

SERFF Tracking Number: AEGG-126732538 State: Arkansas  
Filing Company: Transamerica Life Insurance Company State Tracking Number: 46274  
Company Tracking Number: C-PH-01-00  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Group Policyholder Application  
Project Name/Number: Group Policyholder Application/C-PH-01-00

## Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Group Policyholder Application SERFF Tr Num: AEGG-126732538 State: Arkansas

TOI: H21 Health - Other SERFF Status: Closed-Approved- State Tr Num: 46274  
Closed

Sub-TOI: H21.000 Health - Other

Co Tr Num: C-PH-01-00

State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Rosalind Minor

Author: Billie Baldwin

Disposition Date: 07/22/2010

Date Submitted: 07/21/2010

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Group Policyholder Application

Status of Filing in Domicile: Authorized

Project Number: C-PH-01-00

Date Approved in Domicile: 07/20/2010

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: Employer, Association,  
Blanket, Other

Filing Status Changed: 07/22/2010

Explanation for Other Group Market Type:  
Labor Union

Deemer Date:

State Status Changed: 07/22/2010

Submitted By: Billie Baldwin

Created By: Billie Baldwin

PPACA: Not PPACA-Related

Corresponding Filing Tracking Number:

Filing Description:

July 21, 2010

ARKANSAS

RE: TRANSAMERICA LIFE INSURANCE COMPANY

SERFF Tracking Number: AEGG-126732538 State: Arkansas  
Filing Company: Transamerica Life Insurance Company State Tracking Number: 46274  
Company Tracking Number: C-PH-01-00  
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other  
Product Name: Group Policyholder Application  
Project Name/Number: Group Policyholder Application/C-PH-01-00

NAIC: 468-86231 FEIN: 39-0989781  
NEW POLICYHOLDER APPLICATION FILING  
C-PH-01-00 Life and Health Group Application and Agreement

The above-referenced application is submitted for your review and approval. This is a new form and not intended to replace any forms previously approved by the Department. No part of this filing contains unusual or controversial items that vary from normal company or industry standards.

Our intent is to have a single, multi-product application that can be used to apply for our approved products in your state so that the policyholder only has to complete one application, even if applying for multiple products.

This application is very similar to the applications that were previously approved in your state for the products listed below. Major changes include: 1) adding information needed for billing purposes; 2) simplifying language in the agreements section; 3) replacing employer terms such as "payroll deduction" with broader terms such as "premium contributions"; and 4) reorganizing the information so that all product specific information is contained in the same area.

We request approval for this application to be used in the solicitation of the following policy form(s) previously approved in your state:

Line of Business	Approval Date	SERFF Tracking #	STATE Tracking #
Accident Policy, CPACC100	1/20/2009	AEGG-125985426	41361
Accident Policy, CP200504	7/2/2004	Bulk - Paper	
Cancer Policy, CPCAN200	6/26/2007	AEGG-125157976	35953
Specified Disease Policy, CPCI0200	7/10/2007	AEGG-125214536	36310
Specified Disease Policy, CP200304	6/23/2004	SERT-623SRT107	26682
Disability Policy, CP200400	9/1/2004	SERT-649H6S082/00	27273
Disability Policy, CPDI0100	7/11/2006	SERT-6QXJS6028/00	33093
Supplemental Medical Exp Policy, CP201204	7/22/2004	SERT-623K7D785/00	26733
Health Indemnity Policy, CP200604	7/22/2004	SERT-5ZZP5W834/00	26679
Hospital Indemnity Policy, CPCH0200	3/8/2007	AEGG-125108469	35284

(A separate filing of this Application is being made for the Life TOI category.)

Please see the attached Explanation of Variables for the explanation of text contained in brackets. Minor modifications in paper size, stock, ink, border, Company logo, and column formatting to accommodate system needs may result.

To the best of our knowledge, this filing is complete and in compliance with the insurance laws of your jurisdiction. If you have any questions, please contact me at the phone number or email address below.

Sincerely,

SERFF Tracking Number: AEGG-126732538 State: Arkansas  
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Billie Jean Baldwin, Manager  
 Product Implementation Department  
 Transamerica Life Insurance Company  
 Telephone: (800) 400-3042, ext. 1271098  
 E-Mail: bbaldwin@aegonusa.com

## Company and Contact

### Filing Contact Information

BJ Baldwin, Manager Life Compliance bbaldwin@aegonusa.com  
 PO Box 8063 800-400-3042 [Phone] 1098 [Ext]  
 Little Rock, AR 72203-8063 501-227-1097 [FAX]

### Filing Company Information

Transamerica Life Insurance Company CoCode: 86231 State of Domicile: Iowa  
 PO Box 8063 Group Code: 468 Company Type: Life and Health  
 Little Rock, AR 72203-8063 Group Name: State ID Number:  
 (501) 227-1106 ext. [Phone] FEIN Number: 39-0989781

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$20.00  
 Retaliatory? No  
 Fee Explanation: a separate application form pursuant to Rule/Reg 57, Sec 5, subsec II, Category B (a) (6)  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$20.00	07/21/2010	38183919
Transamerica Life Insurance Company	\$30.00	07/22/2010	38221149

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/22/2010	07/22/2010

### Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Life and Health Group Application and Agreement	Billie Baldwin	07/22/2010	07/22/2010

*SERFF Tracking Number:* AEGG-126732538      *State:* Arkansas  
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*Company Tracking Number:* C-PH-01-00  
*TOI:* H21 Health - Other      *Sub-TOI:* H21.000 Health - Other  
*Product Name:* Group Policyholder Application  
*Project Name/Number:* Group Policyholder Application/C-PH-01-00

## **Disposition**

Disposition Date: 07/22/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AEGG-126732538 State: Arkansas  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Approved-Closed	Yes
Form ( <i>revised</i> )	Life and Health Group Application and Agreement	Approved-Closed	Yes
Form	Life and Health Group Application and Agreement	Replaced	Yes

SERFF Tracking Number: AEGG-126732538 State: Arkansas  
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**Amendment Letter**

Submitted Date: 07/22/2010

**Comments:**

Please review the attached application. After this form was originally submitted, we discovered that it was not the correct document. I'm sorry for any inconvenience.

Also, please note that we have added \$30.00 to the filing fee to be a total of \$50.00 for this application form.

I look forward to your continued review of this form for approval.

Thank you, BJ Baldwin

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
C-PH-01-00	Application/ELife and nrollment Form	Health Group Application and Agreement	Initial				54.600	C-PH-01-00-jd-071510-FINAL.pdf

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 Project Name/Number: Group Policyholder Application/C-PH-01-00

## Form Schedule

### Lead Form Number: C-PH-01-00

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 07/22/2010	C-PH-01-00	Application/Enrollment Form	Life and Health Group Application and Agreement	Initial		54.600	C-PH-01-00- jd-071510- FINAL.pdf



Transamerica Life Insurance Company  
 Home Office: [Cedar Rapids, IA]  
 [Administrative Office: P.O. Box 8063  
 Little Rock, Arkansas 72203-8063]

**Life and Health  
 Group Application  
 and Agreement**  
 [Multi-State Version]

Name of Group ("you, your"): [ABC Plumbing]	Tax ID Number: [123-45-6789]	SIC Code: [12345]	Website Address: [www.company.com]
Street Address: [123 Corporate Street]	City: [Anytown]	State: [ST]	ZIP Code: [12345]
Contact Name: [John Smith]	Email Address: [johnsmith@abc.com]	Phone #: [(123)456-7711]	Fax #: [(123)456-7712]
Nature of Group: [Plumbing company]	# of Employees/Members: [73]	# Eligible for Coverage: [60]	# of Years in Existence: [10]
Billing Address: (if different)	City:	State:	ZIP Code:
Billing Contact Name: (if different) [John Smith]	Email Address: [johnsmith@abc.com]	Phone #: [(123)456-7711]	Fax #: [(123)456-7712]
Billing Address is For: <input checked="" type="checkbox"/> Group Policyholder <input type="checkbox"/> Third Party Administrator <input type="checkbox"/> Premium Collection Agency (Requires a Premium Collection Agreement)			

You hereby authorize Transamerica Life Insurance Company, our authorized agents or our enrollers (collectively referred to as we, us, or our) to offer each of your eligible employees/members the opportunity to purchase insurance coverage as described in this form. This authorization is based upon the following agreements:

- We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
- The initial enrollment shall take place from [10-01-10] to [10-15-10]. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
- Unless otherwise agreed upon by you and us, you will collect premium contributions from your participating employees/members and forward to us when due. We customarily bill you each month. You will forward the premiums due to us within 15 days of the receipt of the monthly bill. You will maintain records of all premium contributions from your employees/members while this agreement remains in force and for two years after it terminates. These records will remain open to inspection and audit by us during normal business hours during this time.
- In the event of any misappropriation by you, your employees or your agents, of funds owed to us, you will reimburse us for our entire loss including attorney fees and expenses incurred in collection, and any benefits we would not have had to pay but for such misappropriation.
- Do benefit selections vary by class?  No  Yes (define classes below)

Definition of Class 1:	
Definition of Class 2:	
Definition of Class 3:	
Definition of Class 4:	

- Eligibility for insurance:
 

	Class 1	Class 2	Class 3	Class 4	
a. Employer Groups - eligible employees are defined as those who work at least	[17.5]				hours per week for you,
and have been so employed for at least	[30]				days.
b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws, who are not currently disabled and are able to perform the normal activities of a person of like age and gender.					
- Is dependent coverage being offered?  Yes  No  
 If yes, do you include same-sex partners?  No  Yes, state mandate  Yes, corporate decision (attach eligibility requirements)

**Billing Information**

Pay periods per year: [26]	Payments will be remitted: <input type="checkbox"/> After each deduction <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Other _____
Payroll deductions per year: [24]	Premium amount on bill should reflect: <input checked="" type="checkbox"/> Levelized amount over 12 months <input type="checkbox"/> Actual amount of deductions occurring each month
First payroll deduction date: [11/01/2010]	Preferred billing sequence: <input checked="" type="checkbox"/> Alphabetical <input type="checkbox"/> Social Security Number <input type="checkbox"/> Employee/Member ID <input type="checkbox"/> Other _____
First bill due date: [12/01/2010]	Preferred Billing Method: <input checked="" type="checkbox"/> Paper <input type="checkbox"/> Electronic (via website) <input type="checkbox"/> Self-Bill
	Multiple Billing Locations: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (attach listing)

Name of Section 125 Plan Administrator (if applicable)	Plan Start Date	Plan Anniversary Date
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## Fraud Warning

### District of Columbia and 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.]

### Florida

I understand that 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.]

### Kansas

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 may be guilty of insurance fraud as determined by a court of law.]

### Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.]

### North Carolina and Oregon

I understand that 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, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.]

### New Jersey

I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.]

### Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.]

### Puerto Rico

Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.]

### Tennessee

It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

### Virginia

I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.]

### Vermont

I understand that 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, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.]

### All other states

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.]

I understand and agree that this application will be made part of each group master policy issued as a result of this application. The Group listed above will be named as the Policyholder for each group master policy. I agree that no insurance will be effective until approved by us at our administrative office.

Signed in (City/State) \_\_\_\_\_ This \_\_\_\_\_ Day of (Month/Year) \_\_\_\_\_, \_\_\_\_\_.

\_\_\_\_\_  
Signature of Officer

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

\_\_\_\_\_  
Print Name and Title of Officer

\_\_\_\_\_  
Signature of Licensed Agent

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

\_\_\_\_\_  
Print Name of Licensed Agent

\_\_\_\_\_  
Agent Number

## Insurance Selections

*(Product and Rider availability subject to state approval)*

<b>Product:</b> <i>[Any Product]</i>	<b>Group Contribution?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, list amount or %:</i>	<b>Requested Effective Date:</b> <i>November 1, 2010</i>
<b>Coverage:</b>  <i>[Base Coverage: \$25,000                  Benefit Period: 12 months                  Any Rider                  Another Rider]</i>		
<b>Replacement:</b> Are you replacing existing coverage? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <i>(attach a copy of the existing contract and most recent billing statement)</i>		
<b>[IRS Type:</b> <input checked="" type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____ ]		
<b>[Workers' Compensation:</b> Are all employees/members covered under Workers' Compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain)</i> _____ . ]		

<b>Product:</b> <i>[Another Product]</i>	<b>Group Contribution?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, list amount or %:</i>	<b>Requested Effective Date:</b> <i>November 1, 2010</i>
<b>Coverage:</b>  <i>[Base Coverage: \$25,000                  Any Rider                  Another Rider]</i>		
<b>Replacement:</b> Are you replacing existing coverage? <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes <i>(attach a copy of the existing contract and most recent billing statement)</i>		
<b>[IRS Type:</b> <input checked="" type="checkbox"/> Section 125 <input type="checkbox"/> Welfare Benefit Plan <input type="checkbox"/> ERISA <input type="checkbox"/> 5500 Required <input type="checkbox"/> Other <i>(please explain)</i> _____ ]		
<b>[Workers' Compensation:</b> Are all employees/members covered under Workers' Compensation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>(explain)</i> _____ . ]		

Please complete, sign and date this application and return to us at the address listed above.  
 Make a photocopy for your records.

SERFF Tracking Number: AEGG-126732538 State: Arkansas  
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 Project Name/Number: Group Policyholder Application/C-PH-01-00

## Supporting Document Schedules

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b>	Flesch Certification	Approved-Closed	07/22/2010
<b>Comments:</b>			
<b>Attachments:</b>			
	Reg 19 Certification.pdf		
	Readability Certification-Policyholder App-071510.pdf		

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Application	Approved-Closed	07/22/2010
<b>Bypass Reason:</b>	Not applicable. This is a new group application filing to previously approved policies listed in the filing description.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Health - Actuarial Justification	Approved-Closed	07/22/2010
<b>Bypass Reason:</b>	Not applicable. This is a group application filing to be used with previously approved policies.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	Outline of Coverage	Approved-Closed	07/22/2010
<b>Bypass Reason:</b>	Not applicable. This is a group application filing.		
<b>Comments:</b>			

		<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b>	PPACA Uniform Compliance Summary	Approved-Closed	07/22/2010
<b>Bypass Reason:</b>	This is not applicable for a group application form to health products that are supplemental or		

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Product Name: Group Policyholder Application  
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limited benefits, not major medical.

**Comments:**

	<b>Item Status:</b>	<b>Status</b>
<b>Satisfied - Item:</b> Explanation of Variables	Approved-Closed	<b>Date:</b> 07/22/2010
<b>Comments:</b>		
<b>Attachment:</b>		
Expanation of Variables - C-PH-01-00.pdf		

**STATE OF ARKANSAS**  
**CERTIFICATION OF COMPLIANCE**

**Company Name:** Transamerica Life Insurance Company  
**Form Titles:** Life and Health Group Application and Agreement  
**Form Numbers:** C-PH-01-00

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



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Patsy J. Napier, FLMI, AIRC, HIA, CCP  
Assistant Secretary

July 21, 2010  
Date

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## Readability Certification

This is to certify that the forms listed below are in compliance with your state's readability requirements.

### A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is \_\_\_\_\_.
2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are attached.

Forms and Form Numbers to Which Certification is Applicable:

**See attached list**

### B. Test Option Selected

1. Test was applied to entire policy form(s)
2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

### C. Standards for Certification

A checked block indicates standard has been achieved

1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

The certification must be signed by an officer of the insurer.

	Assistant Vice President
Signature	Officer's Title
Officer's name: Douglas Simino	Date: July 15, 2010

**GROUP TERM LIFE INSURANCE POLICY AND RELATED FORMS**

<b>FORM NAME</b>	<b>FORM NUMBER</b>	<b>SYLLABLES</b>	<b>WORDS</b>	<b>SENTENCES</b>	<b>SCORE</b>
Life and Health Group Application and Agreement	C-PH-01-00	1710	1144	45	54.6

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa

## POLICYHOLDER APPLICATION EXPLANATION OF VARIABLES

FOR FORM: C-PH-01-00.

Text that is intended to be variable is bracketed. Bracketed text is either intended to be: (1) in or out of the application; or (2) be customized (state specific) to accommodate a specific Policyholder's selections. Each variable bracketed text is described below. No change in the variable areas will be made which will be in conflict with the laws, rules and regulations of your state. In addition, no change in variability will be made which in any way expands the scope of the wording being changed. Transamerica Life Insurance Company ("Company") reserves the right to correct at any time any and all typographical errors that do not impact benefits or intent of language.

### C-PH-01-00 – Life and Health Group Application and Agreement

#### Page 1

1. Home Office Address - The address is bracketed for any future address changes.
2. Administrative Office Address – The address is bracketed for future address changes.
3. Title – The last line of the title is bracketed to be: 1) Multi-State Version; or 2) list a specific state.

#### Page 2

4. Fraud Warning – Each fraud warning is bracketed to either be in or out of the application. The Multi-State Version will contain all fraud warnings as shown. A customized (state specific) version for a specific policyholder will only include the fraud warning for the applicable state.

#### Page 3

5. IRS Type – The IRS Type is bracketed to either be in or out of the application based on whether it is applicable to the product being selected.
6. Workers' Compensation – The Workers' Compensation question is bracketed to either be in or out of the application based on whether it is applicable to the product being selected.
7. Additional Products – The Insurance Selection section is intended to be repeated for each product that is available (for the Multi-State Version) or selected by the Policyholder (for the customized version).

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*Project Name/Number:* Group Policyholder Application/C-PH-01-00

## Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

<b>Creation Date:</b>	<b>Schedule</b>	<b>Schedule Item Name</b>	<b>Replacement Creation Date</b>	<b>Attached Document(s)</b>
07/21/2010	Form	Life and Health Group Application and Agreement	07/22/2010	C-PH-01-00-jd-071510.pdf (Superseded)

## Readability Certification

This is to certify that the forms listed below are in compliance with your state's readability requirements.

### A. Option Selected

1. Policy and its related forms are scored for the Flesch reading ease test as one unit and the combined score is \_\_\_\_\_.
2. Policy and its related forms are scored separately for the Flesch reading ease test. Scores for the policy and each form are attached.

Forms and Form Numbers to Which Certification is Applicable:

**See attached list**

### B. Test Option Selected

1. Test was applied to entire policy form(s)
2. Test was applied on sample basis. Form(s) contain(s) more than 10,000 words. Copy of form(s) enclosed indicating word samples tested.

### C. Standards for Certification

A checked block indicates standard has been achieved

1. The policy text achieves a minimum score of 45 on the Flesch reading ease test in accordance with the option chosen in Section A above.
2. It is printed in not less than ten point type, one point leaded. (This does not apply to specification pages, schedules and tables.)
3. The layout and spacing of the policy separate the paragraphs from each other and from the border of the paper.
4. The section titles are captioned in bold face type or otherwise stand out significantly from the text.
5. Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in the policy.
6. The style, arrangement and overall appearance of the policy give no undue prominence to any portion of the policy or to any endorsements or riders.
7. A table of contents or an index of the principal sections is included in the policy. (This applies only if the policy has more than 3,000 words or consists of more than 3 pages.)

The certification must be signed by an officer of the insurer.

	Assistant Vice President
Signature	Officer's Title
Officer's name: Douglas Simino	Date: July 15, 2010

**POLICYHOLDER APPLICATION**

<b>FORM NAME</b>	<b>FORM NUMBER</b>	<b>SYLLABLES</b>	<b>WORDS</b>	<b>SENTENCES</b>	<b>SCORE</b>
Life and Health Group Application and Agreement	C-PH-01-00	1710	1144	45	54.6