INFORMATION

	Yes	No
1. Are you covered by Medicaid (not Medicare)?.....	☐	☐
2. Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits?.....	☐	☐

OTHER INSURANCE INFORMATION

	Yes	No
3. In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?…….	☐	☐

If Yes, give company name, when and why:

_____

_____

_____

_____

	Yes	No
4. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)?……	☐	☐
If Yes, please give details in the chart below question 9.		
5. Do you currently have a rider in force that provides long term care benefits attached to a life insurance policy or an annuity contract?……..	☐	☐
If Yes, please give details in the chart below question 9.		
6. Did you have a long term care insurance policy or certificate in force in the last twelve (12) months?……	☐	☐
If Yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in the chart below question 9.		
7. Have you currently applied for, or do you intend to apply for any other long term care insurance?……	☐	☐
If Yes, please provide details in the chart below question 9.		
8. Do you intend to replace any in force medical or long term care insurance with this policy?……..	☐	☐
If Yes, please provide details in the chart below question 9 and complete the required replacement form.		
9. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse?…….	☐	☐
If Yes, please provide details below.		

Name	Name of Company	Company Address	Policy #	Type of Plan	Lapse Date

☐ Check here if more space is needed, attach a signed and dated additional sheet.

FULL UNDERWRITING - Please check Yes or No. If Yes, give details in question 12. If any question 1-7 is answered Yes, You are not eligible for coverage.

	Yes	No
1. Have you EVER had, or been diagnosed or treated by a member of the medical profession, or had symptoms of any of the following conditions?……	☐	☐

If Yes, please check the applicable condition(s):

- ☐ AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV
- ☐ Alzheimer's disease or Dementia
- ☐ Amputation due to disease
- ☐ ALS (Lou Gehrig's disease)
- ☐ Arthritis with narcotic pain medication
- ☐ Multiple Strokes/CVA's/TIA's*
- ☐ Organ Transplant (other than Corneal)
- ☐ Multiple Sclerosis
- ☐ Huntington's Chorea
- ☐ Muscular Dystrophy
- ☐ Myasthenia Gravis
- ☐ Organic Brain Syndrome
- ☐ Osteoporosis with fractures
- ☐ Parkinson's disease
- ☐ Polymyositis
- ☐ Scleroderma
- ☐ Memory loss
- ☐ Unplanned weight loss greater than 15 pounds within last 2 years
- ☐ Polycystic Kidney Disease

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete rest of application.

		Yes	No
2.	During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), alcohol abuse, drug or prescription drug addiction?.....	☐	☐
3.	During the last 12 MONTHS, have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?.....	☐	☐
4.	During the last 12 MONTHS, have you been advised to enter, do you reside in or are you confined to a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), rehabilitation facility, attended an adult day care facility, or required home health care?.....	☐	☐
5.	Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease?	☐	☐
6.	In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?.....	☐	☐
7.	Within the last 3 MONTHS, have you had:		
	Heart Attack (MI) or Chest Pain.....	☐	☐
	Uncontrolled Blood Pressure.....	☐	☐
	Cancer.....	☐	☐
	Hip or Back Surgery.....	☐	☐

Please answer each question in number 8 below by checking Yes or No. Each condition should have a separate answer.

8. In the last 5 YEARS, have you been diagnosed by or received treatment from a member of the medical profession for, or had symptoms of:

Y	N		Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Cardiomyopathy	☐	☐	COPD
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Peripheral Vascular Disease	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Congestive Heart Failure (CHF)	☐	☐	Dizziness
☐	☐	Thyroid disease	☐	☐	Stroke	☐	☐	Disorientation
☐	☐	Anemia	☐	☐	Aneurysm	☐	☐	Emphysema
☐	☐	Macular Degeneration	☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Paralysis
☐	☐	Arthritis	☐	☐	Irregular Heartbeat	☐	☐	Fainting
☐	☐	Rheumatoid Arthritis	☐	☐	Carotid Artery Stenosis	☐	☐	Falls
☐	☐	Osteoporosis	☐	☐	Transient Ischemic Attack (TIA)	☐	☐	Blurred Vision
☐	☐	Fractures	☐	☐	Mental or Cognitive Disorder including Memory Loss	☐	☐	Loss of Balance
☐	☐	Fibromyalgia	☐	☐	Heart Surgery	☐	☐	Loss of Strength
☐	☐	Heart Attack	☐	☐	Confusion	☐	☐	Convulsions
☐	☐	Joint Replacement	☐	☐	Asthma	☐	☐	Diabetes
☐	☐	Used a Straight Cane	☐	☐	Mental Retardation	☐	☐	Ulcerative Colitis
☐	☐	Chest Pain	☐	☐	Depression	☐	☐	Crohn's Disease
☐	☐	High Blood Pressure	☐	☐	Epilepsy	☐	☐	Chronic Hepatitis
☐	☐	Heart Murmur				☐	☐	Cirrhosis
☐	☐	Heart Disease				☐	☐	Sarcoidosis
						☐	☐	Systemic Lupus (SLE)

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Pancreas	☐	☐	Lungs
☐	☐	Liver	☐	☐	Bone and Joint			
☐	☐	Small or Large Intestine	☐	☐	Gastrointestinal Tract			

	Yes	No
9. Do you have a handicap sticker, handicap placard, or handicap license plate?……..	☐	☐
10. In the last 24 MONTHS, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?…….	☐	☐
11. In the last 12 MONTHS, have you had unplanned weight loss; or has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed?…….	☐	☐

PRIMARY PHYSICIAN'S NAME: | **TELEPHONE NUMBER:**

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE LAST CONSULTED: | **[YOUR HEALTH INSURANCE OR PPO MEDICAL ID#]** (if known):

REASON LAST SEEN: _____

List All Medications Prescribed Or Taken Within The Last 12 Months

12. Give details for all Yes answers to questions 1 - 11.

☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

PLAN SELECTION

Rate Class Applying For:
[☐ Preferred] [☐ Standard] [☐ Class 1] [☐ Class 2] [☐ Class 3] [☐ Class 4]

Daily Benefit: [Facility] [Facility/Home Care] $_____ [Home Care $_____]

Policy Maximum Amount: $_____

Elimination Period: [☐ 0] [☐ 20] [☐ 30] [☐ 50] [☐ 60] [☐ 90] [☐ 100] [☐ 120] [☐ 150] [☐ 180] [☐ 365] Days

Benefit Increase Option: ☐ Compound 5%
[☐ Compound 3%] [☐ Simple 3%] [☐ Simple 5%] [☐ Step Rated 3%] [☐ Step Rated 5%] [☐ Tailored 5%/3%] [☐ Deferred]
[☐ Guaranteed Purchase Option]

If not selecting the 5% Compound Benefit Increase Option, you must check and sign the Rejection of 5% Compound Benefit Increase Option statement below.

☐ **Rejection of 5% Compound Benefit Increase Option:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of my coverage with and without inflation protection. Specifically, I have reviewed the features of the 5% Compound Benefit Increase Option and I reject the option.

Signature:_____

Nonforfeiture Benefit:
☐ Shortened Benefit Period
If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture Benefit statement below.

☐ **Rejection of Nonforfeiture Benefit:** I understand that if I fail to pay my premium when due or prior to the end of the grace period, my policy will lapse and I will not be eligible for any future benefits because I have chosen not to purchase the Nonforfeiture Benefit. Nevertheless, I reject the option.

Signature:_____

Other Benefits:

[☐ Shared Care Rider –
Spouse/Partner's name:_____]
[☐ Full Restoration of Benefits Rider]
[☐ Monthly Benefit Rider]
[☐ Waiver of Premium Rider - Cash Benefit]
[☐ Waiver of Premium Rider - Home Care and Adult Day Care]
[☐ Return of Premium Rider]
[☐ Survivorship Rider]
[☐ 0/10] [☐ 10/10]
[☐ Joint Waiver of Premium Rider]
[☐ Rate Guarantee _____ years]

BENEFICIARY NAME:	**RELATIONSHIP:**
ADDRESS (Street, City, State, Zip Code)	

PREMIUM PAYMENT (total premium cost may vary depending on mode of payment selected)

Initial Premium Payment:
[☐ Check] [☐ EFT] [☐ Credit Card]

Premium Payment Mode:
[☐ Annual] [☐ Semi-Annual] [☐ Quarterly]
[☐ Monthly (available only with [EFT][and][List Bill])]

Recurring Payment Method:
[☐ Direct Bill] [☐ List Bill] [☐ EFT]
[☐ Credit Card] [☐ Payroll Deduction]

Premium Paying Period:
[☐ Lifetime] [☐ 5 years] [☐ 10 years] [☐ 15 years]
[☐ 20 years] [☐ Paid-Up to Age 65] [☐ Single Pay]

Annual Premium:	Mode Premium:	Payment w/ Application
$	$	$

FAMILY HISTORY PROFILE – Please answer with biological parent information, if known

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

PROTECTION AGAINST UNINTENDED LAPSE

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

AGREEMENT: I understand that I am applying for an individual long term care insurance policy and not for coverage under a group policy. I understand and agree that no agent/insurance producer or other person except an officer of Transamerica Life Insurance Company has the authority to alter or waive any of the above conditions or any questions in the application, or to determine insurability. I understand and agree that the policy will not take effect unless it is issued by the company.

STATEMENT OF RECEIPT: I certify that I have received the Outline of Coverage, "A Shopper's Guide to Long Term Care Insurance," HIPAA Privacy Notice, the Potential Rate Increase disclosure form, "Things You Should Know Before You Buy Long Term Care Insurance," the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

APPLICANT'S ACKNOWLEDGMENT OF SUITABILITY: I acknowledge that the agent/insurance producer identified in this application made the necessary inquiries concerning my insurance needs, and proposed a program of insurance that is suitable for my needs.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY, SUBJECT TO THE TIME LIMIT ON CERTAIN DEFENSES PROVISION IN THE POLICY.

ACKNOWLEDGMENT: I, the undersigned applicant, acknowledge and represent that I have read, or had read to me, the complete application. I, the applicant, represent to the best of my knowledge and belief, that I am competent and the answers contained in this application are true, complete and correctly recorded. This application will be part of the policy for which I am applying.

Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive information or statements is guilty of insurance fraud.

SIGNATURE: **X** **DATE**

PLACE SIGNED (City/State)

EFFECTIVE DATE (if not date of application)

SPECIAL INSTRUCTIONS:_____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGMENT OF COMPLIANCE: I certify that I personally discussed with the applicant and followed the Company's written guidelines provided to me concerning comparisons of coverage and suitability in the marketing of this insurance coverage. I also certify, to the best of my knowledge and belief, that the answers contained in this application are true, complete, and correctly recorded.

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

AGENT/INSURANCE PRODUCER'S SIGNATURE X	**AGENT/INSURANCE PRODUCER'S NAME (Print Name)**	
AGENT/INSURANCE PRODUCER'S WRITING NO.	**TELEPHONE NO.**	**DATE**
E-MAIL ADDRESS	**SHARE %**	

FOR THE AGENT/INSURANCE PRODUCER

	Yes	No
1. Did you interview the applicant in person, ask all questions, and witness signatures?.....	☐	☐
If No, please give details:_____		
2. Did you see, hear, or were you advised of any physical or cognitive impairments of the applicant including but not limited to walking, speaking, any form of tremor, or any signs of confusion?	☐	☐
If Yes, please give details:_____		
3. To the best of your knowledge, is the information provided in this application true and complete?.....	☐	☐

LIST ANY OTHER HEALTH INSURANCE POLICIES YOU HAVE SOLD TO THE APPLICANT

(1) List policies sold that are still in force; and

(2) List policies sold within the last five (5) years that are no longer in force.

COMPANY	POLICY #	TYPE OF COVERAGE	IN FORCE	LAPSE DATE
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

TRANSAMERICA® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. BOX 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Application for Long Term Care Insurance (Full Underwriting)

ID Number	Application No. (Home Office Use)

APPLICANT INFORMATION - PLEASE PRINT

APPLYING FOR: ☐ New Coverage ☐ Reinstatement ☐ Upgrade Please provide policy #:_____

BUSINESS INFORMATION (to be completed by the Agent/Insurance Producer)

SERVICE GROUP NAME (includes employers/association):

SERVICE GROUP # (from implementation memo):

☐ Employee: Date of Hire _____ ☐ Employee's Spouse/Partner ☐ Family Member

PERSONAL INFORMATION

APPLICANT 1		APPLICANT 2	
Name: First MI Last		**Name:** First MI Last	
Date of Birth: / /	**State of Birth:**	**Date of Birth:** / /	**State of Birth:**
Social Security No.: / /		**Social Security No.:** / /	
Sex: ☐ Male ☐ Female		**Sex:** ☐ Male ☐ Female	
Height: _____ Feet _____ Inches	**Weight:** _____ lbs.	**Height:** _____ Feet _____ Inches	**Weight:** _____ lbs.

APPLICANT STATUS:

☐ COUPLE, and Spouse/Partner is also applying for (or has) Transamerica Life coverage. Spouse's/Partner's name _____

☐ INDIVIDUAL who is part of a couple, but Spouse/Partner is not applying. Why is Spouse/Partner not applying?_____

_____

☐ INDIVIDUAL who is single, divorced or widowed.

TOBACCO STATUS:	**APPLICANT 1**	**APPLICANT 2**
Do you currently use any form of tobacco products?.....	☐ Yes ☐ No	☐ Yes ☐ No
If no, have you ever used any tobacco products?.....	☐ Yes ☐ No	☐ Yes ☐ No
If yes, have you used within the last.....	[☐ 2 yrs.] [☐ 3 yrs.] [☐ 3+ yrs.]	[☐ 2 yrs.] [☐ 3 yrs.] [☐ 3+ yrs.]

CONTACT INFORMATION

PLEASE CHECK YOUR PREFERRED METHOD OF CONTACT & COMPLETE PHONE NUMBER AND E-MAIL ADDRESS

APPLICANT 1	APPLICANT 2
☐ Home Phone:	☐ Home Phone:
☐ Work Phone:	☐ Work Phone:
☐ Cell Phone:	☐ Cell Phone:
[☐] E-Mail Address:	[☐] E-Mail Address:
BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.	BEST TIME TO CONTACT: _____ ☐ A.M. ☐ P.M.

ADDRESS/Apt No.: _____ **CITY:** _____

_____ **STATE:** _____ **ZIP:** _____

OCCUPATION, PROFESSION OR BUSINESS (If retired, give year retired and from what occupation)

Applicant 1: _____ Applicant 2: _____

DRIVER'S LICENSE NO. AND STATE (If applicant does not have a driver's license, please give passport number instead)

Applicant 1: _____ State:_____
☐ Driver's License No.
☐ Passport No.

Applicant 2: _____ State:_____
☐ Driver's License No.
☐ Passport No.

OTHER INSURANCE INFORMATION

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
1. Are you covered by Medicaid (not Medicare)?……	☐	☐	☐	☐
2. Have you received any long term care benefits, disability income benefits, or Social Security Disability benefits?	☐	☐	☐	☐
3. In the last 5 years, have you been declined long term care insurance, life insurance, disability income insurance or offered such insurance with an increased premium or restricted benefits?……	☐	☐	☐	☐

If Yes, give company name, when and why:

Applicant 1:	Applicant 2:

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
4. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)?…… If Yes, please give details in the chart below question 9.	☐	☐	☐	☐
5. Do you currently have a rider in force that provides long term care benefits attached to a life insurance policy or an annuity contract?…… If Yes, please give details in the chart below question 9.	☐	☐	☐	☐
6. Did you have a long term care insurance policy or certificate in force in the last twelve (12) months?…… If Yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in the chart below question 9.	☐	☐	☐	☐
7. Have you currently applied for, or do you intend to apply for any other long term care insurance?…… If Yes, please provide details in the chart below question 9.	☐	☐	☐	☐
8. Do you intend to replace any in force medical or long term care insurance with this policy?…… If Yes, please provide details in the chart below question 9 and complete the required replacement form.	☐	☐	☐	☐
9. In the last 6 months, have you allowed any medical/health/long term care insurance to lapse?…… If Yes, please provide details below.	☐	☐	☐	☐

Name	Name of Company	Company Address	Policy #	Type of Plan	Lapse Date

☐ Check here if more space is needed, attach a signed and dated additional sheet.

FULL UNDERWRITING - Please check Yes or No. If Yes, give details in question 12. If any question 1-7 is answered Yes, You are not eligible for coverage.

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
1. Have you EVER had, or been diagnosed or treated by a member of the medical profession, or had symptoms of any of the following conditions?……	☐	☐	☐	☐

If Yes, please check the applicable condition(s):

Applicant 1	Applicant 2	
☐	☐	AIDS (Acquired Immune Deficiency Syndrome), or tested positive for HIV
☐	☐	Alzheimer's disease or Dementia
☐	☐	Amputation due to disease
☐	☐	ALS (Lou Gehrig's disease)
☐	☐	Arthritis with narcotic pain medication
☐	☐	Multiple Strokes/CVA's/TIA's*
☐	☐	Organ Transplant (other than Corneal)
☐	☐	Multiple Sclerosis
☐	☐	Huntington's Chorea
☐	☐	Muscular Dystrophy
☐	☐	Myasthenia Gravis
☐	☐	Organic Brain Syndrome
☐	☐	Osteoporosis with fractures
☐	☐	Parkinson's disease
☐	☐	Polymyositis
☐	☐	Scleroderma
☐	☐	Memory loss
☐	☐	Unplanned weight loss greater than 15 pounds within last 2 years
☐	☐	Polycystic Kidney Disease

*If applicant has had a single Stroke/CVA/TIA more than 2 years ago, complete rest of application.

		Applicant 1		Applicant 2	
		Yes	No	Yes	No
2.	During the last 3 YEARS, have you used over 60 units of insulin per day to treat Diabetes, or have you been diagnosed or treated for Diabetes WITH COMPLICATIONS (Neuropathy, Retinopathy, Heart Disease, Stroke), alcohol abuse, drug or prescription drug addiction?.....	☐	☐	☐	☐
3.	During the last 12 MONTHS, have you used a catheter, dialysis, oxygen equipment, a quad or three-pronged cane, respirator, walker, wheelchair, crutches, motorized scooter or chair lift?.....	☐	☐	☐	☐
4.	During the last 12 MONTHS, have you been advised to enter, do you reside in or are you confined to a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), rehabilitation facility, attended an adult day care facility, or required home health care?.....	☐	☐	☐	☐
5.	Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease?	☐	☐	☐	☐
6.	In the last 12 months have you had COPD/Emphysema with oxygen use, or Cardiomyopathy?.....	☐	☐	☐	☐
7.	Within the last 3 MONTHS, have you had:				
	Heart Attack (MI) or Chest Pain.....	☐	☐	☐	☐
	Uncontrolled Blood Pressure.....	☐	☐	☐	☐
	Cancer.....	☐	☐	☐	☐
	Hip or Back Surgery.....	☐	☐	☐	☐

Please answer each question in number 8 below by checking Yes or No. Each condition should have a separate answer.

8. In the last 5 YEARS, have you been diagnosed by or received treatment from a member of the medical profession for, or had symptoms of:

Applicant 1:

Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Transient Ischemic Attack (TIA)
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Mental or Cognitive Disorder including Memory Loss
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Heart Surgery
☐	☐	Thyroid disease	☐	☐	Confusion
☐	☐	Anemia	☐	☐	Asthma
☐	☐	Macular Degeneration	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Rheumatoid Arthritis	☐	☐	Epilepsy
☐	☐	Osteoporosis	☐	☐	COPD
☐	☐	Fractures	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Fibromyalgia			
☐	☐	Heart Attack	☐	☐	Dizziness
☐	☐	Joint Replacement	☐	☐	Disorientation
☐	☐	Used a Straight Cane	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Paralysis
☐	☐	High Blood Pressure	☐	☐	Fainting
☐	☐	Heart Murmur	☐	☐	Falls
☐	☐	Heart Disease	☐	☐	Blurred Vision
☐	☐	Cardiomyopathy	☐	☐	Loss of Balance
☐	☐	Peripheral Vascular Disease	☐	☐	Loss of Strength
			☐	☐	Convulsions
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Diabetes
			☐	☐	Ulcerative Colitis
☐	☐	Stroke	☐	☐	Crohn's Disease
☐	☐	Aneurysm	☐	☐	Chronic Hepatitis
☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Cirrhosis
			☐	☐	Sarcoidosis
☐	☐	Irregular Heartbeat	☐	☐	Systemic Lupus (SLE)
☐	☐	Carotid Artery Stenosis			

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Liver
☐	☐	Small or Large Intestine	☐	☐	Pancreas
☐	☐	Bone and Joint	☐	☐	Gastrointestinal Tract
☐	☐	Lungs			

Applicant 2:

Y	N		Y	N	
☐	☐	Cancer or Any Kind of Tumor	☐	☐	Transient Ischemic Attack (TIA)
☐	☐	Chronic Lymphocytic Leukemia	☐	☐	Mental or Cognitive Disorder including Memory Loss
☐	☐	Any Disorder or Disease of the Blood	☐	☐	Heart Surgery
☐	☐	Thyroid disease	☐	☐	Confusion
☐	☐	Anemia	☐	☐	Asthma
☐	☐	Macular Degeneration	☐	☐	Mental Retardation
☐	☐	Arthritis	☐	☐	Depression
☐	☐	Rheumatoid Arthritis	☐	☐	Epilepsy
☐	☐	Osteoporosis	☐	☐	COPD
☐	☐	Fractures	☐	☐	COPD (Emphysema) with Oxygen Use
☐	☐	Fibromyalgia			
☐	☐	Heart Attack	☐	☐	Dizziness
☐	☐	Joint Replacement	☐	☐	Disorientation
☐	☐	Used a Straight Cane	☐	☐	Emphysema
☐	☐	Chest Pain	☐	☐	Paralysis
☐	☐	High Blood Pressure	☐	☐	Fainting
☐	☐	Heart Murmur	☐	☐	Falls
☐	☐	Heart Disease	☐	☐	Blurred Vision
☐	☐	Cardiomyopathy	☐	☐	Loss of Balance
☐	☐	Peripheral Vascular Disease	☐	☐	Loss of Strength
			☐	☐	Convulsions
☐	☐	Congestive Heart Failure (CHF)	☐	☐	Diabetes
			☐	☐	Ulcerative Colitis
☐	☐	Stroke	☐	☐	Crohn's Disease
☐	☐	Aneurysm	☐	☐	Chronic Hepatitis
☐	☐	Cerebrovascular Accident (CVA)	☐	☐	Cirrhosis
			☐	☐	Sarcoidosis
☐	☐	Irregular Heartbeat	☐	☐	Systemic Lupus (SLE)
☐	☐	Carotid Artery Stenosis			

Any Disease or Disorder of the:

☐	☐	Kidney	☐	☐	Liver
☐	☐	Small or Large Intestine	☐	☐	Pancreas
☐	☐	Bone and Joint	☐	☐	Gastrointestinal Tract
☐	☐	Lungs			

	Applicant 1 Yes	Applicant 1 No	Applicant 2 Yes	Applicant 2 No
9. Do you have a handicap sticker, handicap placard, or handicap license plate?.....	☐	☐	☐	☐
10. In the last 24 MONTHS, have you had to or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies?.....	☐	☐	☐	☐
11. In the last 12 MONTHS, have you had unplanned weight loss; or has any medical treatment, follow-up, diagnostic testing, or surgery been recommended, but not yet completed?.....	☐	☐	☐	☐

Applicant 1:	**Applicant 2:**
PRIMARY PHYSICIAN'S NAME:	**PRIMARY PHYSICIAN'S NAME:**
TELEPHONE NUMBER:	**TELEPHONE NUMBER:**
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____	**ADDRESS:** _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
DATE LAST CONSULTED:	**DATE LAST CONSULTED:**
REASON LAST SEEN: _____	**REASON LAST SEEN:** _____
[YOUR HEALTH INSURANCE OR PPO MEDICAL ID#] (if known):	**[YOUR HEALTH INSURANCE OR PPO MEDICAL ID#]** (if known):

Applicant 1	**List All Medications Prescribed Or Taken Within The Last 12 Months**	**Applicant 2**

12. **Give details for all Yes answers to questions 1 - 11.**

Applicant 1: ☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

Applicant 2: ☐ Check here if more space is needed, attach a signed and dated additional sheet.

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/ Medication Taken	Name of Physician Seen/ Physician's Address

Comments:

PLAN SELECTION

Rate Class Applying For:
[☐ Preferred] [☐ Standard] [☐ Class 1] [☐ Class 2] [☐ Class 3] [☐ Class 4]

Daily Benefit: [Facility] [Facility/Home Care] $_____ [Home Care $_____]
Policy Maximum Amount: $_____
Elimination Period: [☐ 0] [☐ 20] [☐ 30] [☐ 50] [☐ 60] [☐ 90] [☐ 100] [☐ 120] [☐ 150] [☐ 180] [☐ 365] Days

Benefit Increase Option: ☐ Compound 5%
[☐ Compound 3%] [☐ Simple 3%] [☐ Simple 5%] [☐ Step Rated 3%] [☐ Step Rated 5%] [☐ Tailored 5%/3%] [☐ Deferred]
[☐ Guaranteed Purchase Option]

If not selecting the 5% Compound Benefit Increase Option, you must check and sign the Rejection of 5% Compound Benefit Increase Option statement below.

☐ **Rejection of 5% Compound Benefit Increase Option:** I have reviewed the Outline of Coverage and the graphs that compare the benefits and premiums of my coverage with and without inflation protection. Specifically, I have reviewed the features of the 5% Compound Benefit Increase Option and I reject the option.

Signature of Applicant 1:_____ Signature of Applicant 2:_____

Nonforfeiture Benefit:
☐ Shortened Benefit Period

If not selecting the Nonforfeiture Benefit, you must check and sign the Rejection of Nonforfeiture Benefit statement below.

☐ **Rejection of Nonforfeiture Benefit:** I understand that if I fail to pay my premium when due or prior to the end of the grace period, my policy will lapse and I will not be eligible for any future benefits because I have chosen not to purchase the Nonforfeiture Benefit. Nevertheless, I reject the option.

Signature of Applicant 1:_____ Signature of Applicant 2:_____

Other Benefits:
[☐ Shared Care Rider – Spouse/Partner only]
[☐ Full Restoration of Benefits Rider]
[☐ Monthly Benefit Rider]
[☐ Waiver of Premium Rider - Cash Benefit]
[☐ Waiver of Premium Rider - Home Care and Adult Day Care]
[☐ Return of Premium Rider]
[☐ Survivorship Rider]
[☐ 0/10] [☐ 10/10]
[☐ Joint Waiver of Premium Rider]
[☐ Rate Guarantee _____ years]

Applicant 1:		Applicant 2:	
BENEFICIARY NAME:	**RELATIONSHIP:**	**BENEFICIARY NAME:**	**RELATIONSHIP:**
ADDRESS (Street, City, State, Zip Code)		**ADDRESS (Street, City, State, Zip Code)**	

PREMIUM PAYMENT (total premium cost may vary depending on mode of payment selected)

Applicant 1:	Applicant 2:
Initial Premium Payment: [☐ Check] [☐ EFT] [☐ Credit Card]	Initial Premium Payment: [☐ Check] [☐ EFT] [☐ Credit Card]
Recurring Payment Method: [☐ Direct Bill] [☐ List Bill] [☐ EFT] [☐ Credit Card] [☐ Payroll Deduction]	Recurring Payment Method: [☐ Direct Bill] [☐ List Bill] [☐ EFT] [☐ Credit Card] [☐ Payroll Deduction]
Premium Payment Mode: [☐ Annual] [☐ Semi-Annual] [☐ Quarterly] [☐ Monthly (available only with [EFT][and][List Bill])]	Premium Payment Mode: [☐ Annual] [☐ Semi-Annual] [☐ Quarterly] [☐ Monthly (available only with [EFT][and][List Bill])]
Premium Paying Period: [☐ Lifetime] [☐ 5 years] [☐ 10 years] [☐ 15 years] [☐ 20 years] [☐ Paid-Up to Age 65] [☐ Single Pay]	Premium Paying Period: [☐ Lifetime] [☐ 5 years] [☐ 10 years] [☐ 15 years] [☐ 20 years] [☐ Paid-Up to Age 65] [☐ Single Pay]

Applicant 1:		Applicant 2:	
Annual Premium: $	Mode Premium: $	Annual Premium: $	Mode Premium: $
Payment w/ Application: $		Payment w/ Application: $	

FAMILY HISTORY PROFILE – Please answer with biological parent information, if known

Applicant 1:

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Applicant 2:

Father: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your father have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

Mother: Age:_____ ☐ Not Applicable

☐ Living ☐ Deceased Age at Death:_____ ☐ Unknown

Did/Does your mother have any of the following illnesses?

☐ Diabetes:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Heart Disease or Stroke:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

☐ Alzheimer's or other Dementia:
Age of Onset: ☐ Less than age 45 ☐ 46 – 64 ☐ 65 or older

PROTECTION AGAINST UNINTENDED LAPSE

Applicant 1:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

Applicant 2:

I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this long term care insurance policy for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. Check the applicable box.

☐ I designate the following person to receive notice prior to cancellation of my policy for nonpayment of premium:

FULL NAME **TELEPHONE NO.**

ADDRESS

CITY **STATE** **ZIP**

☐ I elect **NOT** to designate any person to receive such notice.

AGREEMENT: I understand that I am applying for an individual long term care insurance policy and not for coverage under a group policy. I understand and agree that no agent/insurance producer or other person except an officer of Transamerica Life Insurance Company has the authority to alter or waive any of the above conditions or any questions in the application, or to determine insurability. I understand and agree that the policy will not take effect unless it is issued by the company.

STATEMENT OF RECEIPT: I certify that I have received the Outline of Coverage, "A Shopper's Guide to Long Term Care Insurance," HIPAA Privacy Notice, the Potential Rate Increase disclosure form, "Things You Should Know Before You Buy Long Term Care Insurance," the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

APPLICANT'S ACKNOWLEDGMENT OF SUITABILITY: I acknowledge that the agent/insurance producer identified in this application made the necessary inquiries concerning my insurance needs, and proposed a program of insurance that is suitable for my needs.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR POLICY, SUBJECT TO THE TIME LIMIT ON CERTAIN DEFENSES PROVISION IN THE POLICY.

ACKNOWLEDGMENT: I, the undersigned applicant, acknowledge and represent that I have read, or had read to me, the complete application. I, the applicant, represent to the best of my knowledge and belief, that I am competent and the answers contained in this application are true, complete and correctly recorded. This application will be part of the policy for which I am applying.

Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing false or deceptive information or statements is guilty of insurance fraud.

Applicant 1:		Applicant 2:	
SIGNATURE: X	DATE	SIGNATURE: X	DATE
PLACE SIGNED (City/State)		PLACE SIGNED (City/State)	
EFFECTIVE DATE (if not date of application)		EFFECTIVE DATE (if not date of application)	

SPECIAL INSTRUCTIONS: _____

AGENT/INSURANCE PRODUCER'S ACKNOWLEDGMENT OF COMPLIANCE: I certify that I personally discussed with the applicant(s) and followed the Company's written guidelines provided to me concerning comparisons of coverage and suitability in the marketing of this insurance coverage. I also certify, to the best of my knowledge and belief, that the answers contained in this application are true, complete, and correctly recorded.

AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	
AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	
AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	
AGENT/INSURANCE PRODUCER'S SIGNATURE X	AGENT/INSURANCE PRODUCER'S NAME (Print Name)	
AGENT/INSURANCE PRODUCER'S WRITING NO.	TELEPHONE NO.	DATE
E-MAIL ADDRESS	SHARE %	

FOR THE AGENT/INSURANCE PRODUCER

	Yes	No
1. Did you interview the applicant(s) in person, ask all questions, and witness signatures?.....	☐	☐
If No, please give details:_____		
2. Did you see, hear, or were you advised of any physical or cognitive impairments of the applicant(s) including but not limited to walking, speaking, any form of tremor, or any signs of confusion?	☐	☐
If Yes, please give details, including which applicant:_____		
3. To the best of your knowledge, is the information provided in this application true and complete?.....	☐	☐

LIST ANY OTHER HEALTH INSURANCE POLICIES YOU HAVE SOLD TO THE APPLICANT(S)

(1) List policies sold that are still in force; and

(2) List policies sold within the last five (5) years that are no longer in force.

APPLICANT #	COMPANY	POLICY #	TYPE OF COVERAGE	IN FORCE	LAPSE DATE
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	
Applicant: ☐ 1 ☐ 2				☐ Yes ☐ No	

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be $_____ per _____.

Type of Policy (noncancellable/guaranteed renewable): _Guaranteed Renewable_____.

The Company's Right to Increase Premiums: The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

Through various related companies the Company has sold long-term care insurance products since 1987 and has sold this policy since [2010]. The Company has requested nationwide rate increases for several previously sold policy forms (within the last 10 years) providing similar coverage. The increased rates on various policy forms are as shown in the table below.

Policy Form Series	Years Available	Rate History
3132 (00) 288, 6122 (00) 688, GLTC 2 1289, LTC 2 390, GLTC 3 1091, LTC 3 1091, IP-70-00-794, LTC 5 196, FLEX 2 196	1988 – 2001	Varies by state, but the largest increases in any state were 35% in 2003, 35% in 2005, 25% in 2007 and 25% in 2009.
GCC 1 387 CERT, LTC5 TQ 1096, FTQ 197	1987 – 2001	Varies by state, but the largest increases in any state were 35% in 2005, 25% in 2007 and 25% in 2009.
LTCP 889, GCPLUS 1290 and GCPLUS 2 1290, GCPRO 193	1990 – 2001	Varies by state, but the largest increases in any state were 30% in 2001, 45% in 2003, 35% in 2005, 29% in 2007 and 25% in 2009.
KLTCP 1 490, LI-LTCP 192, GCPRO-II 794	1990 – 2001	Varies by state, but the largest increases in any state were 45% in 2003, 35% in 2005, 29% in 2007 and 25% in 2009.

LI-LTCP TQ 197, GCPRO-III TQ 197, LI-LTCP TQ 898, GC001 796	1996 – 2003	Varies by state, but the largest increases in any state were 35% in 2005, 29% in 2007 and 25% in 2009.
1-811 11-190; 1-820 11-191 and 1-822 11-191; LTC-100 11-193; LTC 104-194	1991 – 1999	Varies by state, but the largest increases in any state were 45% in 2003, 35% in 2005 and 25% in 2009.
LTC 124-197; LTC 304-198 and LTC 305-198	1997 – 2004	Varies by state, but the largest increase in any state was 35% in 2005 and 25% in 2009.

This represents the largest increases that have been filed with and approved by various state insurance departments. Some states have allowed two (or more) smaller increases and some states have approved the increases in years different than those shown above.

Questions Related to Your Income

How will you pay each year's premium?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

❑ Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (check one)

❑ Under $10,000 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ❑ Yes ❑ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

The national average annual cost of care in [2008] was [$68,255], but this figure varies across the country. In ten years the national average annual cost would be about [$111,180] if costs increase 5% annually.

What elimination period are you considering?

Number of days_____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20,000-$30,000 ❑ $30,000-$50,000 ❑ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

❑ Stay about the same ❑ Increase ❑ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

❑ The answers to the questions above describe my financial situation. OR ❑ I choose not to complete this information, but I do wish to purchase this coverage. (Check one.)
❑ I acknowledge that the carrier and/or its agent/insurance producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed: _____ _____
(Applicant) (Date)

❑ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent/Insurance Producer) (Date)

Agent's/Insurance Producer's Printed Name: _____

Note: In order for us to process your application, please return this signed statement to Transamerica Life Insurance Company, along with your application.

❑ My agent/insurance producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Long-Term Care Insurance
Personal Worksheet

People buy long-term care insurance for many reasons. Some don't want to use their own assets to pay for long-term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long-term care insurance may be expensive, and may not be right for everyone.

By state law, the insurance company must fill out part of the information on this worksheet and **ask** you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Numbers _____

The premium for the coverage you are considering will be a one-time single premium of $ _____.

Type of Policy (noncancellable/guaranteed renewable): _Guaranteed Renewable_____.

The Company's Right to Increase Premiums: The company cannot raise your rates on this policy.

Rate Increase History

Through various affiliated companies the Company has sold long-term care insurance products since 1987 and has sold this policy since [2010]. The Company has requested nationwide rate increases for several previously sold policy forms (within the last 10 years) providing similar coverage. The increased rates on various policy forms are as shown in the table below.

Policy Form Series	Years Available	Rate History
3132 (00) 288, 6122 (00) 688, GLTC 2 1289, LTC 2 390, GLTC 3 1091, LTC 3 1091, IP-70-00-794, LTC 5 196, FLEX 2 196	1988 – 2001	Varies by state, but the largest increases in any state were 35% in 2003, 35% in 2005, 25% in 2007 and 25% in 2009.
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TQ 197, LI-LTCP TQ 898, GC001 796		any state were 35% in 2005, 29% in 2007 and 25% in 2009.
1-811 11-190; 1-820 11-191 and 1-822 11-191; LTC-100 11-193; LTC 104-194	1991 – 1999	Varies by state, but the largest increases in any state were 45% in 2003, 35% in 2005 and 25% in 2009.
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This represents the largest increases that have been filed with and approved by various state insurance departments. Some states have allowed two (or more) smaller increases and some states have approved the increases in years different than those shown above.

Questions Related to Your Income

How will you pay each year's premium?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

What is your annual income? (check one)

❑ Under $10,000 ❑ $10-20,000 ❑ $20-30,000 ❑ $30-50,000 ❑ Over $50,000

How do you expect your income to change over the next 10 years? (check one)

❑ No change ❑ Increase ❑ Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (check one) ❑ Yes ❑ No

If not, have you considered how you will pay for the difference between future costs and your daily benefit amount?

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

The national average annual cost of care in [2008] was [$68,255], but this figure varies across the country. In ten years the national average annual cost would be about [$111,180] if costs increase 5% annually.

What elimination period are you considering?

Number of days_____ Approximate cost $_____ for that period of care.

How are you planning to pay for your care during the elimination period? (check one)

❑ From my Income ❑ From my Savings\Investments ❑ My Family will Pay

Questions Related to Your Savings and Investments

Not counting your home, about how much are all of your assets (your savings and investments) worth? (check one)

❑ Under $20,000 ❑ $20,000-$30,000 ❑ $30,000-$50,000 ❑ Over $50,000

How do you expect your assets to change over the next ten years? (check one)

❑ Stay about the same ❑ Increase ❑ Decrease

If you are buying this policy to protect your assets and your assets are less than $30,000, you may wish to consider other options for financing your long-term care.

Disclosure Statement

❑ The answers to the questions above describe my financial situation. OR ❑ I choose not to complete this information, but I do wish to purchase this coverage. (Check one.)
❑ I acknowledge that the carrier and/or its agent/insurance producer (below) has reviewed this form with me including the premium, premium rate increase history and potential for premium increases in the future. I understand the above disclosures. **I understand that the rates for this policy may increase in the future.** (This box must be checked.)

Signed: _____ _____
(Applicant) (Date)

❑ I explained to the applicant the importance of completing this information.

Signed: _____ _____
(Agent/Insurance Producer) (Date)

Agent's/Insurance Producer's Printed Name: _____

Note: In order for us to process your application, please return this signed statement to Transamerica Life Insurance Company, along with your application.

❑ My agent/insurance producer has advised me that this policy does not seem to be suitable for me. However, I still want the company to consider my application.

Signed: _____ _____
(Applicant) (Date)

The company may contact you to verify your answers.

Home Office: Cedar Rapids, Iowa
Long Term Care Division
[P.O. Box 95302]
[Hurst, TX 76053-5302]
[1-800-227-3740]

Long Term Care Insurance
Potential Rate Increase Disclosure Form

Instructions:

This form provides information to the applicant regarding premium rate schedules, rate schedule adjustments, potential rate revisions, and policyholder options in the event of a rate increase.

Insurers shall provide all of the following information to the applicant:

1. **Premium Rate:** Premium rates that are applicable to you and that will be in effect until a request is made and filed and approved for an increase are on the application.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

   The company will provide a description of when premium rate or rate schedule adjustments will be effective: Next premium due date after the notification period.

4. **Potential Rate Revisions:**

   This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rates can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

   If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

   - Pay the increased premium and continue your policy in force as is.
   - Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
   - Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
   - Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a separate nonforfeiture option.)

* **Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and

- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage, (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the $1,000 annual premium for 10 years, so you have paid a total of $10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or $500 for a new annual premium of $1,500, and you decide to lapse the policy (not pay any more premiums).

- Your "paid-up" policy benefits are $10,000 (provided you have at least $10,000 of benefits remaining under your policy.)

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

Issue Age	Percent Increase Over Initial Premium
29 and under	200%
30-34	190%
35-39	170%
40-44	150%
45-49	130%
50-54	110%
55-59	90%
60	70%
61	66%
62	62%
63	58%
64	54%
65	50%
66	48%
67	46%
68	44%
69	42%
70	40%
71	38%
72	36%
73	34%
74	32%
75	30%
76	28%
77	26%
78	24%
79	22%
80	20%
81	19%
82	18%
83	17%
84	16%
85	15%
86	14%
87	13%
88	12%
89	11%
90 and over	10%

In addition to the contingent nonforfeiture benefits described above, the following reduced "paid-up" contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit when you bought your policy. If both the reduced "paid-up" benefit AND the contingent benefit described above are triggered by the same rate increase, you can choose either of the two benefits.

You are eligible for the reduced "paid-up" contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below:

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND

3. The ratio of the number of months you already paid premiums is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced "paid-up" status. That means there will be no additional premiums required. Your benefits will change in the following ways:

a. The total lifetime amount of benefits your reduced paid up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.

b. The daily benefit amounts you purchased will also be adjusted by the same ratio.

If you purchased lifetime benefits, only the daily benefit amounts you purchased will be adjusted by the applicable ratio.

Example:

You bought the policy at age 65 with an annual premium payable for 10 years.

In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.

Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your "paid-up" policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced "paid-up" policy.

Things You Should Know Before You Buy
Long - Term Care Insurance

Long-Term Care Insurance:

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare:

- Medicare does **not** pay for most long-term care.

Medicaid:

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide:

- Make sure the insurance company or agent/insurance producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling:

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state.

Facilities:

- Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Applicant should retain this Disclosure

Things You Should Know Before You Buy
Long - Term Care Insurance

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Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:*	Rate Action Information:	Attachments
Approved 10/11/2010	Rates	TLC 2-P AR 0410, TLC 2-ACCB-E 0410, TLC 2-CNFB-E 0410, TLC 2-CNFB-LP-E 0410, TLC 2-ROP-E 0410, TLC 2-RELB-E 0410, TLC 2-SC-R 0410, TLC 2-MB-R 0410, TLC 2-FROB-R 0410, TLC 2-SBIOLC-R 0410, TLC 2-CBIOLC-R 0410, TLC 2-SRBIOLC-R 0410, TLC 2-TBIOLC-R 0410, TLC 2-FCBIO-R 0410, TLC 2-FSBIO-R 0410, TLC 2-FSRBIO-R 0410, TLC 2-FTBIO-R 0410, TLC 2-DBIO-E 0410, TLC 2-GPO-E 0410,	New		AR - Uni-2 Filing Rates.pdf

TLC 2-WOPCB-R 0410, TLC 2-WOPHC-R 0410, TLC 2-JWP-R 0410, TLC 2-FSWP-R 0410, TLC 2-SWP-R 0410, TLC 2-ROP-R 0410, TLC 2-NFB-R 0410

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Single Standard 1 Premium Rates
per $10 of Daily Benefit

	Benefit Periods*						
	365 Days	730 Days	1095 Days	1460 Days	1825 Days	2190 Days	Unlimited
Facility Benefit	42.67	56.89	66.01	74.79	84.56	99.82	111.85
Home Health Care	17.41	23.22	26.94	30.53	34.51	40.74	45.65

* Benefit Periods between years are interpolated between full year benefit periods

Example: Rate for a 1,000 day BP would be calculated as follows:

730 day rate x (1095 - 1000) / (1095 - 730) + 1095 day rate x (1000 - 730) / (1095 - 730)

56.89 x (95 / 365) + 66.01 x (270 / 365) = 63.64

Unlimited is assumed to be 3650 days for purposes of interpolating.

Single Standard Underwriting Factors	
Class	Rate
Standard 0	0.95
Standard 1	1.00
Standard 2	1.05

Preferred Underwriting Discounts	
Class	Rate
Discount 1	10%
Discount 2	15%
Discount 3	20%

Married Spouse Not Applying Discount:	15%
Married Discount:	30%

Select Classes	
Class I	1.25
Class II	1.50
Class III	1.75
Class IV	2.00
Class V	3.00

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Elimination Period Factors

	Elimination Period										
Benefit	0 Day	20 Day	30 Day	50 Day	60 Day	90 Day	100 Day	120 Day	150 Day	180 Day	365 Day
Facility	1.40	1.30	1.25	1.18	1.15	1.00	0.98	0.95	0.90	0.85	0.80
HHC	1.00	0.91	0.87	0.81	0.78	0.65	0.64	0.61	0.58	0.54	0.50

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Age Factors

Issue Age	Non-Lifetime Benefit Periods	Lifetime Benefit Period
0	0.36	0.36
31	0.36	0.36
32	0.36	0.36
33	0.36	0.36
34	0.36	0.36
35	0.37	0.36
36	0.37	0.36
37	0.37	0.36
38	0.39	0.38
39	0.40	0.39
40	0.42	0.41
41	0.44	0.42
42	0.45	0.44
43	0.46	0.45
44	0.47	0.47
45	0.48	0.48
46	0.49	0.50
47	0.50	0.51
48	0.52	0.53
49	0.53	0.54
50	0.54	0.56
51	0.56	0.57
52	0.57	0.59
53	0.60	0.63
54	0.62	0.66
55	0.65	0.70
56	0.67	0.73
57	0.70	0.77
58	0.77	0.84
59	0.83	0.91
60	0.90	0.97
61	0.96	1.04
62	1.03	1.11
63	1.13	1.22
64	1.24	1.34
65	1.34	1.45
66	1.45	1.57
67	1.55	1.68
68	1.74	1.87
69	1.94	2.06
70	2.13	2.25
71	2.33	2.43
72	2.52	2.62
73	2.89	3.04
74	3.26	3.45
75	3.62	3.87
76	3.99	4.28
77	4.36	4.70
78	5.10	5.37
79	5.83	6.04
80	6.57	6.71
81	7.31	7.38
82	8.05	8.05
83	8.83	8.78
84	9.61	9.51
85	10.40	10.24
86	11.18	10.98
87	11.96	11.71
88	12.71	12.41
89	13.46	13.11
90	14.21	13.80
91	14.96	14.50
92	15.71	15.20
93	17.02	16.44
94	18.32	17.67
95	19.63	18.91
96	20.93	20.14
97	22.24	21.38
98	23.45	22.60
99	24.67	23.82
100	25.88	25.02

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Miscellaneous Riders

Rider		Rate
Monthly Benefit	=	9.25% of the entire rate
Waiver of Premium - Cash Benefit Only	=	3.5% of the Home Health Care rate
Waiver of Premium - Home Care and Adult Day Care	=	1.5% of the Home Health Care rate
Nonforfeiture Benefit - Shortened Benefit Period	=	10% of the entire rate
Joint Waiver of Premium	=	2% of the entire rate
Rate Guarantee	=	2% for each year of guarantee beyond 5 years (e.g. 10-yr guarantee is 10%)

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Shared Care Rider

Benefit Period		Rate
1 Year	=	32%
2 Year	=	28%
3 Year	=	17%
4 Year	=	12%
5 Year	=	9%
6 Year	=	7%
7 Year	=	6%
8 Year	=	4%
9 Year	=	3%
Lifetime	=	0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Restoration of Benefits

Benefit Period	Rate
1 Year	9%
2 Year	6%
3 Year	5%
4 Year	4%
5+ Year *	3%

* Does not apply to Unlimited Benefit Period

Survivorship Rider

Minimum Number of Years With No Death Nor Claims				
Issue Age		**0/0**		**10/10**
< 66		20.0%		15.0%
>= 66		25.0%		15.0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Return of Premium Upon Death Rider

Issue Age	Rate
18 - 30	20%
31	20%
32	20%
33	20%
34	20%
35	21%
36	21%
37	21%
38	21%
39	22%
40	22%
41	23%
42	23%
43	24%
44	25%
45	26%
46	27%
47	28%
48	29%
49	31%
50	32%
51	34%
52	35%
53	37%
54	39%
55	40%
56	42%
57	44%
58	46%
59	48%
60	51%
61	53%
62	55%
63	58%
64	61%
65	64%
66	67%
67	70%
68	74%
69	79%
70	83%
71	88%
72	92%
73	98%
74	104%
75	109%
76	115%
77	121%
78	127%
79	133%
80	138%
81	144%
82	150%
83	156%
84	162%
85	168%
86	174%
87	180%
88	187%
89	194%
90	201%
91	208%
92	215%
93	223%
94	231%
95	239%
96	247%
97	255%
98	263%
99	273%
100 +	283%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Limited Pay Factors

Issue Age	1 Pay	5 Pay	10 Pay	15 Pay	20 Pay	Paid Up at 65
0	33.22	7.71	3.85	3.07	2.38	1.75
31	33.22	7.71	3.85	3.07	2.38	1.75
32	33.22	7.71	3.85	3.07	2.38	1.75
33	33.22	7.71	3.82	3.02	2.36	1.77
34	33.22	7.71	3.79	2.98	2.34	1.79
35	33.22	7.71	3.76	2.93	2.32	1.80
36	33.22	7.71	3.73	2.89	2.31	1.82
37	33.22	7.71	3.71	2.85	2.29	1.84
38	32.84	7.63	3.66	2.80	2.27	1.85
39	32.46	7.55	3.61	2.76	2.25	1.87
40	32.08	7.46	3.57	2.72	2.23	1.89
41	31.70	7.38	3.52	2.67	2.21	1.90
42	31.32	7.30	3.48	2.63	2.20	1.92
43	30.95	7.17	3.41	2.58	2.17	1.97
44	30.58	7.03	3.35	2.54	2.14	2.02
45	30.21	6.90	3.29	2.50	2.11	2.11
46	29.83	6.76	3.22	2.45	2.08	2.13
47	29.46	6.63	3.16	2.41	2.05	2.16
48	28.97	6.46	3.10	2.36	2.02	2.19
49	28.49	6.29	3.05	2.30	2.00	2.22
50	28.00	6.12	2.99	2.25	1.97	2.25
51	27.51	5.95	2.94	2.19	1.95	2.34
52	27.02	5.78	2.88	2.14	1.92	2.42
53	26.37	5.65	2.82	2.09	1.88	2.51
54	25.72	5.52	2.75	2.04	1.84	2.60
55	25.07	5.38	2.69	2.00	1.80	2.69
56	24.41	5.25	2.62	1.95	1.76	3.08
57	23.76	5.11	2.56	1.90	1.72	3.48
58	23.00	4.97	2.48	1.86	1.67	3.88
59	22.25	4.82	2.41	1.82	1.62	4.28
60	21.49	4.67	2.34	1.78	1.56	4.67
61	20.74	4.53	2.27	1.73	1.51	0.00
62	19.98	4.38	2.20	1.69	1.46	0.00
63	19.14	4.22	2.13	1.62	1.41	0.00
64	18.30	4.07	2.07	1.55	1.36	0.00
65	17.45	3.91	2.00	1.48	1.30	0.00
66	16.61	3.76	1.93	1.41	1.25	0.00
67	15.77	3.60	1.86	1.34	1.20	0.00
68	15.10	3.42	1.81	1.28	1.17	0.00
69	14.42	3.23	1.75	1.22	1.13	0.00
70	13.75	3.05	1.70	1.15	1.10	0.00
71	13.07	2.86	1.64	1.09	1.07	0.00
72	12.40	2.68	1.59	1.02	1.04	0.00
73	11.71	2.53	1.53	1.02	1.03	0.00
74	11.02	2.37	1.47	1.02	1.03	0.00
75	10.32	2.22	1.42	1.02	1.02	0.00
76	9.63	2.07	1.36	1.01	1.02	0.00
77	8.94	1.92	1.30	1.01	1.01	0.00
78	8.70	1.81	1.26	1.01	1.01	0.00
79	8.47	1.71	1.21	1.01	1.01	0.00
80	8.23	1.61	1.16	1.01	1.01	0.00
81	8.00	1.51	1.12	1.01	1.01	0.00
82	7.76	1.40	1.07	1.01	1.01	0.00
83	7.71	1.36	1.06	1.01	1.01	0.00
84	7.67	1.32	1.05	1.01	1.01	0.00
85	7.62	1.28	1.04	1.01	1.01	0.00
86	7.58	1.24	1.03	1.01	1.01	0.00
87	7.53	1.20	1.02	1.01	1.01	0.00
88	7.51	1.18	1.02	1.01	1.01	0.00
89	7.49	1.17	1.02	1.01	1.01	0.00
90	7.46	1.16	1.01	1.01	1.01	0.00
91	7.44	1.14	1.01	1.01	1.01	0.00
92	7.42	1.13	1.01	1.01	1.01	0.00
93	7.40	1.12	1.01	1.01	1.01	0.00
94	7.38	1.11	1.01	1.01	1.01	0.00
95	7.35	1.09	1.01	1.01	1.01	0.00
96	7.33	1.08	1.01	1.01	1.01	0.00
97	7.31	1.07	1.01	1.01	1.01	0.00
98	7.29	1.05	1.01	1.01	1.01	0.00
99	7.26	1.03	1.01	1.01	1.01	0.00
100	7.24	1.01	1.01	1.01	1.01	0.00

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Benefit Increase Option Factors for 1- Year and 2-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	96%	56%	230%	97%	135%	48%	26%
31	96%	56%	230%	97%	135%	48%	26%
32	96%	56%	230%	97%	135%	48%	26%
33	96%	56%	229%	97%	134%	48%	26%
34	96%	56%	228%	97%	134%	48%	26%
35	96%	56%	227%	97%	134%	48%	26%
36	96%	56%	226%	97%	134%	48%	26%
37	96%	56%	225%	97%	134%	48%	26%
38	96%	56%	225%	97%	134%	48%	26%
39	96%	56%	225%	97%	133%	48%	26%
40	96%	56%	225%	97%	133%	48%	26%
41	96%	56%	225%	97%	133%	48%	26%
42	96%	56%	224%	97%	133%	48%	26%
43	96%	56%	224%	97%	129%	48%	26%
44	96%	56%	224%	97%	125%	48%	26%
45	96%	56%	224%	97%	121%	48%	26%
46	96%	56%	224%	97%	118%	48%	26%
47	96%	56%	223%	97%	114%	48%	26%
48	96%	56%	220%	97%	110%	47%	26%
49	96%	56%	216%	97%	106%	47%	26%
50	96%	56%	213%	97%	102%	46%	26%
51	96%	56%	209%	97%	99%	46%	26%
52	96%	56%	206%	97%	95%	45%	26%
53	95%	55%	199%	94%	90%	44%	26%
54	95%	55%	192%	92%	85%	43%	25%
55	94%	55%	186%	89%	81%	42%	25%
56	93%	54%	179%	87%	76%	41%	25%
57	92%	54%	173%	84%	71%	40%	25%
58	90%	53%	167%	82%	66%	38%	23%
59	88%	52%	160%	79%	62%	36%	21%
60	86%	51%	154%	76%	57%	34%	20%
61	84%	50%	148%	74%	52%	32%	18%
62	82%	49%	142%	71%	47%	30%	16%
63	78%	47%	134%	67%	43%	27%	14%
64	74%	46%	127%	63%	38%	24%	13%
65	70%	45%	119%	59%	33%	22%	11%
66	66%	43%	111%	55%	28%	19%	10%
67	62%	42%	103%	51%	24%	16%	8%
68	58%	40%	96%	49%	20%	15%	8%
69	53%	38%	89%	46%	17%	14%	7%
70	48%	37%	81%	43%	14%	13%	7%
71	43%	35%	74%	40%	11%	12%	6%
72	39%	33%	67%	37%	8%	11%	6%
73	37%	31%	63%	35%	6%	10%	5%
74	35%	30%	59%	33%	5%	9%	5%
75	33%	28%	56%	31%	3%	8%	4%
76	31%	27%	52%	29%	2%	7%	4%
77	29%	25%	48%	27%	0%	6%	3%
78	28%	24%	45%	25%	0%	5%	3%
79	26%	23%	42%	24%	0%	5%	3%
80	25%	21%	39%	22%	0%	5%	3%
81	23%	20%	36%	21%	0%	5%	3%
82	22%	19%	33%	19%	0%	4%	2%
83	21%	18%	31%	18%	0%	4%	2%
84	20%	18%	31%	17%	0%	3%	2%
85	19%	17%	29%	16%	0%	3%	1%
86	18%	15%	27%	16%	0%	2%	1%
87	17%	15%	26%	15%	0%	1%	1%
88	17%	14%	25%	14%	0%	1%	1%
89	16%	13%	24%	13%	0%	1%	1%
90	15%	13%	22%	13%	0%	1%	1%
91	15%	12%	21%	12%	0%	1%	1%
92	14%	12%	20%	12%	0%	1%	0%
93	13%	11%	19%	11%	0%	1%	0%
94	13%	11%	18%	11%	0%	1%	0%
95	12%	11%	18%	10%	0%	1%	0%
96	12%	10%	17%	10%	0%	1%	0%
97	12%	10%	16%	9%	0%	1%	0%
98	11%	9%	15%	9%	0%	1%	0%
99	11%	9%	15%	8%	0%	1%	0%
100	10%	9%	14%	8%	0%	1%	0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Benefit Increase Option Factors for 3-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	99%	57%	248%	97%	135%	47%	25%
31	99%	57%	248%	97%	135%	47%	25%
32	99%	57%	248%	97%	135%	47%	25%
33	99%	57%	248%	97%	134%	47%	25%
34	99%	57%	248%	97%	134%	47%	25%
35	99%	57%	248%	97%	134%	47%	25%
36	99%	57%	248%	97%	134%	47%	25%
37	99%	57%	248%	97%	134%	47%	25%
38	99%	57%	248%	97%	134%	47%	25%
39	99%	57%	248%	97%	133%	47%	25%
40	99%	57%	248%	97%	133%	47%	25%
41	99%	57%	248%	97%	133%	47%	25%
42	99%	57%	248%	97%	133%	47%	25%
43	99%	56%	245%	97%	129%	47%	25%
44	99%	56%	242%	97%	125%	47%	25%
45	99%	56%	240%	97%	121%	47%	25%
46	99%	56%	237%	97%	118%	46%	25%
47	99%	56%	234%	97%	114%	46%	25%
48	99%	56%	231%	97%	110%	46%	25%
49	99%	56%	227%	97%	106%	46%	25%
50	99%	56%	223%	97%	102%	46%	25%
51	99%	56%	219%	97%	99%	45%	25%
52	99%	56%	216%	97%	95%	45%	25%
53	98%	55%	209%	95%	90%	44%	25%
54	98%	55%	202%	92%	85%	43%	25%
55	97%	55%	195%	90%	81%	42%	25%
56	96%	54%	188%	88%	76%	41%	25%
57	95%	54%	181%	86%	71%	40%	25%
58	93%	53%	175%	83%	66%	38%	25%
59	91%	52%	169%	80%	62%	35%	25%
60	89%	51%	162%	77%	57%	33%	24%
61	87%	50%	156%	75%	52%	31%	24%
62	85%	49%	149%	72%	47%	28%	24%
63	81%	47%	141%	68%	43%	26%	21%
64	78%	46%	133%	64%	38%	24%	18%
65	74%	45%	125%	61%	33%	21%	15%
66	70%	43%	117%	57%	28%	19%	12%
67	66%	42%	109%	53%	24%	16%	10%
68	61%	40%	101%	50%	20%	15%	9%
69	57%	38%	93%	47%	17%	14%	8%
70	52%	37%	86%	43%	14%	13%	7%
71	47%	35%	78%	40%	11%	12%	6%
72	43%	33%	71%	37%	8%	11%	6%
73	40%	31%	67%	35%	6%	10%	5%
74	38%	30%	63%	33%	5%	9%	5%
75	35%	28%	59%	31%	3%	8%	4%
76	33%	27%	55%	29%	2%	7%	4%
77	31%	25%	51%	27%	0%	6%	3%
78	29%	24%	48%	25%	0%	5%	3%
79	28%	23%	45%	24%	0%	5%	3%
80	26%	21%	42%	22%	0%	5%	3%
81	24%	20%	38%	21%	0%	5%	2%
82	23%	19%	35%	19%	0%	4%	2%
83	22%	18%	33%	18%	0%	4%	2%
84	21%	18%	32%	17%	0%	3%	2%
85	20%	17%	30%	16%	0%	3%	1%
86	19%	15%	28%	16%	0%	2%	1%
87	18%	15%	27%	15%	0%	1%	1%
88	18%	14%	26%	14%	0%	1%	1%
89	17%	13%	25%	13%	0%	1%	1%
90	16%	13%	23%	13%	0%	1%	1%
91	15%	12%	22%	12%	0%	1%	0%
92	15%	12%	21%	12%	0%	1%	0%
93	14%	11%	20%	11%	0%	1%	0%
94	14%	11%	19%	11%	0%	1%	0%
95	13%	11%	19%	10%	0%	1%	0%
96	12%	10%	18%	10%	0%	1%	0%
97	12%	10%	17%	9%	0%	1%	0%
98	11%	9%	16%	9%	0%	1%	0%
99	11%	9%	16%	8%	0%	1%	0%
100	11%	9%	15%	8%	0%	1%	0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Benefit Increase Option Factors for 4-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	108%	65%	271%	110%	152%	53%	28%
31	108%	65%	271%	110%	152%	53%	28%
32	108%	65%	271%	110%	152%	53%	28%
33	108%	65%	269%	110%	152%	53%	28%
34	108%	65%	268%	110%	151%	53%	28%
35	108%	65%	267%	110%	151%	53%	28%
36	108%	65%	266%	110%	151%	53%	28%
37	108%	65%	265%	110%	151%	53%	28%
38	108%	65%	264%	110%	151%	53%	28%
39	108%	65%	263%	110%	150%	53%	28%
40	108%	65%	261%	110%	150%	53%	28%
41	108%	65%	260%	110%	150%	53%	28%
42	108%	65%	259%	110%	150%	53%	28%
43	108%	65%	259%	110%	145%	53%	28%
44	108%	65%	259%	110%	139%	53%	28%
45	108%	65%	259%	110%	134%	53%	28%
46	108%	65%	258%	110%	129%	53%	28%
47	108%	65%	258%	110%	123%	53%	28%
48	108%	65%	254%	110%	119%	53%	28%
49	108%	65%	250%	110%	116%	53%	28%
50	108%	65%	246%	110%	112%	53%	28%
51	108%	65%	242%	110%	108%	53%	28%
52	108%	65%	238%	110%	104%	52%	28%
53	107%	65%	231%	108%	100%	51%	28%
54	105%	64%	224%	105%	95%	49%	28%
55	104%	64%	217%	102%	90%	48%	28%
56	103%	63%	210%	99%	85%	46%	28%
57	102%	63%	203%	97%	81%	44%	28%
58	99%	61%	193%	93%	74%	42%	27%
59	97%	60%	184%	89%	68%	40%	26%
60	95%	58%	175%	85%	62%	37%	26%
61	93%	56%	166%	82%	55%	35%	25%
62	91%	55%	157%	78%	49%	32%	24%
63	86%	53%	148%	74%	44%	29%	21%
64	81%	51%	139%	70%	39%	26%	18%
65	77%	49%	130%	66%	34%	23%	15%
66	72%	47%	121%	61%	29%	19%	11%
67	67%	46%	112%	57%	24%	16%	8%
68	63%	44%	105%	54%	21%	15%	8%
69	58%	42%	99%	51%	18%	14%	7%
70	54%	40%	92%	48%	15%	13%	7%
71	49%	38%	85%	46%	12%	12%	6%
72	45%	36%	79%	43%	9%	11%	6%
73	42%	34%	74%	40%	7%	10%	5%
74	39%	33%	70%	37%	5%	9%	5%
75	36%	31%	65%	35%	4%	8%	4%
76	32%	29%	61%	32%	2%	7%	4%
77	29%	28%	56%	30%	0%	6%	3%
78	28%	26%	53%	28%	0%	5%	3%
79	26%	25%	50%	26%	0%	5%	3%
80	25%	23%	46%	24%	0%	5%	3%
81	23%	22%	43%	23%	0%	5%	2%
82	22%	20%	39%	21%	0%	4%	2%
83	21%	19%	37%	20%	0%	4%	2%
84	20%	19%	36%	19%	0%	3%	2%
85	19%	18%	33%	18%	0%	3%	1%
86	19%	17%	31%	18%	0%	2%	1%
87	17%	17%	30%	17%	0%	1%	1%
88	17%	16%	29%	15%	0%	1%	1%
89	16%	14%	28%	14%	0%	1%	1%
90	15%	14%	25%	14%	0%	1%	1%
91	15%	13%	24%	13%	0%	1%	0%
92	14%	13%	23%	13%	0%	1%	0%
93	13%	12%	22%	12%	0%	1%	0%
94	13%	12%	21%	12%	0%	1%	0%
95	12%	12%	21%	11%	0%	1%	0%
96	12%	11%	20%	11%	0%	1%	0%
97	12%	11%	18%	10%	0%	1%	0%
98	11%	10%	17%	10%	0%	1%	0%
99	11%	10%	17%	9%	0%	1%	0%
100	10%	10%	16%	9%	0%	1%	0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Benefit Increase Option Factors for 5-Year Benefit Period

Issue Age	Simple 5%	Simple 3%	Compound 5%	Compound 3%	Tailored 5%	Step-Rate Compound 5%	Step-Rate Compound 3%
0	108%	65%	271%	100%	139%	50%	28%
31	108%	65%	271%	100%	139%	50%	28%
32	108%	65%	271%	100%	139%	50%	28%
33	108%	65%	269%	100%	139%	50%	28%
34	108%	65%	268%	100%	139%	50%	28%
35	108%	65%	267%	100%	139%	50%	28%
36	108%	65%	266%	100%	139%	50%	28%
37	108%	65%	265%	100%	138%	50%	28%
38	108%	65%	264%	100%	138%	50%	28%
39	108%	65%	263%	100%	138%	50%	28%
40	108%	65%	261%	100%	138%	50%	28%
41	108%	65%	260%	100%	138%	50%	28%
42	108%	65%	259%	100%	138%	50%	28%
43	108%	65%	259%	100%	132%	50%	28%
44	108%	65%	259%	100%	127%	50%	28%
45	108%	65%	259%	100%	122%	50%	28%
46	108%	65%	258%	100%	117%	50%	28%
47	108%	65%	258%	100%	112%	50%	28%
48	108%	65%	254%	100%	108%	49%	28%
49	108%	65%	250%	100%	105%	49%	28%
50	108%	65%	246%	100%	101%	49%	28%
51	108%	65%	242%	100%	97%	48%	28%
52	108%	65%	238%	100%	94%	48%	28%
53	107%	65%	231%	97%	89%	47%	28%
54	105%	64%	224%	95%	85%	46%	28%
55	104%	64%	217%	92%	81%	45%	28%
56	103%	63%	210%	89%	76%	44%	28%
57	102%	63%	203%	87%	72%	43%	28%
58	99%	61%	193%	83%	66%	41%	27%
59	97%	60%	184%	80%	60%	39%	26%
60	95%	58%	175%	76%	54%	37%	26%
61	93%	56%	166%	73%	48%	34%	25%
62	91%	55%	157%	69%	42%	32%	24%
63	86%	53%	148%	65%	37%	29%	21%
64	81%	51%	139%	61%	32%	26%	18%
65	77%	49%	130%	57%	27%	23%	15%
66	72%	47%	121%	53%	23%	20%	11%
67	67%	46%	112%	49%	18%	17%	8%
68	63%	44%	105%	47%	15%	16%	8%
69	58%	42%	99%	44%	12%	15%	7%
70	54%	40%	92%	41%	9%	13%	7%
71	49%	38%	85%	38%	6%	12%	6%
72	45%	36%	79%	35%	4%	11%	6%
73	42%	34%	74%	33%	3%	10%	5%
74	39%	33%	70%	31%	2%	9%	5%
75	36%	31%	65%	28%	1%	8%	4%
76	32%	29%	61%	26%	1%	7%	4%
77	29%	28%	56%	23%	0%	6%	3%
78	28%	26%	53%	22%	0%	5%	3%
79	26%	25%	50%	20%	0%	5%	3%
80	25%	23%	46%	19%	0%	5%	3%
81	23%	22%	43%	18%	0%	5%	2%
82	22%	20%	39%	16%	0%	4%	2%
83	21%	19%	37%	15%	0%	4%	2%
84	20%	19%	36%	15%	0%	3%	2%
85	19%	18%	33%	14%	0%	3%	1%
86	19%	17%	31%	14%	0%	2%	1%
87	17%	17%	30%	13%	0%	1%	1%
88	17%	16%	29%	12%	0%	1%	1%
89	16%	14%	28%	11%	0%	1%	1%
90	15%	14%	25%	11%	0%	1%	1%
91	15%	13%	24%	10%	0%	1%	0%
92	14%	13%	23%	10%	0%	1%	0%
93	13%	12%	22%	9%	0%	1%	0%
94	13%	12%	21%	9%	0%	1%	0%
95	12%	12%	21%	9%	0%	1%	0%
96	12%	11%	20%	9%	0%	1%	0%
97	12%	11%	18%	8%	0%	1%	0%
98	11%	10%	17%	8%	0%	1%	0%
99	11%	10%	17%	7%	0%	1%	0%
100	10%	10%	16%	7%	0%	1%	0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Benefit Increase Option Factors for Benefit Periods Greater Than 5 Years

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	186%	100%	444%	201%	199%	92%	55%
31	186%	100%	444%	201%	199%	92%	55%
32	186%	100%	444%	201%	199%	92%	55%
33	186%	100%	444%	201%	199%	92%	55%
34	186%	100%	443%	201%	198%	92%	55%
35	186%	100%	443%	200%	198%	92%	55%
36	186%	100%	442%	200%	197%	92%	55%
37	186%	100%	442%	199%	197%	92%	55%
38	185%	100%	440%	198%	197%	92%	55%
39	184%	100%	438%	197%	196%	92%	55%
40	183%	100%	436%	196%	196%	92%	55%
41	182%	100%	434%	195%	195%	92%	55%
42	181%	100%	432%	194%	195%	92%	55%
43	179%	99%	424%	191%	187%	91%	55%
44	178%	99%	416%	188%	179%	90%	55%
45	176%	99%	408%	185%	171%	89%	54%
46	174%	98%	400%	182%	163%	88%	54%
47	172%	98%	392%	179%	155%	87%	54%
48	171%	96%	381%	176%	148%	85%	53%
49	169%	94%	371%	173%	141%	84%	52%
50	168%	91%	360%	170%	134%	82%	51%
51	166%	89%	350%	167%	127%	81%	51%
52	164%	87%	339%	164%	120%	79%	50%
53	162%	85%	326%	160%	114%	76%	49%
54	159%	84%	312%	156%	108%	73%	47%
55	157%	83%	298%	152%	102%	70%	46%
56	154%	81%	285%	148%	96%	67%	45%
57	151%	80%	271%	144%	90%	64%	43%
58	147%	78%	260%	139%	84%	61%	41%
59	142%	77%	250%	134%	78%	57%	40%
60	138%	75%	239%	128%	72%	54%	38%
61	133%	73%	229%	123%	66%	50%	36%
62	128%	72%	218%	118%	60%	47%	34%
63	124%	70%	209%	113%	54%	43%	32%
64	120%	68%	200%	109%	48%	38%	29%
65	117%	66%	190%	104%	42%	34%	27%
66	113%	64%	181%	100%	36%	30%	25%
67	109%	63%	172%	95%	30%	25%	23%
68	104%	60%	163%	91%	26%	24%	21%
69	100%	58%	155%	87%	22%	22%	20%
70	96%	56%	146%	83%	17%	21%	19%
71	92%	54%	138%	79%	13%	20%	17%
72	88%	51%	129%	75%	9%	18%	16%
73	84%	49%	123%	72%	7%	17%	15%
74	80%	47%	117%	69%	5%	16%	15%
75	77%	45%	111%	66%	4%	15%	14%
76	73%	43%	105%	63%	2%	14%	14%
77	69%	41%	99%	60%	0%	13%	13%
78	66%	39%	93%	57%	0%	12%	13%
79	62%	37%	87%	53%	0%	12%	12%
80	58%	35%	81%	50%	0%	11%	11%
81	55%	33%	74%	46%	0%	10%	11%
82	51%	31%	68%	42%	0%	10%	10%
83	49%	29%	64%	40%	0%	8%	9%
84	47%	29%	62%	38%	0%	7%	7%
85	46%	27%	58%	36%	0%	6%	6%
86	44%	25%	54%	36%	0%	5%	5%
87	40%	25%	52%	33%	0%	3%	3%
88	40%	23%	50%	31%	0%	3%	3%
89	38%	22%	48%	29%	0%	3%	3%
90	36%	22%	44%	29%	0%	2%	2%
91	35%	20%	42%	27%	0%	2%	2%
92	33%	20%	40%	27%	0%	2%	2%
93	31%	18%	38%	25%	0%	2%	2%
94	31%	18%	36%	25%	0%	2%	2%
95	29%	18%	36%	22%	0%	2%	2%
96	27%	16%	34%	22%	0%	2%	2%
97	27%	16%	32%	20%	0%	2%	2%
98	26%	14%	30%	20%	0%	2%	2%
99	26%	14%	30%	18%	0%	2%	2%
100	24%	14%	28%	18%	0%	2%	2%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Full Benefit Increase Option Factors for 1-Year and 2-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	111%	68%	288%	132%	176%	74%	36%
31	111%	68%	288%	132%	176%	74%	36%
32	111%	68%	288%	132%	176%	74%	36%
33	111%	68%	287%	132%	176%	74%	36%
34	111%	68%	286%	132%	176%	74%	36%
35	111%	68%	284%	132%	176%	74%	36%
36	111%	68%	283%	132%	175%	74%	36%
37	111%	68%	282%	132%	175%	74%	36%
38	111%	68%	282%	132%	175%	74%	36%
39	111%	68%	282%	132%	175%	74%	36%
40	111%	68%	282%	132%	174%	74%	36%
41	111%	68%	282%	132%	174%	74%	36%
42	111%	68%	282%	132%	174%	74%	36%
43	111%	68%	277%	130%	167%	72%	36%
44	111%	68%	273%	127%	160%	70%	36%
45	111%	68%	269%	125%	152%	68%	36%
46	111%	68%	264%	122%	145%	66%	35%
47	111%	68%	260%	120%	138%	65%	35%
48	111%	68%	255%	119%	133%	64%	35%
49	111%	68%	250%	118%	128%	63%	35%
50	111%	68%	246%	118%	124%	62%	35%
51	111%	68%	241%	117%	119%	61%	35%
52	111%	68%	236%	116%	114%	60%	35%
53	111%	68%	229%	114%	109%	59%	35%
54	110%	67%	222%	111%	104%	58%	35%
55	109%	67%	214%	108%	99%	56%	35%
56	108%	66%	207%	105%	93%	55%	35%
57	107%	66%	200%	103%	88%	54%	35%
58	105%	65%	192%	99%	82%	52%	33%
59	103%	64%	185%	96%	77%	50%	31%
60	101%	62%	178%	92%	71%	47%	30%
61	99%	61%	170%	89%	66%	45%	28%
62	97%	60%	163%	86%	60%	43%	26%
63	91%	57%	153%	80%	54%	39%	23%
64	84%	54%	143%	75%	48%	34%	20%
65	78%	51%	133%	69%	41%	30%	17%
66	72%	48%	123%	64%	35%	26%	14%
67	66%	45%	112%	58%	29%	22%	11%
68	61%	43%	105%	55%	26%	20%	10%
69	57%	42%	97%	52%	23%	19%	10%
70	52%	40%	89%	49%	19%	18%	9%
71	47%	38%	82%	46%	16%	17%	9%
72	42%	36%	74%	43%	13%	16%	8%
73	40%	35%	70%	41%	10%	15%	8%
74	38%	33%	67%	39%	8%	14%	7%
75	36%	31%	63%	37%	5%	12%	7%
76	34%	30%	59%	35%	3%	11%	6%
77	32%	28%	55%	33%	0%	10%	6%
78	31%	27%	52%	31%	0%	10%	5%
79	29%	25%	48%	29%	0%	9%	5%
80	27%	24%	45%	27%	0%	9%	5%
81	26%	22%	41%	25%	0%	8%	5%
82	24%	21%	38%	23%	0%	8%	4%
83	23%	20%	36%	22%	0%	7%	4%
84	22%	20%	35%	21%	0%	6%	3%
85	21%	18%	32%	19%	0%	5%	3%
86	20%	17%	30%	19%	0%	4%	2%
87	19%	17%	29%	18%	0%	3%	1%
88	19%	16%	28%	17%	0%	2%	1%
89	18%	15%	27%	16%	0%	2%	1%
90	17%	15%	25%	16%	0%	2%	1%
91	16%	14%	24%	15%	0%	2%	1%
92	15%	14%	22%	15%	0%	1%	1%
93	14%	12%	21%	13%	0%	1%	1%
94	14%	12%	20%	13%	0%	1%	1%
95	14%	12%	20%	12%	0%	1%	1%
96	13%	11%	19%	12%	0%	1%	1%
97	13%	11%	18%	11%	0%	1%	1%
98	12%	10%	17%	11%	0%	1%	1%
99	12%	10%	17%	10%	0%	1%	1%
100	11%	10%	16%	10%	0%	1%	1%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Full Benefit Increase Option Factors for 3-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	108%	64%	291%	122%	163%	65%	30%
31	108%	64%	291%	122%	163%	65%	30%
32	108%	64%	291%	122%	163%	65%	30%
33	108%	64%	291%	121%	163%	65%	30%
34	108%	64%	291%	121%	163%	65%	30%
35	108%	64%	290%	121%	163%	65%	30%
36	108%	64%	290%	121%	162%	65%	30%
37	108%	64%	290%	121%	162%	65%	30%
38	108%	64%	290%	121%	162%	65%	30%
39	108%	64%	290%	121%	162%	65%	30%
40	108%	64%	290%	121%	162%	65%	30%
41	108%	64%	290%	121%	161%	65%	30%
42	108%	64%	290%	121%	161%	65%	30%
43	108%	64%	284%	119%	155%	63%	30%
44	108%	64%	277%	117%	148%	62%	31%
45	108%	63%	271%	115%	142%	60%	31%
46	108%	63%	265%	113%	136%	59%	31%
47	108%	63%	258%	111%	129%	57%	31%
48	108%	63%	253%	111%	124%	56%	31%
49	108%	63%	248%	110%	119%	55%	31%
50	108%	63%	242%	109%	115%	54%	31%
51	108%	63%	237%	108%	110%	53%	31%
52	108%	63%	232%	107%	105%	52%	31%
53	108%	63%	225%	104%	100%	51%	31%
54	107%	62%	217%	102%	95%	50%	31%
55	106%	62%	210%	100%	90%	49%	31%
56	105%	61%	203%	97%	85%	48%	31%
57	104%	61%	196%	95%	80%	47%	31%
58	102%	60%	189%	92%	75%	45%	31%
59	100%	59%	182%	89%	70%	42%	30%
60	98%	58%	175%	86%	65%	40%	30%
61	96%	57%	169%	84%	60%	37%	30%
62	94%	56%	162%	81%	55%	35%	30%
63	89%	53%	153%	76%	49%	32%	26%
64	84%	51%	143%	72%	44%	29%	23%
65	80%	49%	134%	67%	39%	26%	19%
66	75%	47%	125%	63%	33%	23%	16%
67	70%	45%	116%	58%	28%	20%	12%
68	65%	43%	108%	55%	25%	19%	11%
69	60%	42%	100%	52%	21%	18%	11%
70	56%	40%	92%	48%	18%	17%	10%
71	51%	38%	84%	45%	15%	16%	9%
72	46%	36%	76%	42%	12%	14%	8%
73	44%	35%	72%	40%	9%	13%	8%
74	41%	33%	68%	38%	7%	12%	7%
75	39%	31%	64%	36%	5%	11%	7%
76	36%	30%	60%	33%	2%	10%	6%
77	34%	28%	56%	31%	0%	9%	5%
78	32%	27%	53%	30%	0%	9%	5%
79	30%	25%	49%	28%	0%	8%	5%
80	29%	24%	46%	26%	0%	8%	5%
81	27%	22%	42%	24%	0%	7%	4%
82	25%	21%	39%	22%	0%	7%	4%
83	24%	20%	37%	21%	0%	6%	4%
84	23%	20%	36%	20%	0%	5%	3%
85	22%	18%	33%	19%	0%	4%	3%
86	21%	17%	31%	19%	0%	3%	2%
87	20%	17%	30%	17%	0%	2%	1%
88	20%	16%	29%	16%	0%	2%	1%
89	19%	15%	27%	15%	0%	2%	1%
90	18%	15%	25%	15%	0%	2%	1%
91	17%	14%	24%	14%	0%	1%	1%
92	16%	14%	23%	14%	0%	1%	1%
93	15%	12%	22%	13%	0%	1%	1%
94	15%	12%	21%	13%	0%	1%	1%
95	14%	12%	21%	12%	0%	1%	1%
96	13%	11%	19%	12%	0%	1%	1%
97	13%	11%	18%	10%	0%	1%	1%
98	13%	10%	17%	10%	0%	1%	1%
99	13%	10%	17%	9%	0%	1%	1%
100	12%	10%	16%	9%	0%	1%	1%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Full Benefit Increase Option Factors for 4-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	117%	72%	328%	143%	191%	77%	34%
31	117%	72%	328%	143%	191%	77%	34%
32	117%	72%	328%	143%	191%	77%	34%
33	117%	72%	327%	143%	191%	77%	34%
34	117%	72%	325%	143%	190%	77%	34%
35	117%	72%	324%	143%	190%	77%	34%
36	117%	72%	323%	143%	190%	77%	34%
37	117%	72%	321%	143%	190%	77%	34%
38	117%	72%	320%	143%	189%	77%	34%
39	117%	72%	319%	143%	189%	77%	34%
40	117%	72%	317%	143%	189%	77%	34%
41	117%	72%	316%	143%	189%	77%	34%
42	117%	72%	315%	143%	189%	77%	34%
43	117%	72%	310%	140%	180%	75%	34%
44	117%	72%	306%	138%	171%	73%	34%
45	117%	73%	301%	135%	162%	71%	34%
46	118%	73%	296%	132%	153%	69%	34%
47	118%	73%	292%	130%	144%	67%	34%
48	118%	73%	286%	129%	139%	66%	34%
49	118%	73%	280%	128%	134%	66%	34%
50	118%	73%	274%	127%	129%	65%	34%
51	118%	73%	268%	126%	124%	64%	34%
52	117%	73%	262%	125%	119%	64%	34%
53	116%	73%	255%	123%	114%	62%	34%
54	115%	72%	247%	120%	109%	60%	34%
55	114%	71%	240%	117%	104%	58%	34%
56	112%	71%	232%	114%	99%	57%	34%
57	111%	70%	225%	111%	94%	55%	34%
58	109%	69%	215%	107%	87%	52%	33%
59	106%	67%	205%	103%	80%	50%	32%
60	104%	65%	196%	99%	74%	47%	31%
61	102%	63%	186%	95%	67%	45%	31%
62	100%	62%	176%	92%	61%	42%	30%
63	94%	59%	165%	86%	54%	38%	26%
64	88%	57%	154%	81%	48%	34%	22%
65	83%	54%	143%	75%	42%	30%	18%
66	77%	52%	132%	70%	35%	26%	15%
67	71%	49%	122%	64%	29%	22%	11%
68	67%	47%	115%	61%	26%	20%	10%
69	62%	45%	108%	58%	23%	19%	10%
70	58%	43%	101%	55%	20%	18%	9%
71	53%	41%	94%	52%	17%	17%	9%
72	48%	39%	87%	49%	14%	16%	8%
73	45%	38%	82%	46%	11%	15%	8%
74	42%	36%	77%	44%	8%	14%	7%
75	39%	34%	73%	41%	6%	12%	7%
76	36%	32%	68%	38%	3%	11%	6%
77	32%	31%	63%	36%	0%	10%	5%
78	31%	29%	60%	33%	0%	10%	5%
79	29%	27%	56%	31%	0%	9%	5%
80	27%	26%	52%	29%	0%	9%	5%
81	26%	24%	48%	27%	0%	8%	4%
82	24%	23%	44%	25%	0%	8%	4%
83	23%	21%	41%	24%	0%	7%	4%
84	22%	21%	40%	22%	0%	6%	3%
85	21%	20%	38%	21%	0%	5%	3%
86	20%	19%	35%	21%	0%	4%	2%
87	19%	19%	34%	20%	0%	3%	1%
88	19%	17%	32%	18%	0%	2%	1%
89	18%	16%	31%	17%	0%	2%	1%
90	17%	16%	29%	17%	0%	2%	1%
91	16%	15%	27%	16%	0%	2%	1%
92	15%	15%	26%	16%	0%	1%	1%
93	14%	13%	25%	14%	0%	1%	1%
94	14%	13%	23%	14%	0%	1%	1%
95	14%	13%	23%	13%	0%	1%	1%
96	13%	12%	22%	13%	0%	1%	1%
97	13%	12%	21%	12%	0%	1%	1%
98	12%	11%	19%	12%	0%	1%	1%
99	12%	11%	19%	11%	0%	1%	1%
100	11%	11%	18%	11%	0%	1%	1%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Full Benefit Increase Option Factors for 5-Year Benefit Period

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	113%	69%	320%	127%	171%	70%	31%
31	113%	69%	320%	127%	171%	70%	31%
32	113%	69%	320%	127%	171%	70%	31%
33	113%	69%	319%	126%	171%	70%	31%
34	113%	69%	317%	126%	171%	70%	31%
35	113%	69%	316%	126%	171%	70%	31%
36	113%	69%	315%	126%	170%	70%	31%
37	113%	69%	313%	126%	170%	70%	31%
38	113%	69%	312%	126%	170%	70%	31%
39	113%	69%	311%	126%	170%	70%	31%
40	113%	69%	309%	126%	170%	70%	31%
41	113%	69%	308%	126%	169%	70%	31%
42	113%	69%	307%	126%	169%	70%	31%
43	113%	69%	303%	124%	161%	68%	31%
44	113%	69%	298%	122%	153%	67%	31%
45	113%	69%	294%	119%	144%	65%	31%
46	113%	69%	290%	117%	136%	63%	31%
47	113%	69%	286%	115%	128%	61%	31%
48	113%	69%	279%	114%	123%	60%	31%
49	113%	69%	273%	112%	118%	59%	31%
50	113%	69%	266%	111%	113%	57%	31%
51	113%	69%	259%	110%	108%	56%	31%
52	113%	69%	253%	109%	103%	55%	31%
53	112%	69%	246%	106%	98%	54%	31%
54	110%	68%	238%	103%	93%	53%	31%
55	109%	68%	231%	101%	89%	52%	31%
56	108%	67%	224%	98%	84%	51%	31%
57	106%	67%	216%	95%	80%	50%	31%
58	104%	65%	207%	91%	73%	47%	30%
59	102%	63%	197%	88%	67%	45%	30%
60	100%	62%	187%	84%	61%	43%	29%
61	98%	60%	178%	80%	54%	40%	28%
62	95%	58%	168%	77%	48%	38%	27%
63	90%	56%	159%	73%	43%	35%	23%
64	84%	53%	150%	69%	38%	32%	20%
65	79%	51%	140%	64%	33%	29%	16%
66	73%	48%	131%	60%	28%	26%	12%
67	67%	46%	122%	56%	23%	23%	8%
68	63%	44%	115%	53%	20%	21%	8%
69	58%	42%	108%	50%	17%	20%	7%
70	54%	40%	101%	47%	14%	18%	7%
71	49%	38%	94%	44%	11%	17%	6%
72	45%	36%	87%	42%	8%	16%	6%
73	42%	34%	82%	39%	7%	15%	5%
74	39%	33%	77%	36%	5%	14%	5%
75	36%	31%	73%	34%	3%	12%	4%
76	32%	29%	68%	31%	2%	11%	4%
77	29%	28%	63%	29%	0%	10%	3%
78	28%	26%	60%	27%	0%	10%	3%
79	26%	25%	56%	25%	0%	9%	3%
80	25%	23%	52%	24%	0%	9%	3%
81	23%	22%	48%	22%	0%	8%	2%
82	22%	20%	44%	20%	0%	8%	2%
83	21%	19%	41%	19%	0%	7%	2%
84	20%	19%	40%	18%	0%	6%	2%
85	19%	18%	38%	17%	0%	5%	1%
86	19%	17%	35%	17%	0%	4%	1%
87	17%	17%	34%	16%	0%	3%	1%
88	17%	16%	32%	15%	0%	2%	1%
89	16%	14%	31%	14%	0%	2%	1%
90	15%	14%	29%	14%	0%	2%	1%
91	15%	13%	27%	13%	0%	2%	0%
92	14%	13%	26%	13%	0%	1%	0%
93	13%	12%	25%	12%	0%	1%	0%
94	13%	12%	23%	12%	0%	1%	0%
95	12%	12%	23%	11%	0%	1%	0%
96	12%	11%	22%	11%	0%	1%	0%
97	12%	11%	21%	10%	0%	1%	0%
98	11%	10%	19%	10%	0%	1%	0%
99	11%	10%	19%	9%	0%	1%	0%
100	10%	10%	18%	9%	0%	1%	0%

Transamerica Life Insurance Company
Long Term Care Policy TLC 2-P AR 0410

Full Benefit Increase Option Factors for Benefit Periods Greater Than 5 Years

Issue	Simple		Compound		Tailored	Step-Rate Compound	
Age	5%	3%	5%	3%	5%	5%	3%
0	186%	100%	444%	201%	199%	92%	55%
31	186%	100%	444%	201%	199%	92%	55%
32	186%	100%	444%	201%	199%	92%	55%
33	186%	100%	444%	201%	199%	92%	55%
34	186%	100%	443%	201%	198%	92%	55%
35	186%	100%	443%	200%	198%	92%	55%
36	186%	100%	442%	200%	197%	92%	55%
37	186%	100%	442%	199%	197%	92%	55%
38	185%	100%	440%	198%	197%	92%	55%
39	184%	100%	438%	197%	196%	92%	55%
40	183%	100%	436%	196%	196%	92%	55%
41	182%	100%	434%	195%	195%	92%	55%
42	181%	100%	432%	194%	195%	92%	55%
43	179%	99%	424%	191%	187%	91%	55%
44	178%	99%	416%	188%	179%	90%	55%
45	176%	99%	408%	185%	171%	89%	54%
46	174%	98%	400%	182%	163%	88%	54%
47	172%	98%	392%	179%	155%	87%	54%
48	171%	96%	381%	176%	148%	85%	53%
49	169%	94%	371%	173%	141%	84%	52%
50	168%	91%	360%	170%	134%	82%	51%
51	166%	89%	350%	167%	127%	81%	51%
52	164%	87%	339%	164%	120%	79%	50%
53	162%	85%	326%	160%	114%	76%	49%
54	159%	84%	312%	156%	108%	73%	47%
55	157%	83%	298%	152%	102%	70%	46%
56	154%	81%	285%	148%	96%	67%	45%
57	151%	80%	271%	144%	90%	64%	43%
58	147%	78%	260%	139%	84%	61%	41%
59	142%	77%	250%	134%	78%	57%	40%
60	138%	75%	239%	128%	72%	54%	38%
61	133%	73%	229%	123%	66%	50%	36%
62	128%	72%	218%	118%	60%	47%	34%
63	124%	70%	209%	113%	54%	43%	32%
64	120%	68%	200%	109%	48%	38%	29%
65	117%	66%	190%	104%	42%	34%	27%
66	113%	64%	181%	100%	36%	30%	25%
67	109%	63%	172%	95%	30%	25%	23%
68	104%	60%	163%	91%	26%	24%	21%
69	100%	58%	155%	87%	22%	22%	20%
70	96%	56%	146%	83%	17%	21%	19%
71	92%	54%	138%	79%	13%	20%	17%
72	88%	51%	129%	75%	9%	18%	16%
73	84%	49%	123%	72%	7%	17%	15%
74	80%	47%	117%	69%	5%	16%	15%
75	77%	45%	111%	66%	4%	15%	14%
76	73%	43%	105%	63%	2%	14%	14%
77	69%	41%	99%	60%	0%	13%	13%
78	66%	39%	93%	57%	0%	12%	13%
79	62%	37%	87%	53%	0%	12%	12%
80	58%	35%	81%	50%	0%	11%	11%
81	55%	33%	74%	46%	0%	10%	11%
82	51%	31%	68%	42%	0%	10%	10%
83	49%	29%	64%	40%	0%	8%	9%
84	47%	29%	62%	38%	0%	7%	7%
85	46%	27%	58%	36%	0%	6%	6%
86	44%	25%	54%	36%	0%	5%	5%
87	40%	25%	52%	33%	0%	3%	3%
88	40%	23%	50%	31%	0%	3%	3%
89	38%	22%	48%	29%	0%	3%	3%
90	36%	22%	44%	29%	0%	2%	2%
91	35%	20%	42%	27%	0%	2%	2%
92	33%	20%	40%	27%	0%	2%	2%
93	31%	18%	38%	25%	0%	2%	2%
94	31%	18%	36%	25%	0%	2%	2%
95	29%	18%	36%	22%	0%	2%	2%
96	27%	16%	34%	22%	0%	2%	2%
97	27%	16%	32%	20%	0%	2%	2%
98	26%	14%	30%	20%	0%	2%	2%
99	26%	14%	30%	18%	0%	2%	2%
100	24%	14%	28%	18%	0%	2%	2%

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	10/11/2010

Comments:

Attachment:

AR-Uni2 Certification of Compliance.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	10/11/2010
Bypass Reason:	On Form Schedule Tab		

Comments:

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	10/11/2010
Bypass Reason:	On Form Schedule Tab		

Comments:

		Item Status:	Status Date:
Satisfied - Item:	Cover Letter	Approved	10/11/2010

Comments:

Attachment:

AR-Uni2 Filing Letter.pdf

		Item Status:	Status Date:
Satisfied - Item:	Partnership Certification	Approved	10/11/2010

Comments:

Attachment:

AR-Uni2 Issuer Certification Form.PDF

TRANSAMERICA
® LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa
Long Term Care Division
P O Box 95302
Hurst, Texas 76053-5302

CERTIFICATION OF COMPLIANCE

New Form Numbers	Form Titles	Flesch Scores
TLC 2-P AR 0410	Long Term Care Insurance Policy	50.1
TLC 2-ACCB-E 0410	Accident Benefit Endorsement	50.4
TLC 2-CNFB-E 0410	Contingent Nonforfeiture Benefit Endorsement	51.3
TLC 2-CNFB-LP-E 0410	Limited Premium Payment Period Contingent Nonforfeiture Benefit Endorsement	55.4
TLC 2-ROP-E 0410	Return of Premium To Age 67 Endorsement	59.3
TLC 2-RELB-E 0410	Relocation Benefit Endorsement	50
TLC 2-SC-R 0410	Shared Care Benefit Rider	52.3
TLC 2-MB-R 0410	Monthly Benefit Rider	53.4
TLC 2-FROB-R 0410	Full Restoration of Benefits Rider	50.4
TLC 2-SBIOLC-R 0410	Simple Benefit Increase Option Rider	53.1
TLC 2-CBIOLC-R 0410	Compound Benefit Increase Option Rider	51.3
TLC 2-SRBIOLC-R 0410	Step-Rated Compound Benefit Increase Option Rider	51.2
TLC 2-TBIOLC-R 0410	Tailored Benefit Increase Option Rider	50.5
TLC 2-FCBIO-R 0410	Full Compound Benefit Increase Option Rider	52.2
TLC 2-FSBIO-R 0410	Full Simple Benefit Increase Option Rider	51.7
TLC 2-FSRBIO-R 0410	Full Step-Rated Compound Benefit Increase Option Rider	54.3
TLC 2-FTBIO-R 0410	Full Tailored Benefit Increase Option Rider	50.5
TLC 2-DBIO-E 0410	Deferred Benefit Increase Option Endorsement	51.5
TLC 2-GPO-E 0410	Guaranteed Purchase Option Endorsement	50.8
TLC 2-WOPCB-R 0410	Waiver of Premium Rider - Cash Benefit	50.5
TLC 2-WOPHC-R 0410	Waiver of Premium Rider – Home Care and Adult Day Care	50.2
TLC 2-JWP-R 0410	Joint Waiver of Premium Rider	53.4
TLC 2-FSWP-R 0410	Full Survivorship Rider	54.8
TLC 2-SWP-R 0410	Survivorship Rider	58.3
TLC 2-ROP-R 0410	Return of Premium Upon Death Rider	55.8
TLC 2-NFB-R 0410	Nonforfeiture Benefit – Shortened Benefit Period Rider	50.3
TLC 2-P AR 0410 OC	Outline of Coverage	50
TLC 2-ABCAPP 0410	Application	Scored with the Policy
TLC 2-JABCAPP 0410	Application	Scored with the Policy
TLC 2-CAPP 0410	Application	Scored with the Policy
TLC 2-JCAPP 0410	Application	Scored with the Policy
TLC 2-PWS 0410	Personal Worksheet	50
TLC 2-PWS-SP 0410	Personal Worksheet – Single Premium	49.3
TLC 2-PRI-DF-LP 0410	Potential Rate Increase Disclosure Form	41.3
TLC 2-DF 0410	Disclosure Form	47.5
TLC 2-DF-SP 0410	Disclosure Form – Single Premium	46.9

I hereby certify that to the best of my knowledge and belief the above form submission complies with the laws, rules and regulations of the State of Arkansas.

I also certify that the above form submission complies with all pertinent sections of P.L. 104-191, the Health Insurance Portability and Accountability Act of 1996.

I also certify that to the best of my knowledge and belief that this plan meets the requirements for and is eligible to be called a tax qualified plan.

I also certify that the above form submission complies with Rule and Regulation 19 regarding unfair sex discrimination. This submission meets the provisions of this rule.

I also certify that we provide the notices described in Rule and Regulation 49, ACA 23-79-138 and Bulletin 15-2009.

I also certify compliance that the Flesch scores(s) for the form(s) indicated above are accurate and correct. Therefore, this filing meets the minimum reading ease score on the test used.

Suzanne M. Schaake

Signature of Officer or Counsel

Suzanne M. Schaake
Name (Typed or Printed)

Assistant Vice President & Director of Product Compliance
Title

08/20/10
Date

Home Office: Cedar Rapids, Iowa
Long Term Care Division
P.O. Box 95302
Hurst, TX 76053-5302
1-800-553-7600, ext 3353

August 20, 2010

Honorable Jay Bradford
Commissioner of Insurance
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, AR 72201-1904

RE: TRANSAMERICA LIFE INSURANCE COMPANY
NAIC# 86231, FEIN# 39-0989781
Individual Long Term Care Insurance
Actuarial Memoranda & Rates

Form Numbers	Description
TLC 2-P AR 0410	Long Term Care Insurance Policy
TLC 2-ACCB-E 0410	Accident Benefit Endorsement
TLC 2-CNFB-E 0410	Contingent Nonforfeiture Benefit Endorsement
TLC 2-CNFB-LP-E 0410	Limited Premium Payment Period Contingent Nonforfeiture Benefit Endorsement
TLC 2-ROP-E 0410	Return of Premium To Age 67 Endorsement
TLC 2-RELB-E 0410	Relocation Benefit Endorsement
TLC 2-SC-R 0410	Shared Care Benefit Rider
TLC 2-MB-R 0410	Monthly Benefit Rider
TLC 2-FROB-R 0410	Full Restoration of Benefits Rider
TLC 2-SBIOLC-R 0410	Simple Benefit Increase Option Rider
TLC 2-CBIOLC-R 0410	Compound Benefit Increase Option Rider
TLC 2-SRBIOLC-R 0410	Step-Rated Compound Benefit Increase Option Rider
TLC 2-TBIOLC-R 0410	Tailored Benefit Increase Option Rider
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TLC 2-FSBIO-R 0410	Full Simple Benefit Increase Option Rider
TLC 2-FSRBIO-R 0410	Full Step-Rated Compound Benefit Increase Option Rider
TLC 2-FTBIO-R 0410	Full Tailored Benefit Increase Option Rider
TLC 2-DBIO-E 0410	Deferred Benefit Increase Option Endorsement
TLC 2-GPO-E 0410	Guaranteed Purchase Option Endorsement
TLC 2-WOPCB-R 0410	Waiver of Premium Rider- Cash Benefit
TLC 2-WOPHC-R 0410	Waiver of Premium Rider – Home Care and Adult Day Care
TLC 2-JWP-R 0410	Joint Waiver of Premium Rider
TLC 2-FSWP-R 0410	Full Survivorship Rider
TLC 2-SWP-R 0410	Survivorship Rider
TLC 2-ROP-R 0410	Return of Premium Upon Death Rider
TLC 2-NFB-R 0410	Nonforfeiture Benefit – Shortened Benefit Period Rider
TLC 2-P AR 0410 OC	Outline of Coverage
TLC 2-ABCAPP 0410	Application
TLC 2-JABCAPP 0410	Application
TLC 2-CAPP 0410	Application
TLC 2-JCAPP 0410	Application
TLC 2-PWS 0410	Personal Worksheet
TLC 2-PWS-SP 0410	Personal Worksheet – Single Premium
TLC 2-PRI-DF-LP 0410	Potential Rate Increase Disclosure Form
TLC 2-DF 0410	Disclosure Form
TLC 2-DF-SP 0410	Disclosure Form – Single Premium

To Be Used With Approved Forms

SGH 201	Statement of Good Health and Insurability
-Approved 3/29/01	
TLC END 908	Endorsement
TLC END-S 908	Endorsement
-Approved 12/19/08 under State Tracking # 41067, SERFF Tracking # AEGJ-125933510	
TLC PDN (AR) 708	Policy Disclosure Form
TLC PPN (AR) 708	Solicitation Disclosure Form
-Approved 10/23/08 under State Tracking # 40132, SERFF Tracking # AEGJ-125799440	

Dear Commissioner Bradford:

Enclosed for your review and approval are the above referenced individual long-term care insurance forms intended to be tax qualified under Section 7702B(b). These forms will not replace any forms currently on file with your Department.

These forms was approved in Iowa, our state of domicile, on 7/6/10. When approved in your state, we intend to use and/or deliver these forms, including the applications, in both paper and electronic form with or without electronic signatures.

We have written these forms in clearer, more readable language with the hope that they will be easier to understand for the consumers. We have listened to and responded to questions that we have received from our customers in designing these forms. Consequently, you may see provisions written differently than the wording used in the regulations. However, the intent of those words is the same as required by your state.

This policy is an individual policy of insurance. Each policy contains the core benefits, which include a Long Term Care Facility, Home Care and Adult Day Care, Hospice Care, Optional Care Coordination, Respite Care, Remain At Home (Therapeutic Device or Technology, Home Modification, Medical Alert System, and Caregiver Training), Cash Benefit, Facility Bed Reservation, Facility Extension of Benefits, Global Coverage Benefit, and Waiver of Premium. Please note that there is no separation between Nursing Homes and Assisted Living Facilities – they are all Long Term Care Facilities under the policy. Therefore, there is only one definition in the policy.

Each policy will be issued with the Nonforfeiture Benefit Rider if the applicant chooses it, or if not, then either the Contingent Nonforfeiture Benefit Endorsement or the Limited Premium Payment Period Contingent Nonforfeiture Benefit Endorsement will be issued, depending on whether the applicant has chosen a lifetime or a limited premium paying period.

The Shared Care Benefit Rider will allow two persons (spouses, domestic partners, civil union partners, etc.) to use the other person's policy once the first policy is exhausted. Both insureds may use the second policy's benefits at the same time. If one person dies, the remaining Policy Maximum Amount is transferred to the other person's policy.

The Accident Benefit Endorsement provides up to twice the daily benefit for Out of Pocket Expenses due to an injury that results in being a Chronically Ill Individual. However, only one times the daily benefit will be subtracted from the Lifetime Maximum. The Endorsement will only be issued to persons under age 68 at purchase and the benefits will only be paid until the 67th birthday of the insured. Some worksites, due to underwriting risk, may not qualify for this benefit to be added to their policy. Additionally, we will use both the Relocation Benefit Endorsement and the Return of Premium To Age 67 Endorsement primarily in worksite settings.

There are two sets of riders for the Benefit Increase Options. One set (the “Full” versions) is paid without consideration of claims paid under the policy. The other set (the ones that do not have “Full” in their titles) is paid with the claims subtracted before the increase percentage is applied. A 5% Compound Benefit Increase Option Rider will always be offered.

Please note that all information on the Schedule page is intended to be variable. Only those benefits purchased by an insured will be shown on the Schedule and included in his or her policy. Please be assured that the benefit amounts available will never be less than those required by your state.

The Outline of Coverage has the variable portions marked. Depending upon which endorsements/riders are offered in a benefit package, the Outline of Coverage will include only those endorsements/riders being marketed.

The applications will be used with this product, as well as any policies that may be approved in the future. The complete Plan Selection section, including Other Benefits, of each application should be considered variable as to benefits offered, wording and format. Other variable portions are marked. The differences between the applications are that those with "ABC" are available to individuals, worksites or associations, and depending on participation and size of the group, whether they will have full or limited underwriting. Those with the "C" in the form number are for individual applicants that will have full underwriting. The applications with a "J" are for two applicants and contain appropriate questions and signatures for both applicants. Each applicant will be issued an individual policy of his/her own.

Please be advised that the following inflation protection options will be used in Arkansas with Partnership Policies:

<u>For Issue Ages under 61:</u>
TLC 2-CBIOLC-R 0410, TLC 2-FCBIO-R 0410, TLC 2-SRBIOLC-R 0410, TLC 2-FSRBIO-R 0410, TLC 2-TBIOLC-R 0410 and TLC 2-FTBIO-R 0410 qualify as adequate inflation protection.

<u>For Issue Ages 61 through 75:</u>
TLC 2-SBIOLC-R 0410, TLC 2-FSBIO-R 0410 , TLC 2-CBIOLC-R 0410, TLC 2-FCBIO-R 0410, TLC 2-SRBIOLC-R 0410, TLC 2-FSRBIO-R 0410, TLC 2-TBIOLC-R 0410, and TLC 2-FTBIO-R 0410 qualify as adequate inflation protection.

<u>For Issue Ages 76 and over:</u>
There is no inflation protection requirement.

We trust that this filing will meet with your approval. If you should have any questions regarding this submission, please feel free to call me toll-free at 1-800-553-7600, extension 3353. My email address is LAleman@aegonusa.com. Thank you in advance for your consideration.

Sincerely,

Laura Aleman

Laura Aleman, HIA, AIRC, LTCP, AIAA, ACS
Senior Policy Analyst
Long Term Care Division

ISSUER CERTIFICATION FORM
(relating to Qualified State Long-Term Care Insurance Partnership)

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, *e.g.*, as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:
Transamerica Life Insurance Company
P.O. Box 95302
Hurst, Texas 76053-5302
(800) 227-3740

B. Name, address, telephone number, and email address (if available) of an employee of issuer who will be the contact person for information relating to this form:
Laura Aleman
C/O Transamerica Life Insurance Company
P.O. Box 95302
Hurst, Texas 76053-5302
(800) 553-7600 x3353
LAleman@aegonusa.com

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):
TLC 2-P AR 0410, et al.

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. CERTIFICATIONS

A. I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.

B. I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on Transamerica Life Insurance Company's behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.

C. I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

08/20/10
Date

Suzanne M. Schaake,
Assistant Vice President and Director of Product Compliance
Name and title of officer of the Issuer

Suzanne M Schaake
Signature of officer of the Issuer