

SERFF Tracking Number: AEGX-G126862423 State: Arkansas  
Filing Company: Transamerica Life Insurance Company State Tracking Number: 47198  
Company Tracking Number: AR005840700008  
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR005840700008

## Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Accidental Death SERFF Tr Num: AEGX-G126862423 State: Arkansas  
TOI: H03G Group Health - Accidental Death & Dismemberment SERFF Status: Closed-Approved-Closed State Tr Num: 47198  
Sub-TOI: H03G.000 Health - Accidental Death & Dismemberment Co Tr Num: AR005840700008 State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor  
Author: SPI ADMSLH Disposition Date: 11/14/2010  
Date Submitted: 11/02/2010 Disposition Status: Approved-Closed  
Implementation Date Requested: Implementation Date:

State Filing Description:

## General Information

Project Name: Accidental Death Status of Filing in Domicile:  
Project Number: AR005840700008 Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Overall Rate Impact: Group Market Type: Discretionary  
Filing Status Changed: 11/14/2010 Explanation for Other Group Market Type:  
State Status Changed: 11/14/2010  
Deemer Date: Created By: SPI ADMSLH  
Submitted By: SPI ADMSLH Corresponding Filing Tracking Number:  
Filing Description:  
Transamerica Life Insurance Company  
Out-of-State Group Accidental Death Form Filing  
NAIC Product Code Matrix SubType: Ho3G.000  
Company NAIC Group #:468 NAIC #: 8621 FEIN #: 39-0989781

Group accidental death insurance certificates AD3200GCT and AD3210GCT are being submitted for review and

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approval in accordance to your state's rules for filing out-of-state group life forms. These forms are new and do not replace any existing forms.

The controlling group term life insurance policy AD3200GPT was approved by the District of Columber on September 9, 2010 and will be issued to the National Financial Institution Group Insurance Trust. Accidental death insurance coverage will be made available to customers of participating banks and financial institutions who agree to participate in the Trust. The Trust is sitused in the District of Columbia.

Two certificates may be issued under a group policy:

1. Certificate AD3200GCT provides accidental death insurance to age 85. The death benefit is paid in 60 equal monthly installments. The benefit amount reduces 50% if an insured dies from a covered injury that occurs on or after they attain age 75.
2. Certificate AD3210GCT provides accidental death insurance for a period of one year. The death benefit is paid in 12 equal monthly installments. This certificate will be provided by the participating bank or financial institution to its direct deposit accountholders on a non-contributory basis. The premium is paid by the participating bank or financial institution.

Application form AD3000GET(0609) will be used when marketing the insurance. Coverage is guaranteed issue.

The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format.

## Company and Contact

### Filing Contact Information

Sam Hunt, Manager, Product Filing & Compliance shunt@aegonusa.com  
300 Eagleview Boulevard 610-648-5816 [Phone]  
Exton, PA 19341-1191 610-648-4703 [FAX]

### Filing Company Information

Transamerica Life Insurance Company CoCode: 86231 State of Domicile: Iowa  
4333 Edgewood Road, N.E. Group Code: 468 Company Type: Life and Health

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Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR005840700008  
Cedar Rapids, IA 52499 Group Name: State ID Number:  
(410) 685-5500 ext. [Phone] FEIN Number: 39-0989781

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**Filing Fees**

Fee Required? Yes  
Fee Amount: \$150.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$150.00	11/02/2010	41444270

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/14/2010	11/14/2010

*SERFF Tracking Number:* AEGX-G126862423      *State:* Arkansas  
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Dismemberment      Dismemberment  
*Product Name:* Accidental Death  
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## **Disposition**

Disposition Date: 11/14/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Explanation of Variability	Approved-Closed	Yes
<b>Supporting Document</b>	Actuarial Memorandum	Approved-Closed	No
<b>Supporting Document</b>	AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	Yes
<b>Supporting Document</b>	AR - NAIC FORM FILING ATTACHMENT	Approved-Closed	Yes
<b>Form</b>	Accident Death Certificate	Approved-Closed	Yes
<b>Form</b>	One Year Accidental Death Certificate	Approved-Closed	Yes
<b>Form</b>	Enrollment Form	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: AD3200GCT

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 11/14/2010	AD3200GC T	Certificate	Accident Death Certificate	Initial		48.200	AD3200GCT Contrib AD Certificate 9-9-10.PDF
Approved-Closed 11/14/2010	AD3210GC T	Certificate	One Year Accidental Death Certificate	Initial		49.400	AD3210GCT - Non-Contrib AD Certificate 9-9-10.PDF
Approved-Closed 11/14/2010	AD3000GE T(0609)	Application/Enrollment Form Enrollment Form		Initial		49.300	AD3000GET(0609).PDF



# TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499  
Administrative Office: [520 Park Avenue, Baltimore, MD 21201]

## GROUP ACCIDENTAL DEATH INSURANCE TO AGE 85 CERTIFICATE

We certify that, subject to the terms of the Group Policy, the Insured to whom this Certificate is issued is insured for the benefits described in this Certificate on and following the Effective Date. The Insured is hereafter referred to as “you”, “your”, and “yours”. Transamerica Life Insurance Company is called “we”, “our”, or “us”. This Certificate summarizes certain provisions of the Group Policy. All coverage and provisions are subject to those in the Group Policy issued to the Policyholder.

### Limited Benefit. Please Read Carefully.

Our President and Secretary witness this Certificate.

Secretary

President

**IMPORTANT CANCELLATION INFORMATION:** Please read the provision entitled “WHEN COVERAGE ENDS”.

**YOUR RIGHT TO EXAMINE THE CERTIFICATE FOR 30 DAYS:** You may return this Certificate for any reason within 30 days of the date you receive your Certificate. Any Premium paid is immediately refunded. The Certificate is treated as if it never existed. No benefits are paid.

### CERTIFICATE SCHEDULE

Insured:	[John Doe]	Effective Date:	[01-01-2010]
Certificate Number:	[01-01-2010]	Expiration Date:	[01-1-2XXX]
		[Monthly] Premium:	[\$[XX.XX]
Policyholder:	[ National Financial Institutions Group Insurance Trust ]		
Group Policy No.:	[MZ1234567890]		
Participating Organization:	[ ABC Bank ]		

Accidental Death Benefits are determined by this Schedule and the terms of the Group Policy.

### ACCIDENTAL DEATH INSURANCE BENEFIT

Benefit Amount:	[\$500] per month for a period of 60 consecutive months
Benefit Reduction:	Benefit Amount reduces 50% at Age 75
Discount Rate:	[5.0]%

### DEFINITIONS

When used in this Certificate the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**AEGON AFFILIATE** includes Stonebridge Casualty Insurance Company, Stonebridge Life Insurance Company, Transamerica Financial Life Insurance Company and Monumental Life Insurance Company.

**AGE** means on the Certificate Effective Date your current age based on your last birthday. Your age increases by one year on each Certificate Anniversary.

**CERTIFICATE ANNIVERSARY** means the same day and month each succeeding year of the date this Certificate takes effect.

**EXPIRATION DATE** means the date you reach age 85 under the terms of the Group Policy.

**INJURY** means bodily harm caused by an accident. The accident must occur while your insurance is in force under the Policy. The Injury must be the direct cause of the Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by disease, bodily or mental infirmity.

**LOSS** means loss of life covered under the terms of the Policy.

**PARTICIPATING ORGANIZATION** means an organization which has signed a Participation Agreement adopting the Policyholder's plan of insurance

#### **WHEN COVERAGE BEGINS**

The insurance takes effect at 12:01 A.M. on the Effective Date shown on the Certificate Schedule.

#### **WHEN COVERAGE ENDS**

Your insurance automatically ends on the earliest of the following dates: the date the Group Policy is terminated; the premium due date you fail to pay the required premium except as provided in the Grace Period; or the Expiration Date. Termination of the Group Policy will not prejudice any claim originating prior to termination, subject to all other terms of the Group Policy.

#### **ACCIDENTAL DEATH BENEFIT**

If as a result of Injury, not otherwise excluded, you suffer a Loss within 90 days after the date of an accident which was the direct cause of such injury, we will pay the benefit shown on the Certificate Schedule. The benefit amount is reduced by 50% if the Injury occurs while you are age 75 or older.

#### **EXCLUSIONS**

No benefit shall be paid for Loss or Injury that is caused by, results from, or contributed to by:

1. An intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri while sane);
2. Any active participation in a riot, insurrection or war, either declared or undeclared;
3. Your taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a physician;
4. Your blood alcohol level being .08 percent weight by volume or higher;
5. Your operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. Your committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. Sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. Voluntary gas inhalation or poison voluntarily taken, administered, or inhaled;
9. Taking alcohol in combination with any drug, medication or sedative; or
10. Military or combative activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

#### **WHO RECEIVES THE BENEFIT**

**BENEFICIARY:** At your death, unless you specify otherwise, any benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any; otherwise equally to your then living parents or parent, otherwise to your estate. Any payment made under this section will fully release us to the extent of the payment.

**CHANGING THE BENEFICIARY:** You can change your beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable.

#### **PREMIUMS**

We provide accidental death coverage in return for premium payment. Premiums are payable by you. Your first premium is due on your Effective Date. Premiums are paid to us on or before their due date subject to the Grace Period provision.

**GRACE PERIOD:** You have a 31 day Grace Period for the payment of each premium due after the first premium. Coverage will continue in force during the Grace Period. It will terminate at the end of the Grace Period if all premiums which are due are not paid. We will require payment of all premiums for the period this coverage continues in force including the premiums for the Grace Period.

**UNPAID PREMIUM:** When a claim is paid for a Loss incurred during the Grace Period, any premium due and unpaid may be deducted from the claim payment.

**REINSTATEMENT:** Your Certificate will lapse if you do not pay your premium before the end of the Grace Period. If we later accept a premium and do not require an application for reinstatement, that payment will put the Certificate back in force. If we require an application for reinstatement, this Certificate will be put back in force when we approve it and the required premium is received. If we do not approve the application but fail to give you prior written disapproval of your application then this Certificate will be put back in force on the 45th day after the date of application for reinstatement.

The reinstated Certificate only covers Loss due to an Injury that occurs after the date of reinstatement. In all other respects, you and we have the same rights under the Certificate as were in effect before it lapsed, unless special conditions are added in connection with the reinstatement.

**MISSTATEMENT OF AGE:** If the age of a Covered Person has been misstated, all amounts payable shall be in the amount the premium paid would have bought for the correct age. If, as a result of misstatement, we accept a premium for any period when coverage would not normally have been in effect, then our liability for such period shall be a refund, upon request, of all premiums paid for such period.

#### **WHEN THERE IS A CLAIM**

**PAYMENT OF CLAIMS:** Benefits are payable in accordance with the beneficiary designation in effect at the time of payment. The Benefit Amount is paid in monthly installments.

If the benefit is payable to an estate, the Benefit Amount will be paid as a lump sum payment. The lump sum payment is the present value of the Benefit Amount, determined by discounting each monthly installment that would have been payable upon your death at a rate determined by us but not to exceed the discount rate shown on the Certificate Schedule.

If the beneficiary survives the Insured but dies prior to all monthly installments having been paid to such beneficiary, the present value of the total remaining unpaid monthly installments will be paid to the beneficiary's estate in a lump-sum amount.

**NOTICE OF CLAIM:** We must be given written notice of claim within 30 days after a covered Loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain your name and enough information to identify you. Notice may be mailed to us or to our agent.

**CLAIM FORMS:** When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the Loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

**PROOF OF LOSS:** Written proof must be sent to us within 90 days after the date the Loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if it is shown that written proof of the Loss was given as soon as reasonably possible.

**TIME OF PAYMENT OF CLAIMS:** We will pay all benefits covered by the Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

**AUTOPSY:** At our expense, we may require an autopsy unless the law forbids it.

#### **GENERAL PROVISIONS**

**ENTIRE CONTRACT:** Your Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

**INCONTESTABILITY:** We cannot contest this Certificate except for fraud or for not paying premiums.

**LEGAL ACTIONS:** No legal action may be brought to recover against the Group Policy within 60 days after written Proof of Loss has been given. No such action will be brought after three years from the time written Proof of Loss is required to be given. If a time limit of the Group Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

**OTHER INSURANCE:** If you are insured under more than one Accidental Death Policy or Certificate in effect with us or any AEGON Affiliate at any one time, our maximum liability is limited to the lesser of the total amount of benefits payable under all such policies and certificates or [\$1,000,000]. Upon discovery of duplication in excess of our maximum liability, we will refund all premiums paid for all such Policies or Certificates. The excess will be voided and all premiums paid for such excess shall be returned to you or to your beneficiary.



# TRANSAMERICA LIFE INSURANCE COMPANY

A Stock Company – Home Office: 4333 Edgewood Road N.E., Cedar Rapids IA 52499  
Administrative Office: [520 Park Avenue, Baltimore, MD 21201]

## GROUP 1-YEAR ACCIDENTAL DEATH INSURANCE CERTIFICATE

We certify that, subject to the terms of the Group Policy, the Insured to whom this Certificate is issued is insured for the benefits described in this Certificate on and following the Effective Date. The Insured is hereafter referred to as “you”, “your”, and “yours”. Transamerica Life Insurance Company is called “we”, “our”, or “us”. This Certificate summarizes certain provisions of the Group Policy. All coverage and provisions are subject to those in the Group Policy issued to the Policyholder.

### Limited Benefit. Please Read Carefully.

Our President and Secretary witness this Certificate.

Secretary

President

**IMPORTANT CANCELLATION INFORMATION: Please read the provision entitled “WHEN COVERAGE ENDS”.**

**YOUR RIGHT TO EXAMINE THE CERTIFICATE FOR 30 DAYS:** You may return this Certificate for any reason within 30 days of the date you receive your Certificate. Any Premium paid is immediately refunded. The Certificate is treated as if it never existed. No benefits are paid.

### CERTIFICATE SCHEDULE

Insured:	[John Doe]	Effective Date:	[01-01-2010]
Certificate Number:	[01-01-2010]	Expiration Date:	[01-01-2011]
Policyholder:	[National Financial Institutions Group Insurance Trust]		
Group Policy No.:	[MZ1234567890]		
Participating Organization:	[ABC Bank]		

Accidental Death Benefits are determined by this Schedule and the terms of the Group Policy.

### NON-CONTRIBUTORY ACCIDENTAL DEATH INSURANCE BENEFIT

Benefit Amount:	[\$100] per month for 12 consecutive months
Discount Rate:	[5.0]%

### DEFINITIONS

When used in this Certificate the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**INJURY** means bodily harm caused by an accident. The accident must occur while your insurance is in force under the Policy. The Injury must be the direct cause of the Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by disease, bodily or mental infirmity.

**LOSS** means loss of life that is covered under the terms of the Policy.

**NON-CONTRIBUTORY** means the premium for this certificate is paid by the Participating Organization.

**PARTICIPATING ORGANIZATION** means an organization which has signed a Participation Agreement adopting the Policyholder’s plan of insurance.

### **WHEN COVERAGE BEGINS**

The insurance takes effect at 12:01 A.M. on the Effective Date shown on the Certificate Schedule.

### **WHEN COVERAGE ENDS**

Your insurance automatically ends on the Expiration Date. Termination of the Group Policy will not prejudice any claim originating prior to termination, subject to all other terms of the Group Policy.

### **ACCIDENTAL DEATH BENEFIT**

If as a result of Injury, not otherwise excluded, you suffer a Loss within 90 days after the date of the accident which was the direct cause of such Injury, we will pay the Benefit Amount shown on the Certificate Schedule.

### **EXCLUSIONS**

No benefit shall be paid for Loss or Injury that is caused by, results from, or contributed to by:

1. An intentionally self-inflicted Injury, suicide, or any attempt at suicide, while sane or insane (in Colorado and Missouri while sane);
2. Any active participation in a riot, insurrection or war, either declared or undeclared;
3. Your taking or using any narcotic, barbiturate or any other drug or medication, unless taken or used as prescribed by a physician;
4. Your blood alcohol level being .08 percent weight by volume or higher;
5. Your operating or riding in any kind of aircraft, except as a fare-paying passenger on a regularly scheduled commercial flight;
6. Your committing or attempting to commit a felony or an assault or being engaged in an illegal activity;
7. Sickness, bodily or mental infirmity or their medical or surgical treatment including diagnosis (except bacterial infections which result from an Injury) or mental disease or disorder;
8. Voluntary gas inhalation or poison voluntarily taken, administered, or inhaled;
9. Taking alcohol in combination with any drug, medication or sedative; or
10. Military or combative activities while serving in the armed forces, National Guard or organized reserve corps in any state, country or international authority.

### **WHO RECEIVES THE BENEFIT**

**BENEFICIARY:** At your death, unless you specify otherwise, any benefit for loss of life will be paid to your then living lawful spouse; otherwise equally to your then living lawful children, if any; otherwise equally to your then living parents or parent, otherwise to your estate. Any payment made under this section will fully release us to the extent of the payment.

**CHANGING THE BENEFICIARY:** You can change your beneficiary at any time by writing to us at our Administrative Office. Once we record the change, it will take effect as of the day you signed the request, subject to any claim payment made before such recording. The consent of the beneficiary is not needed for the change, unless the beneficiary designation was irrevocable.

### **WHEN THERE IS A CLAIM**

**PAYMENT OF CLAIMS:** Benefits are payable in accordance with the beneficiary designation in effect at the time of payment. The Benefit Amount is paid in monthly installments.

If the benefit is payable to an estate, the Benefit Amount will be paid as a lump sum payment. The lump sum payment is the present value of the Benefit Amount, determined by discounting each monthly installment that would have been payable upon your death at a rate determined by us but not to exceed the discount rate shown on the Certificate Schedule.

If the beneficiary survives the Insured but dies prior to all monthly installments having been paid to such beneficiary, the present value of the total remaining unpaid monthly installments will be paid to the beneficiary's estate in a lump-sum amount.

**NOTICE OF CLAIM:** We must be given written notice of claim within 30 days after a covered Loss occurs. If notice cannot be given within that time, it must be given as soon as reasonably possible. The notice must contain your name and enough information to identify you. Notice may be mailed to us or to our agent.

**CLAIM FORMS:** When we receive notice of claim, the claimant will be sent forms to file Proof of Loss. If the forms are not sent within 15 days after we receive notice, then the claimant will meet the Proof of Loss requirements by giving us a written statement of the nature and extent of the Loss. This must be sent to us within the time limit stated in the Proof of Loss provision.

**PROOF OF LOSS:** Written proof must be sent to us within 90 days after the date the Loss occurs. If it was not reasonably possible to give us written proof within 90 days, we will not reduce or deny a claim for this reason, if it is shown that written proof of the Loss was given as soon as reasonably possible.

**TIME OF PAYMENT OF CLAIMS:** We will pay all benefits covered by the Policy as soon as we receive proper written Proof of Loss sufficient to determine liability.

**AUTOPSY:** At our expense, we may require an autopsy unless the law forbids it.

**ENTIRE CONTRACT:** Your Certificate is furnished in accordance with and subject to the terms of the Policy. It is not part of the Policy, but it is evidence of the insurance provided under the Policy. The Policy and any attachments form the entire contract of insurance. No agent may change or waive any provisions of the Policy under which this coverage is provided.

**INCONTESTABILITY:** We cannot contest this Certificate except for fraud or for not paying premiums.

**LEGAL ACTIONS:** No legal action may be brought to recover against the Group Policy within 60 days after written Proof of Loss has been given. No such action will be brought after three years from the time written Proof of Loss is required to be given. If a time limit of the Group Policy is less than allowed by the laws of the state where you live, the limit is extended to meet the minimum time allowed by such law.

### ABOUT PROPOSED INSURED (Please answer each question completely)

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Phone \_\_\_\_\_

Best time to call:  Morning  Afternoon  Early Evening

Alternate Phone \_\_\_\_\_

Best time to call:  Morning  Afternoon  Early Evening

Email Address \_\_\_\_\_

Annual Salary \$ \_\_\_\_\_

Monthly Benefit Amount \$ \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Birthplace \_\_\_\_\_  
month day year state or country

SS# \_\_\_\_\_  Male  Female

Are you a citizen of the United States?  Yes  No

If no, do you have a permanent Visa (green card)?  Yes  No

### BENEFICIARY INFORMATION

Name, Relationship and Designated %: \_\_\_\_\_

### PAYMENT OPTIONS (Choose One):

Payer:  Proposed Insured  Policy Owner (if different than proposed insured) Choose a billing frequency:  Monthly  Quarterly  
 Semi-annually  Annually

Automatically Deduct Premium from:  Savings  Checking Bank Name: \_\_\_\_\_

Account Holder (Payer) Name (Please Print): \_\_\_\_\_ Account Number: \_\_\_\_\_

Routing Transit No.: \_\_\_\_\_  Example of routing/transit and account numbers found on the bottom of your personal check

**OR** Charge Premium to:  Visa  MasterCard  Discover  American Express

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Agreement:** I have read or been read all the questions and answers on this application. I understand that no insurance is in effect unless the application is approved by the Insurance Company, and the first premium paid. I acknowledge that I have read or been read the Fraud Warning Statement. I hereby authorize my Financial Institution to make the appropriate periodic account debits for the amount of insurance indicated. I understand that coverage will only become effective if there are sufficient funds in my account at the time of debit, over and above any minimum required to maintain same account. I further understand that any additional coverage will also continue only upon payment of subsequent premiums as they become due. I have read or been read this authorization and have or understand I will receive a copy. Insurance is not a deposit or other obligation of the bank or any bank affiliate; is not guaranteed, issued or underwritten by the FDIC, the bank or any bank affiliate; is not insured by the FDIC or any other agency of the US, the bank or any bank affiliate; and is not a condition to the provision or term of any banking service or activity. **Residents of ARKANSAS, NEW MEXICO, and OHIO:** Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Residents of DISTRICT OF COLUMBIA:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Residents of FLORIDA:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Residents of KENTUCKY:** Any person who knowingly and with intent to defraud or deceive any insurance company,

files a statement or claim containing any false, incomplete, or misleading information is guilty of a felony. **Residents of LOUISIANA:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Residents of MAINE, TENNESSEE and WASHINGTON:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **Residents of MARYLAND:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Residents of NEW JERSEY:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Residents of NEW YORK:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **Residents of PENNSYLVANIA:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed at City \_\_\_\_\_ State \_\_\_\_\_ Date \_\_\_\_\_

Signature of Proposed Insured (Required – Do not print) \_\_\_\_\_

<i>SERFF Tracking Number:</i>	<i>AEGX-G126862423</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Transamerica Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>47198</i>
<i>Company Tracking Number:</i>	<i>AR005840700008</i>		
<i>TOI:</i>	<i>H03G Group Health - Accidental Death &amp; Dismemberment</i>	<i>Sub-TOI:</i>	<i>H03G.000 Health - Accidental Death &amp; Dismemberment</i>
<i>Product Name:</i>	<i>Accidental Death</i>		
<i>Project Name/Number:</i>	<i>Accidental Death/AR005840700008</i>		

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	11/14/2010
<b>Comments:</b>		
<b>Attachment:</b> AR - READABILITY CERTIFICATION.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application	Approved-Closed	11/14/2010
<b>Bypass Reason:</b> Enrollment Form AD3000GET(0609) is attached under the Forms Tab.		
<b>Comments:</b>		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanation of Variability	Approved-Closed	11/14/2010
<b>Comments:</b> Explanation of Variability		
<b>Attachment:</b> EOV AD3200GCT and AD3210GCT.PDF		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> AR - NAIC TRANSMITTAL DOCUMENT	Approved-Closed	11/14/2010
<b>Comments:</b> NAIC Transmittal Document		
<b>Attachment:</b> AR - NAIC TRANSMITTAL DOCUMENT.PDF		

<b>Item Status:</b>	<b>Status</b>
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SERFF Tracking Number: AEGX-G126862423 State: Arkansas  
Filing Company: Transamerica Life Insurance Company State Tracking Number: 47198  
Company Tracking Number: AR005840700008  
TOI: H03G Group Health - Accidental Death & Sub-TOI: H03G.000 Health - Accidental Death &  
Dismemberment Dismemberment  
Product Name: Accidental Death  
Project Name/Number: Accidental Death/AR005840700008

**Satisfied - Item:** AR - NAIC FORM FILING Approved-Closed **Date:** 11/14/2010  
ATTACHMENT

**Comments:**

NAIC Form Filing Attachment

**Attachment:**

AR - NAIC FORM FILING ATTACHMENT.PDF

**STATE OF ARKANSAS**  
**READABILITY CERTIFICATION**

**COMPANY NAME: Transamerica Life Insurance Company**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

<b>Form Number</b>	<b>Score</b>
AD3200GCT	48.2
AD3210GCT	49.4
AD3000GET(0609)	49.3

Signed:   
Name: Laurie A. Renko  
Title: Vice President  
Date: November 1, 2010

## **Explanation of Variables for Group Accidental Death Insurance Master Policy and Certificates**

### **Master Policy – AD3200GPT.TX**

Schedule of Benefits (page 2):

1. Non-Contributory Accidental Death Insurance Benefit and benefit amount will be elected by the policyholder. The coverage amount will be \$100.00 monthly, with a total maximum of \$1,200.00.
2. Contributory Accidental Death Insurance Benefit amount will be elected by the certificate holder. The monthly coverage amount range is \$500.00 - \$10,000.00.
3. The Discount Rate may vary due to financial indexes, but is anticipated never to exceed 5%

### **Certificate – AD3200GCT.TX**

Schedule of Benefits (page 1) – the Insured Member's Name, Certificate Number, The Policyholder, Group Policy Number, Effective Date, and Expiration Date will reflect the specific information for the Member it is issued to.

Accidental Death Insurance Benefit amount will be elected by the certificateholder. The monthly coverage amount range is \$500.00 - \$10,000.00.

The Discount Rate may vary due to financial indexes, but is anticipated never to exceed 5%.

### **Certificate – AD3210GCT.TX**

Schedule of Benefits:

1. The Insured Member's Name, Certificate Number, The Policyholder, Group Policy Number, Effective Date, and Expiration Date will reflect the specific information for the Member it is issued to.
2. Accidental Death Insurance Benefit amount will be elected by the policyholder. The coverage amount will be \$100.00 monthly, with a total maximum of \$1,200.00.
3. The Discount Rate may vary due to financial indexes, but is anticipated never to exceed 5%.

**Life, Accident & Health, Annuity, Credit Transmittal Document**

<b>1.</b>	<b>Prepared for the State of</b>	Arkansas
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<b>2.</b>	<b>Department Use Only</b>	
	<b>State Tracking ID</b>	

3. Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
Transamerica Life Insurance Company 4333 Edgewood Road, N.E. Cedar Rapids IA 52499	IA		468	86231	39-0989781	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Sam Hunt 300 Eagleview Boulevard Exton PA 19341-1191	800-678-5901	610-648-4703	shunt@aegonusa.com

5. Requested Filing Mode	<input checked="" type="checkbox"/> Review & Approval <input type="checkbox"/> File & Use <input type="checkbox"/> Informational <input type="checkbox"/> Combination (please explain): _____ <input type="checkbox"/> Other (please explain): _____
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6. Company Tracking Number	AR005840700008
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7. <input type="checkbox"/> New Submission	<input type="checkbox"/> Resubmission	Previous file # _____
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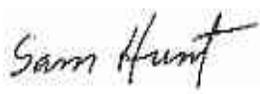
8. Market	<input type="checkbox"/> Individual	<input type="checkbox"/> Franchise
	Group	<input type="checkbox"/> Small <input type="checkbox"/> Large <input checked="" type="checkbox"/> Small and Large <input type="checkbox"/> Employer <input type="checkbox"/> Association <input type="checkbox"/> Blanket <input checked="" type="checkbox"/> Discretionary <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____

9. Type of Insurance	H03G Group Health - Accidental Death & Dismemberment
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10. Product Coding Matrix Filing Code	H03G.000 Health - Accidental Death & Dismemberment
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11. Submitted Documents	<input type="checkbox"/> <b>FORMS</b> <input type="checkbox"/> Policy <input type="checkbox"/> Outline of Coverage <input type="checkbox"/> Certificate <input type="checkbox"/> Application/Enrollment <input type="checkbox"/> Rider/Endorsement <input type="checkbox"/> Advertising <input type="checkbox"/> Schedule of Benefits <input type="checkbox"/> Other: _____  <input type="checkbox"/> <b>RATES</b> <input type="checkbox"/> New Rate <input type="checkbox"/> Revised Rate  <input type="checkbox"/> <b>FILING OTHER THAN FORM OR RATE:</b> Please explain: _____  <b>SUPPORTING DOCUMENTATION</b> <input type="checkbox"/> Articles of Incorporation <input type="checkbox"/> Third Party Authorization <input type="checkbox"/> Association Bylaws <input type="checkbox"/> Trust Agreement <input type="checkbox"/> Statement of Variability <input type="checkbox"/> Certifications <input type="checkbox"/> Actuarial Memorandum <input type="checkbox"/> Other: _____
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<b>12.</b>	<b>Filing Submission Date</b>	
<b>13.</b>	<b>Filing Fee (If required)</b>	Amount _____ Check Date _____ Retaliatory <input type="checkbox"/> Yes <input type="checkbox"/> No Check Number _____
<b>14.</b>	<b>Date of Domiciliary Approval</b>	
<b>15.</b>	<b>Filing Description:</b>	
	<p>Transamerica Life Insurance Company                  Out-of-State Group Accidental Death Form Filing                  NAIC Product Code Matrix SubType: Ho3G.000                  Company NAIC Group #:468 NAIC #: 8621 FEIN #: 39-0989781</p> <p>Group accidental death insurance certificates AD3200GCT and AD3210GCT are being submitted for review and approval in accordance to your state's rules for filing out-of-state group life forms. These forms are new and do not replace any existing forms.</p> <p>The controlling group term life insurance policy AD3200GPT was approved by the District of Columber on September 9, 2010 and will be issued to the National Financial Institution Group Insurance Trust. Accidental death insurance coverage will be made available to customers of participating banks and financial institutions who agree to participate in the Trust. The Trust is situated in the District of Columbia.</p> <p>Two certificates may be issued under a group policy:</p> <ol style="list-style-type: none"> <li>1. Certificate AD3200GCT provides accidental death insurance to age 85. The death benefit is paid in 60 equal monthly installments. The benefit amount reduces 50% if an insured dies from a covered injury that occurs on or after they attain age 75.</li> <li>2. Certificate AD3210GCT provides accidental death insurance for a period of one year. The death benefit is paid in 12 equal monthly installments. This certificate will be provided by the participating bank or financial institution to its direct deposit accountholders on a non-contributory basis. The premium is paid by the participating bank or financial institution.</li> </ol> <p>Application form AD3000GET(0609) will be used when marketing the insurance. Coverage is guaranteed issue.</p> <p>The product will be marketed via direct response means, including mail, telephone solicitation and internet. We intend to use an electronic signature process for the customer's signature of the enrollment form in the telephone and internet channels, and will maintain records of sales of this product in a secure electronic format.</p>	

<b>16.</b>	<b>Certification (If required)</b>	
	<p><b>I HEREBY CERTIFY</b> that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the state of <u>Arkansas</u>.</p> <p>Print Name <u>Sam Hunt</u> Title <u>Manager, Product Filing &amp; Compliance</u></p> <p>Signature  Date _____</p>	

<b>17.</b>	<b>Form Filing Attachment</b>	
<b>This filing transmittal is part of company tracking number</b>	AR005840700008	
<b>This filing corresponds to rate filing company tracking number</b>		

	<b>Document Name</b>	<b>Form Number</b>		<b>Replaced Form Number</b>
	<b>Description</b>			<b>Previous State Filing Number</b>
01	Accident Death Certificate	AD3200GCT	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
02	One Year Accidental Death Certificate	AD3210GCT	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
03	Enrollment Form	AD3000GET(0609)	<input checked="" type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
04			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
05			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
06			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
07			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
08			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
09			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
10			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	
11			<input type="checkbox"/> <b>Initial</b> <input type="checkbox"/> <b>Revised</b> <input type="checkbox"/> <b>Other</b> _____	