

SERFF Tracking Number: AEGX-G126639454 State: Arkansas
Filing Company: Transamerica Life Insurance Company State Tracking Number: 45795
Company Tracking Number: AR0056700001
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Term Life
Project Name/Number: Term Life/AR0056700001

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Term Life SERFF Tr Num: AEGX-G126639454 State: Arkansas
TOI: L04G Group Life - Term SERFF Status: Closed-Approved-Closed State Tr Num: 45795
Sub-TOI: L04G.500 Other Co Tr Num: AR0056700001 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird
Author: SPI ADMSLH Disposition Date: 06/01/2010
Date Submitted: 05/26/2010 Disposition Status: Approved-Closed
Implementation Date Requested: Implementation Date:
State Filing Description:

General Information

Project Name: Term Life
Project Number: AR0056700001
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 06/01/2010

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Discretionary
Explanation for Other Group Market Type:
State Status Changed: 06/01/2010
Created By: SPI ADMSLH
Corresponding Filing Tracking Number:

Deemer Date:
Submitted By: SPI ADMSLH
Filing Description:

In accordance with Code 23-79-109, a copy of the attached form is being submitted for your review and approval. This is a new form, which does not replace any existing form.

This form is intended for use with Group Term Life Certificate TL3000GCT, which was approved by your Department on December 10, 2001. It will be marketed on a direct mail, mass marketed basis. Coverage is provided through an out-of-state policy.

Also enclosed is a Readability Certification.

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Company and Contact

Filing Contact Information

Suzanne Cherluka, Senior Product Filing & Compliance Analyst
 520 Park Avenue
 Baltimore, MD 21201
 scherluka@aegonusa.com
 410-209-5259 [Phone]
 410-209-5910 [FAX]

Filing Company Information

Transamerica Life Insurance Company
 4333 Edgewood Road, N.E.
 Cedar Rapids, IA 52499
 (410) 685-5500 ext. [Phone]

 CoCode: 86231
 Group Code: 468
 Group Name:
 FEIN Number: 39-0989781
 State of Domicile: Iowa
 Company Type: Life and Health
 State ID Number:

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation:
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$50.00	05/26/2010	36838290

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/01/2010	06/01/2010

SERFF Tracking Number: *AEGX-G126639454* *State:* *Arkansas*
Filing Company: *Transamerica Life Insurance Company* *State Tracking Number:* *45795*
Company Tracking Number: *AR0056700001*
TOI: *L04G Group Life - Term* *Sub-TOI:* *L04G.500 Other*
Product Name: *Term Life*
Project Name/Number: *Term Life/AR0056700001*

Disposition

Disposition Date: 06/01/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGX-G126639454 *State:* Arkansas
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Group Term Life Insurance Application		Yes

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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	TL4000GET(0609)	Application/Group Term Life Enrollment Insurance Application Form	Initial		0.000	TL4000GET(0609).PDF

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 _____
 Current Occupation _____
 Annual Salary \$ _____ Male Female
 Product _____
 Monthly Benefit Amount \$ _____
 Payout Period to 65 3 Years 5 Years

Date of Birth _____ Age _____ Birthplace _____
 month day year state or country

Height ____ feet _____ inches Weight _____ pounds
 SS# _____
 Driver's License # _____ State Issued _____
 Are you a citizen of the United States? Yes No
 If no, do you have a permanent Visa (green card)? Yes No

POLICY OWNER'S INFORMATION (If different from Proposed Insured)

Policy Owner's Name: _____
 Policy Owner's Street: _____
 Policy Owner's City _____ State _____ Zip _____
 Policy Owner's SS# or Tax Payer ID#: _____

BENEFICIARY INFORMATION

Name, Relationship and Designated %:

PROPOSED INSURED HISTORY (Check YES or NO for each question. If yes, provide details.)

1. a. Do you have other life insurance applications pending with any other company? Yes No
 - b. By applying for the proposed policy do you intend to replace, discontinue or change an existing policy or contract? Yes No
- If yes, provide details as follows. Attach a separate sheet if more space is needed (*Indicate Type of Coverage: I=Individual; B=Business; or G=Group)

INSURED NAME	INSURANCE COMPANY	POLICY NO.	AMOUNT	*TYPE	PENDING	ISSUE DATE
					<input type="checkbox"/>	
					<input type="checkbox"/>	

2. Have you, in the past 2 years, used tobacco or nicotine products in any form? Yes No
3. Within the past 3 years, have you been refused life insurance or been issued a policy on a modified or rated basis? Yes No
4. Have you, in the past 3 years, participated in or do you plan to participate in any of the following activities: aeronautics, including hang gliding, sky diving, parachuting, or ballooning; racing, including car, motorcycle, or boat; scuba/skin diving; hiking, including mountain/trail climbing or rock climbing; or any similar hazardous activities? Yes No
5. Have you, in the past 3 years, piloted an aircraft, or do you have any intention of flying in the future other than as a passenger on a scheduled airline? Yes No
6. Do you contemplate residence or travel, including military deployment, outside the US during the next 2 years? Yes No
7. Have you, in the past 3 years, had your driver's license suspended, revoked, cancelled, or withdrawn, had 3 or more moving violations, or in the past 5 years pled guilty or no contest to or been convicted of driving under the influence (DUI/DWI) or reckless driving? Yes No
8. Have you, in the past 10 years, pled guilty or no contest to or been convicted of a felony offense, or been incarcerated or on probation for a felony offense, or are felony charges currently outstanding against you? Yes No
9. Have you, in the past 10 years, used illegal drugs, or consulted a physician or other healthcare provider or been treated, hospitalized, or taken medication for abuse of alcohol or drugs (including prescription drugs)? Yes No

10. Have you, in the past 7 years, consulted a physician or other healthcare provider, or been treated, hospitalized or taken medication for: any diseases or disorders of the heart including rheumatic fever, circulatory system, diabetes/endocrine/thyroid, blood, kidneys, liver, digestive system, lungs including allergies, sleep apnea, respiratory disorder, emphysema, or chronic asthma; any mental or nervous disorders, including depression or anxiety; muscular, spinal, joint, or bone disorders or injuries; including concussions; high blood pressure; high cholesterol; cancer; stroke; epilepsy/seizures, including dizziness or fainting; arthritis; congenital defects or physical impairments; or sexually transmitted diseases? Yes No
11. Have you ever tested positive for, or been treated for, been hospitalized for, or been diagnosed by a member of the medical profession as having HIV (Human Immunodeficiency Virus) antibodies or antigens or AIDS (Acquired Immunodeficiency Syndrome) or ARC (AIDS Related Complex) or any immune deficiency disorder? Yes No
12. Have you, in the past 12 months, been confined to a hospital or medical facility of any kind for more than 24 hours? Yes No
13. In the past 12 months, have you scheduled or been advised to have surgery, a diagnostic test, or evaluation of any kind that has not been completed? Yes No

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/Authorization to Obtain and Disclose Information: 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 or will receive copies of the disclosure notices that appear below. I acknowledge that I have read or been read the Fraud Warning Statement where applicable. I acknowledge receiving or being read the "NOTIFICATION" regarding MIB, Inc. and the Fair Credit Reporting Act during the application process. If the "NOTIFICATION" materials were read to me, I understand I will receive them in writing shortly following my completion of this application. The authorization, original or copy, is valid for two years from the effective date of coverage. To determine my insurability or for claims purposes, research or purposes not otherwise prohibited by law, I authorize any medical practitioner, institution, VA Hospital, insurance company or person having knowledge of my health, or MIB, Inc. to give any information about my physical or mental health to Transamerica Life Insurance Company or its reinsurer(s). I have read or been read this authorization and have or will receive a copy. I may revoke this authorization for information not then obtained by notifying the Company in writing. Such revocation will not be effective until received by the Company. I understand that any information that is disclosed pursuant to this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information, but it will not be re-disclosed by the Company except as authorized by me or as required by law. 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. 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) _____

Policy Owner Signature (If Different than Proposed Insured) _____

ADDITIONAL APPLICATION INFORMATION BELOW

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Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR - READABILITY CERTIFICATION.PDF

Item Status:

**Status
Date:**

Bypassed - Item: Application

Bypass Reason: This is not a Policy filing.

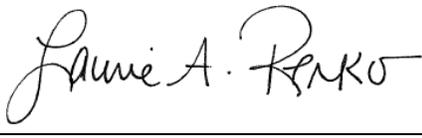
Comments:

STATE OF ARKANSAS
READABILITY CERTIFICATION

COMPANY NAME: Transamerica Life Insurance Company

RE: TL4000GET(0609)

This will certify that the submission meets the requirements of the Life and Health Policy Language Simplification Act. The Flesch Score, when combined with the Certificate, is 47.2.

Signed: 

Name: Laurie A. Renko
Title: Vice President

Date: 5-26-10