

SERFF Tracking Number: AEGG-127016862 State: Arkansas  
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 47915  
 Company Tracking Number:  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: Group Critical Illness Insurance Policy  
 Project Name/Number: /CPCI0400

## Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Group Critical Illness Insurance SERFF Tr Num: AEGG-127016862 State: Arkansas  
 Policy

TOI: H07G Group Health - Specified Disease - SERFF Status: Closed-Approved- State Tr Num: 47915  
 Limited Benefit Closed

Sub-TOI: H07G.001 Critical Illness Co Tr Num: State Status: Approved-Closed  
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: Patsy Napier

Disposition Date: 02/23/2011

Date Submitted: 02/07/2011

Disposition Status: Approved-Closed

Implementation Date Requested: 04/15/2011

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number: CPCI0400

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Filed in Iowa on 2/4/2011.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Association, Other

Explanation for Other Group Market Type:

Labor Unions

Overall Rate Impact:

Filing Status Changed: 02/23/2011

State Status Changed: 02/23/2011

Deemer Date:

Created By: Patsy Napier

Submitted By: Patsy Napier

Corresponding Filing Tracking Number:

Filing Description:

RE: TRANSAMERICA LIFE INSURANCE COMPANY

NAIC: 468-86231 FEIN: 39-0989781

NEW GROUP HEALTH FORM FILING

CPCI0400 – Group Master Policy for Critical Illness Indemnity Insurance

CCC0400 – Certificate for Group Critical Illness Indemnity Insurance

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CECI04AR – Arkansas Amendment  
CRCAN400 – Cancer Benefit Rider  
CRRCI400 – Recurrent Critical Illness Benefit Rider  
CRWEL400 – Wellness Benefit Rider  
CRICU400 – Intensive Care Benefit Rider  
CRINJ400 – Initial Hospitalization for Accidental Bodily Injury Benefit Rider  
CREMT400 – Accident Emergency Treatment Benefit Rider  
CCI-AP-04-00 –Certificate Application

Transmitted via SERFF are the above-referenced forms for your review and approval. These are new forms and are not intended to replace any forms previously approved by the Department. This filing does not contain any unusual or potentially controversial items from industry standards.

CPCI0400 and CCCI0400 - This policy and certificate provide stand-alone, voluntary group, critical illness indemnity insurance that pays lump sum benefits upon the positive diagnosis of a listed critical illness. The covered critical illnesses will be split into four categories. The first two categories are included in the base coverage, whereas the other two categories are provided by two of the optional benefit riders.

Category 1 covers heart attack, stroke, heart transplant, coronary bypass surgery, and angioplasty.

Category 2 covers major organ transplants (excluding heart), end-stage renal failure, paralysis not due to stroke, burns, and Alzheimer's Disease.

Category 3 benefits are provided by the optional Cancer Benefit Rider, CRCAN400. This benefit pays a critical illness benefit for cancer, as defined in the rider, or for a bone marrow transplant.

Category 4 benefits are provided by the optional Occupational HIV Benefit Rider, CRHIV200. The Occupational HIV Benefit Rider pays 100% of the certificate's benefit amount listed on the schedule of benefits for a critical illness when a covered person receives an initial positive diagnosis of HIV that is contracted during the course of employment. This rider was previously approved for use in your state as referenced in the below table. We would like to extend that approval for use with this policy and certificate.

CECI04AR – This state-specific amendment will be attached to the policies and certificates issued in your state. It includes any state-required changes to the policy and certificate.

The remaining optional benefit riders include the following:

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Recurrent Critical Illness Benefit Rider, CRRCI400, provides a certain percentage of the benefit amount for a recurrent critical illness as defined in the rider.

The Quality of Life Rider, Form CRLIF200, is an optional rider that pays 5% of the certificate's benefit amount listed on the schedule of benefits per month when a covered person is confined in a nursing or assisted living facility and meets certain criteria. This rider was previously approved for use in your state as referenced in the below table. We would like to extend that approval for use with this policy and certificate.

Wellness Benefit Rider, CRWEL400, provides a calendar year benefit when a covered person incurs a charge for one of the health screening tests listed in the rider.

The Intensive Care Benefit Rider, CRICU400, provides a certain percentage of the benefit amount for confinement in an intensive care unit, as well as a benefit for ambulance transportation.

Initial Hospitalization for Accidental Bodily Injury Benefit Rider, CRINJ400, provides a lump sum benefit for the initial hospitalization of a Covered Person when hospital confined for a covered accident.

Accident Emergency Treatment Benefit Rider, CREMT400, provides a lump sum benefit for treatment received for a covered accident in a hospital emergency room.

The Group Policyholder Application, form C-PH-01-00, was previously approved by your department as referenced in the below table. We wish to extend the use of the form to the policy form in this filing.

Certificate Application, CCI-AP-04-00 will be used in conjunction with the sale and presentation of the certificate. Two types of underwriting are possible: (1) Guaranteed Issue for those who are purchasing an agreed upon amount of insurance – first two questions (eligibility questions) only; and (2) Simplified Issue – questions 1-6 must be answered. Simplified Issue - questions 7 - 8 are only answered if the Cancer Benefit Rider is included. We do not request health examinations or a consumer credit report. Coverage will be issued based on the answers to the application questions. The application form may be used for internet solicitation and the application process for the above product. If the application is to be used on the internet, no substantial changes will be made to the format, and no changes will be made to the actual application language. For the actual applicant's signature, a PIN or other electronic signature will be required to be captured three times: (1) Applicant's Statements and Agreements; (2) Representation of Applicant; and (3) Authorization to Release Medical Information. A PDF of the application must be submitted to the Administrative Office and should include a checkmark on the applicant's initials line along with a "Signature by PIN" notation to the right.

These forms will be marketed in a Worksire Marketing solicitation to individual employees or members of eligible groups

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as permitted under the laws of your state. Premiums may be paid by the certificateholder or the policyholder or a combination of both.

We wish to use the following previously approved forms with this product:

Date SERFF State  
Form No. Title of Form Approved Tracking No. Tracking No.  
C-PH-01-00 Policyholder Application 9/21/2010 AEGG-126792395  
CRLIF200 Quality of Life Rider 7/10/2007 AEGG-126792395  
CRHIV200 Occupational HIV Benefit Rider 7/10/2007 AEGG-126792395

Also enclosed is an Explanation of Variability (EOV) which includes an explanation of any bracketed material included in each document. The EOV also includes benefit ranges and issue age ranges. Bracketed text is either intended to be (a) in or out of the forms or (b) variable as described in the EOV. 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.

Please note that minor modifications in paper size and stock, ink, border, Company logo, signatures and column formatting to accommodate system needs or internet format can occur. We reserve the right to correct at any time any typographical errors that do not impact benefits or intent of language.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your state. If you have any questions which can be resolved over the telephone, please do not hesitate to contact me at 800-400-3042, extension 127-1664.

Please see the Explanation of Variables an explanation of any bracketed variables contained in these forms.

If you have any questions or comments, please let me know.

Sincerely,

Patsy J. Napier, FLMI, AIRC, HIA, CCP  
Product Filing Supervisor & Assistant Secretary  
Product Implementation Department  
Transamerica Life Insurance Company  
Telephone: 800-400-3042 x127-1664  
Email: pnapier@aegonusa.com

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## Company and Contact

### Filing Contact Information

Patsy Napier, Senior Contract Analyst pnapier@aegonusa.com  
 PO Box 8063 501-227-1664 [Phone]  
 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: \$50.00  
 Retaliatory? No  
 Fee Explanation: Your filing fee - 1 forms submission.  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$50.00	02/07/2011	44443614
Transamerica Life Insurance Company	\$450.00	02/16/2011	44774968

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	02/23/2011	02/23/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	02/21/2011	02/21/2011	Patsy Napier	02/22/2011	02/22/2011
Pending Industry Response	Rosalind Minor	02/16/2011	02/16/2011	Patsy Napier	02/17/2011	02/17/2011

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## Disposition

Disposition Date: 02/23/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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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	Explanation of Variability	Approved-Closed	Yes
Form	Group Master Policy for Critical Illness Indemnity Insurance	Approved-Closed	Yes
Form	Certificate for Group Critical Illness Indemnity Insurance	Approved-Closed	Yes
Form (revised)	State Amendment	Approved-Closed	Yes
Form	State Amendment	Replaced	Yes
Form	Cancer Benefit Rider	Approved-Closed	Yes
Form	Recurrent Critical Illness Benefit Rider	Approved-Closed	Yes
Form	Wellness Benefit Rider	Approved-Closed	Yes
Form	Intensive Care Benefit Rider	Approved-Closed	Yes
Form	Initial Hospitalization for Accidental Bodily Injury Benefit Rider	Approved-Closed	Yes
Form	Accident Emergency Treatment Benefit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/21/2011  
Submitted Date 02/21/2011

Respond By Date

Dear Patsy Napier,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate for Group Critical Illness Indemnity Insurance, CCCI0400 (Form)
- State Amendment, CECI04AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 02/22/2011  
 Submitted Date 02/22/2011

Dear Rosalind Minor,

### Comments:

This is in response to your letter of 2/21/2011.

### Response 1

Comments: The state specific amendment, form CECI04AR, has been revised to reference to the 31 days required to notify us of a dependent child's being handicapped at time coverage would ordinarily terminate at the limiting age.

### Related Objection 1

Applies To:

- Certificate for Group Critical Illness Indemnity Insurance, CCCI0400 (Form)
- State Amendment, CECI04AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
State Amendment	CECI04A	R	Certificate Amendment, Insert Page, Endorsement or Rider	Initial			CECI04A R - State Amendme

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nt 2-22-  
2011.pdf

**Previous Version**

State Amendment CECI04A Certificate Amendment, Initial  
R Insert Page, Endorsement  
or Rider

CECI04A  
R - State  
Amendme  
nt .pdf

No Rate/Rule Schedule items changed.

Your continued review of this submission will be appreciated.

Sincerely,  
Patsy Napier

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Product Name: Group Critical Illness Insurance Policy  
Project Name/Number: /CPCI0400

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 02/16/2011  
Submitted Date 02/16/2011

Respond By Date

Dear Patsy Napier,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Group Master Policy for Critical Illness Indemnity Insurance, CPCI0400 (Form)
- Certificate for Group Critical Illness Indemnity Insurance, CCCI0400 (Form)
- State Amendment, CECI04AR (Form)
- Cancer Benefit Rider, CRCAN400 (Form)
- Recurrent Critical Illness Benefit Rider, CRRCI400 (Form)
- Wellness Benefit Rider, CRWEL400 (Form)
- Intensive Care Benefit Rider, CRICU400 (Form)
- Initial Hospitalization for Accidental Bodily Injury Benefit Rider, CRINJ400 (Form)
- Accident Emergency Treatment Benefit Rider, CREMT400 (Form)
- Application, CCI-AP-04-00 (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$500.00. Please submit an additional \$450.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 02/17/2011  
Submitted Date 02/17/2011

Dear Rosalind Minor,

### Comments:

### Response 1

Comments: The additional filing fees were sent via EFT on 2/16/2011.

### Related Objection 1

Applies To:

- Group Master Policy for Critical Illness Indemnity Insurance, CPCI0400 (Form)
- Certificate for Group Critical Illness Indemnity Insurance, CCCI0400 (Form)
- State Amendment, CECI04AR (Form)
- Cancer Benefit Rider, CRCAN400 (Form)
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- Application, CCI-AP-04-00 (Form)

Comment:

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The fee for this submission is \$50.00 per form for a total of \$500.00. Please submit an additional \$450.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

### Changed Items:



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## Form Schedule

### Lead Form Number: CPCI0400

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 02/23/2011	CPCI0400	Policy/Contract	Group Master Policy for Critical Illness Indemnity Insurance Certificate	Initial		54.000	CPCI0400 Critical Illness Policy-12011.pdf
Approved-Closed 02/23/2011	CCCI0400	Certificate	Certificate for Group Critical Illness Indemnity Insurance	Initial		59.000	CCCI0400 Critical Illness Certificate-2-3-2011.pdf
Approved-Closed 02/23/2011	CECI04AR	Certificate Amendment, Insert	State Amendment	Initial			CECI04AR - State Amendment 2-22-2011.pdf
Approved-Closed 02/23/2011	CRCAN400	Certificate Amendment, Insert	Cancer Benefit Rider	Initial		56.000	CRCAN400 Cancer Benefit Rider-12011.pdf
Approved-Closed 02/23/2011	CRRCI400	Certificate Amendment, Insert	Recurrent Critical Illness Benefit Rider	Initial		57.000	CRRCI400 Recurrent Critical Illness Benefit Rider-12011.pdf
Approved-Closed 02/23/2011	CRWEL400	Certificate Amendment, Insert	Wellness Benefit Rider	Initial		61.000	CRWEL400 Wellness Benefit Rider - 12011.pdf

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Product Name: Group Critical Illness Insurance Policy  
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Approval Status	Policy/Project ID	Document Type	Benefit Description	Initial	Amount	File Name
Approved- Closed 02/23/2011	CRICU400	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Intensive Care Benefit Rider	Initial	58.000	CRICU400 Intensive Care Benefit Rider - 12111.pdf
Approved- Closed 02/23/2011	CRINJ400	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Initial Hospitalization for Accidental Bodily Injury Benefit Rider	Initial	58.000	CRINJ400 Initial Hospitalizatio n for Accidental Bodily Injury Benefit Rider- FINAL 2-3- 2011.pdf
Approved- Closed 02/23/2011	CREMT400	Certificate Amendmen t, Insert Page, Endorseme nt or Rider	Accident Emergency Treatment Benefit Rider	Initial	59.000	CREMT400 Accident Emergency Treatment Benefit Rider- FINAL 2-2- 2011.pdf
Approved- Closed 02/23/2011	CCI-AP-04- 00	Application/ Enrollment Form	Application	Initial	55.000	CCI-AP-04- 00-jd- 011411.pdf

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
A Stock Company

**Policyholder:** [ABC Eligible Group]  
**Address:** [123 Any Street  
Any City, State 01234]  
**Policy Number:** [0123456789B]  
**Policy Effective Date:** [January 1, 2011]  
**Policy Anniversary Date:** [January 1]  
**Premium Rate Guarantee Date:** [January 1, 2012]  
**Governing Jurisdiction:** [Any State]

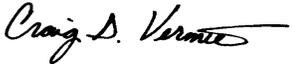
Transamerica Life Insurance Company ("the Company," "we," "us," and "our") agrees to pay the benefits described in this Group Master Policy ("Policy"), subject to all terms, conditions, and limitations, in consideration of:

1. The Policyholder Application, a copy of which is attached to and made a part of this Policy; and
2. The payment of the first premium.

By our acceptance of the first premium paid by the Policyholder ("you," "your," and "yours") and by your receipt of this Policy, you agree:

1. To be bound by the terms of this Policy; and
2. To pay all premiums to us according to the terms of this Policy.

This Policy is subject to the laws of the governing jurisdiction in which it is issued. It is signed for the Company at our Home Office to take effect on the Policy Effective Date.

[  ]  
[General Counsel and Secretary]

[  ]  
[President]

## Group Master Policy for Critical Illness Indemnity Insurance

**LUMP SUM BENEFIT FOR SPECIFIED CRITICAL ILLNESSES ONLY**  
**READ YOUR POLICY CAREFULLY**  
**NONPARTICIPATING - NO ANNUAL DIVIDENDS**

Administrative Office:  
[1400 Centerview Drive, PO Box 8063  
Little Rock, AR 72203-8063]  
Customer Service: [1-888-763-7474]

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## DEFINITIONS

The defined terms below are subject to the provisions of this Policy:

**Active Service** - The Insured, if an employee, will be:

1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. These duties are performed at one of the places of business where the Insured normally does such duties or at some location to which his or her employment sends the Insured.

The Insured is said to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day, and he or she were in Active Service on the last preceding regular work day.

For members, the Insured will be in Active Service if he or she meets the eligibility requirements on the Policyholder Application on the Effective Date of coverage.

**Amendment, Endorsement, or Rider** – Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

**Application** – The form completed and signed to apply or enroll for this insurance coverage.

**Certificate** – The document given to each Insured that describes the terms of the insurance made available to insured employees or members and their insured Spouse or Other Adult Dependent and/or insured Dependent Children, as defined in the Certificate, if applicable.

**Effective Date or Policy Effective Date** - The date coverage is in effect is shown on the cover page of this Policy. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

**Evidence of Insurability** – The correct and complete answers to the questions in the Application and medical history, if necessary, which may be used by us to base our acceptance of any proposed Covered Person.

**Group Master Policy or Policy** – The complete contract of insurance, which includes the Policy as issued to you, as well as any Certificates issued to each Insured, including any Amendments, Endorsements, Riders, and Applications.

**Insured** – The eligible employee or member, as defined by the Policyholder, who has been approved by us for coverage, and whose name appears on the Certificate's Schedule of Benefits.

**Policyholder** – The entity named on the cover page of this Policy.

## ELIGIBILITY

### EMPLOYEE OR MEMBER AND DEPENDENT ELIGIBILITY REQUIREMENTS

**Employees or Members** - To be eligible, an employee or member must:

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Provide satisfactory Evidence of Insurability to us, if required; and
3. Be in Active Service on the Effective Date of coverage.

An Application must be completed, and any required premium paid, within 31 days of the date enrollment is offered to the employee or member. If such Application is not made within that 31-day period, the employee or member will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

**Dependents** - If Dependent coverage is available, a Dependent will be eligible for such coverage on the later of the following dates:

1. The day an employee or member becomes eligible for coverage; or
2. The day a Dependent first meets the definition of Dependent.

The Insured may elect Dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the Dependent becomes eligible;
2. Providing satisfactory Evidence of Insurability to us, if required, and
3. Completing any required form for payroll deduction, if applicable.

If such Application for Dependent coverage is not made within that 31-day period, the Spouse or Other Adult Dependent or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

If an employee or member and his or her Spouse or Other Adult Dependent are both eligible as an employee or member, the Children may be insured as Dependents of either the employee or member or his or her Spouse or Other Adult Dependent, but not both.

## PREMIUMS

**Premium Calculation And Due Dates** - The premium due will be the sum of the premiums applicable for all Insureds. You must pay the premiums to us at our Administrative Office.

The premiums are due and payable to us in advance by you on each premium due date. The first premium due date is the Policy Effective Date.

**Premium Rate Guarantee** - These premium rates are guaranteed until the date shown on the Policy's cover page and are subject to the Change in Premium Rates provision.

**Grace Period** - A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. This Policy will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premiums. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If cancellation is during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force.

**Change in Premium Rates** - We have the right to change the premium rates on any premium due date after the end of the Premium Rate Guarantee. If the rates are changed, we will give you at least a 31-day advance written notice. If an increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased without regard to any Premium Rate Guarantee.

## POLICY CHANGES

**Who May Change This Policy** - The terms of this Policy may be changed at any time by written agreement between you and us. Only our President, Vice President, Secretary, or an Assistant Secretary can authorize a change in this Policy. Such an authorization must be in writing and signed by an officer. The terms of this Policy can be changed only by endorsement or amendment signed by an officer of Transamerica Life Insurance Company. No agent has the right to change or waive any terms of this Policy. All changes are subject to the laws of the governing jurisdiction.

**When Policy Changes Are Effective** - Unless you and we agree otherwise in writing, the Effective Date of any change in benefits will be the first day of the calendar month that coincides with or next follows the date we send notice to you of the change in benefits and any corresponding change in premiums.

## POLICYHOLDER PROVISIONS

**Termination** - This Policy will end on the earliest of the following events:

1. If you submit a 60-day advance written request to us to terminate this Policy, this Policy will terminate on the date specified in that request.
2. If we give a 60-day advance written notice to you that we intend to terminate this Policy, this Policy will terminate on the date specified in that notice.
3. If any premium payable by you is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period.
4. If you fail to comply with any terms of this Policy or the Application, or otherwise fail to fulfill any obligations or duties under or pertaining to this insurance, or fail to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this Policy will terminate on the 32<sup>nd</sup> day after we have given you written notice of our intent to terminate.
5. If the number of Insureds during any 12-month period does not meet the Minimum Participation Requirement, this Policy may terminate at our discretion on the 32<sup>nd</sup> day after we have given you written notice of our intent to terminate.

Termination of an Insured's coverage that was effective prior to the date your coverage terminated will be governed by the Termination of Insurance provision of the Certificate. You are required to notify us of any such termination.

**Duties** - Your duties will include, but are not limited to, the following:

1. As required, give us any and all information we determine to be necessary for the enrollment of your employees or members (and their Spouse or Other Adult Dependent and/or Dependent Children, if such coverage is available and has been elected and approved by us), and for the determination of their eligibility.
2. Receive and forward to us, the Applications of your employees or members.
3. Maintain records pertaining to the insurance of your employees or members as we may reasonably require while this Policy is in force and for two years after this Policy terminates, and allow us the opportunity to examine these records at any reasonable time during normal business hours.
4. Pay premiums to us.
5. In the event that any of this insurance is to be stopped:
  - a. You are required to notify the insured employees or members by either giving them a written notice or mailing a notice to their last known address as shown in your records; and
  - b. You are required to provide the insured employees or members with a notice of their right to opt for the Portability Option, as described in the Certificate.

**Minimum Participation Requirement** – You must maintain the participation levels described in the Policyholder Application. If participation falls below the minimum participation limit, we have the right to cancel this Policy.

## GENERAL PROVISIONS

**Certificates** - A Certificate will be issued for delivery to each Insured. The Certificate will describe:

1. The benefits under this Policy;
2. To whom benefits will be paid;
3. The limitations and terms of this Policy; and
4. All other essential features of the Policy.

If more than one Certificate is issued to an Insured under this Policy, only the last one issued will be in effect.

**Conformity With State Laws** - A provision of the Policy and any Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

**Entire Contract** - The entire contract consists of: this Policy; Policyholder Application; the Certificates; any attached Amendments, Endorsements, Riders; and Insureds' Applications.

**Legal Action** - No legal action may be brought to recover under the Policy and any Certificate:

1. Within 60 days after written Proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

**New Insureds** - The group originally insured may be modified from time to time to add eligible new persons in accordance with the terms of the Policy.

**Time Limit On Certain Defenses** - Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after this Policy has been in force for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

The validity of this Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums.

### **CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY**

The remainder of this Policy consists of the provisions that appear in the Certificate, including any Amendments, Endorsements, or Riders, that describe the insurance made available to the employees or members (and their Spouse or Other Adult Dependent and/or Dependent Children, if applicable) under this Policy.

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
A Stock Company

This Certificate explains the Group Master Policy for Critical Illness Indemnity Insurance ("Policy") that is underwritten by Transamerica Life Insurance Company (the "Insurer"). Read it closely to become familiar with your coverage.

Terms important to understanding this Certificate are defined in the **Definitions** section or in separate Certificate Provisions and are capitalized in this Certificate.

**Important Notice** – Benefits are payable for loss due to a covered Critical Illness while the Covered Person is insured under the Policy, subject to the provisions of this coverage. The Policy does not provide benefits for any other sickness or condition.

The Policy under which this Certificate is issued may be amended or canceled, as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to periodic changes.

The benefits for Dependents described in this Certificate will be applicable to each of your Dependents only if you are insured and you have applied for Dependent coverage. Any Application requesting Dependent coverage must be approved by us, and the required premium paid for each Dependent.

This Certificate is signed for the Company at our Home Office to take effect on the Effective Date.

  
[General Counsel and Secretary]

  
[President]

## Certificate for Group Critical Illness Indemnity Insurance

**LUMP SUM BENEFIT FOR SPECIFIED CRITICAL ILLNESSES ONLY  
READ YOUR CERTIFICATE CAREFULLY  
NONPARTICIPATING - NO ANNUAL DIVIDENDS**

Administrative Office:  
[1400 Centerview Drive, PO Box 8063  
Little Rock, AR 72203-8063]  
Customer Service: [1-888-763-7474]

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## SCHEDULE OF BENEFITS

INSURED: [John Doe]	AGE AT ISSUE: [35]
CERTIFICATE NUMBER: [123456789ABC]	EFFECTIVE DATE: [JUNE 1, 2007]
COVERAGE TYPE: [INDIVIDUAL]	RATE CLASS: [NONTOBACCO]
PREMIUM CONTRIBUTION FROM INSURED: [\$52.50]	PREMIUM MODE: [MONTHLY]
INSURED BENEFIT AMOUNT: [\$50,000] [PROVIDED BY POLICYHOLDER: [\$5,000]]	[PURCHASED BY INSURED: [\$45,000]]
DEPENDENT BENEFIT AMOUNT: [\$25,000] PER COVERED DEPENDENT [PROVIDED BY POLICYHOLDER: [\$5,000]]	[PURCHASED BY INSURED: [\$20,000]]

LIFETIME MAXIMUM IS 3 TIMES THE APPLICABLE BENEFIT AMOUNT PER COVERED PERSON

**TYPE OF COVERAGE**

**PERCENTAGE OF BENEFIT AMOUNT**

**CATEGORY 1**

Heart Attack	100%
Stroke	100%
Heart Transplant	100%
Coronary Bypass Surgery	25%
Angioplasty/Stent	5%

**CATEGORY 2**

Major Organ Transplants (excluding Heart)	100%
End Stage Renal Failure	100%
Paralysis Not Due to Stroke (all 4 limbs)	100%; 50% (if fewer than 4 limbs)]
Burns	100%
Coma	100%
Loss of Sight, Speech, and/or Hearing	100%
Miscellaneous Diseases	100%
Alzheimer's Disease	30%

**[CATEGORY 3 – Optional Cancer Benefit Rider**

Invasive Cancer	100%
Bone Marrow Transplant	100%
Carcinoma In Situ	25%
Prostate Cancer with TNM Classification of T1	25%
Skin Cancer	5%]

**[CATEGORY 4 – Occupational HIV Benefit Rider (Insured Only–No Dependent Coverage)100%]**

**[OPTIONAL BENEFIT RIDERS**

[Recurrent Critical Illness Benefit Rider	[50%]]
[Quality of Life Benefit Rider	5% of Benefit Amount per month (not to exceed 100% of Benefit Amount in aggregate)]
[Policyholder Provided-Wellness Benefit Rider	[\$50] per Covered Person per Calendar Year]
[[Insured Purchased] Wellness Benefit Rider	[\$50] per Covered Person per Calendar Year]
[Policyholder Provided Intensive Care Benefit Rider (ICU) Daily Indemnity Benefit	[\$100] per day of ICU Confinement]
[[Insured Purchased] Intensive Care Benefit Rider (ICU) Daily Indemnity Benefit	[\$100] per day of ICU Confinement]]
[Initial Hospitalization for Accidental Bodily Injury Benefit Rider	[\$500] per one Hospital Confinement per Covered Accident per Covered Person]
[Accident Emergency Treatment Benefit Rider	[\$150] per Covered Accident per Covered Person]

## DEFINITIONS

The defined terms below are subject to the provisions of the Policy and this Certificate.

**Active Service** – For employees, you are:

1. Performing in the usual manner all of the regular duties of your occupation on a scheduled work day; and
2. These duties are performed at one of the places of business where you normally do such duties or at some location to which your employer sends you.

You are said to be in Active Service on a day which is not a scheduled work day only if you would be able to perform in the usual manner all of the regular duties of your occupation if it were a scheduled work day, and you were in Active Service on the last preceding regular work day.

For members, you are in Active Service if you meet the eligibility requirements on the Policyholder Application on the Effective Date of coverage.

**Amendment, Endorsement, or Rider** – Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provisions or benefits.

**Application** – The form completed and signed to apply or enroll for this insurance coverage.

**Calendar Year** - The period from January 1 through December 31 of the same year.

**Category** - A grouping of Critical Illnesses as identified within the Schedule of Benefits. Each separate Category comes with its own set of benefits.

**Certificate** – This document that describes your Critical Illness Indemnity Insurance coverage.

**Child** - A Child of yours who is under the Age of 26 and is:

1. Your natural Child; or
2. Your legally adopted Child or a Child who has been placed for adoption with you; or
3. Your stepchild or foster Child; or
4. Your grandchild who lives with you; or
5. A Child for whom you have been appointed legal guardian; or
6. A Child for whom you are legally required to provide support.

Child also includes a Child who is incapable of self-support due to a mental retardation or physical handicap. If a Child has reached Age 26, but is incapable of self-support because of mental retardation or physical impairment, we will continue the Child's coverage under the following conditions:

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate;
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains Age 26; and
4. Your coverage must remain in force.

**Covered Person** – You and any of your Dependents who have been accepted by us for coverage.

**Critical Illness** - One of the illnesses or conditions listed below for which positive diagnosis is made by a Physician. It must be based on diagnostic criteria generally accepted by the medical profession, as defined below under Categories 1 and 2.

### **CATEGORY 1**

**Heart Attack** – The ischemic death of a portion of heart muscle as a result of obstruction of one or more of the coronary arteries. A positive diagnosis must be supported by either of the following criteria:

1. The presence of three or more of the following indicators:
  - a. typical chest pain suggestive of Heart Attack;
  - b. new EKG changes indicative of myocardial infarction;
  - c. diagnostic increase of specific cardiac markers typical for Heart Attack; and
  - d. confirmatory imaging studies.
2. In the event of death, an autopsy confirmation identifying Heart Attack as the cause of death will be accepted.

**Stroke** – A cerebrovascular event resulting in permanent neurological damage, including infarction, hemorrhage, or embolization of brain tissue from an extracranial source. The diagnosis must be based on:

1. Documented neurological deficits; and
2. Confirmatory neuroimaging studies.

Stroke does not include cerebral symptoms due to:

1. Transient Ischemic Attack (TIA);
2. Reversible neurological deficit;
3. Migraine;
4. Cerebral injury resulting from trauma or hypoxia; or
5. Vascular disease affecting the eye, optic nerve or vestibular functions.

**Heart Transplant** – The irreversible failure of a Covered Person's heart for which a Physician has determined that the complete replacement of such heart with an entire heart from a human donor is Necessary. Such Covered Person has been placed on the Transplant List or the transplant procedure has been performed.

**Coronary Bypass Surgery** - Undergoing of a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts on the advice of a board-certified cardiologist. Angiographic evidence to support the necessity for this surgery will be required. The following procedures are not considered coronary artery by-pass surgery: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

**Angioplasty/Stent** - Balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries. Coronary angioplasty must be performed by a Physician who is also a board-certified cardiologist. This benefit is confined to the heart; therefore, angioplasty/stenting of renal arteries or other peripheral arteries are excluded from this benefit.

## **CATEGORY 2**

**Major Organ Transplant (excluding Heart)** – The irreversible failure of a Covered Person's lung, pancreas, entire kidney or any combination, for which a Physician has determined that the complete replacement of such organ with an entire organ from a human donor is Necessary. It can also be the irreversible failure of a Covered Person's liver for which a Physician has determined that the complete or partial replacement of the liver or liver tissue from a human donor is Necessary. Such Covered Person has been placed on the Transplant List or the transplant procedure has been performed.

**End Stage Renal Failure** – The end stage failure which presents a chronic irreversible failure of both kidneys, and requires treatment by renal dialysis or kidney transplant.

**Paralysis** - Means quadriplegia, paraplegia, or hemiplegia that is expected to last for a continuous 12-month period or longer from the date of diagnosis to determine if paralysis is permanent. "Quadriplegia" means the complete and irreversible paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible paralysis of the upper and lower limbs on the same side of the body. "Limb" means an entire arm or an entire leg. A benefit will not be paid for paralysis that results from a stroke or psychiatric related causes.

**Burns** - The cosmetic disfigurement of body surface or area that is a full-thickness or third-degree burn covering at least 50% of the body surface. A full-thickness or third-degree burn is the injury and destruction of skin through the entire thickness or depth of the dermis and possibly to underlying tissue with a loss of fluid and sometimes shock caused by exposure to fire, heat, caustics, electricity, or radiation.

**Coma** – The state of unconsciousness for 30 consecutive days with:

1. No reaction to external stimuli;
2. No reaction to internal needs; and
3. The use of life support systems.

The diagnosis of Coma must indicate that permanent neurological deficit is present.

**Loss of Sight, Speech, and/or Hearing** – will mean:

1. Loss of Sight - the total and irreversible loss of all sight in both eyes;
2. Loss of Speech - the total and permanent loss of the ability to speak as the result of physical injury or disease;
3. Loss of Hearing - the total and irreversible loss of hearing in both ears. Loss of Hearing that can be corrected by the use of any hearing aid or device will not be considered an irrevocable loss.

**Miscellaneous Diseases** – The following diseases will be considered Category 2 Critical Illnesses when diagnosed by a Physician:

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

Encephalitis/meningitis

Rocky Mountain Spotted Fever

Typhoid Fever

Anthrax

Cholera

Primary Sclerosing Cholangitis (Walter Payton's Disease)

Tuberculosis

**Alzheimer's Disease** - A clinically established diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, 2 or more of the following activities of daily living:

1. Bathing;
2. Dressing;
3. Eating;
4. Toileting;
5. Transferring; or
6. Incontinence.

**Dependent** – Your Spouse or Other Adult Dependent and Child(ren) covered under this Certificate.

**Effective Date** - The date coverage is in force is shown on the Schedule of Benefits. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

**Evidence of Insurability** – The correct and complete answers to the questions in the Application and medical history, if applicable, which may be used by us to base our acceptance of any proposed Covered Person.

**First Occurrence** - A Critical Illness that was diagnosed for the very first time and is the first Critical Illness ever diagnosed within the applicable Category to which the diagnosed Critical Illness belongs. (Diagnosis can occur after death, if the death is due to a Critical Illness.)

**Grace Period** – The period of 31 days allowed for each premium payment after the first premium.

**Group Master Policy or Policy** – The complete contract of insurance, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to Insureds, including any Amendments, Endorsements, Riders, and Applications.

**Immediate Family Member** – You, your Dependents, mother, father, brother, sister, or other close family member of the Covered Person.

**Insured, you, your, or yours** – The employee or member covered for this insurance and named in the Schedule of Benefits.

**Necessary** – There is medical evidence to support the diagnosis.

**Other Adult Dependent** - Your common law marriage partner, domestic partner, or civil union partner, if legally required in the governing jurisdiction or as otherwise agreed upon between the Policyholder and us.

**Physician** - A licensed practitioner of the healing arts who:

1. Performs only those services permitted by his or her license; and
2. Is not an Immediate Family Member.

**Policyholder** – The entity named on the Policy's Cover Page.

**Schedule of Benefits or Schedule** - The benefit schedule set forth in this Certificate.

**Spouse** - Your legally married Spouse named in the Application-

**Transplant List** - The Organ Procurement and Transportation Network (OPTN) list.

**Treatment Free** - The Covered Person is no longer receiving care from a Physician, nor regular office visits, or being prescribed medication for a Critical Illness, other than routine check ups or maintenance medication for that Critical Illness.

**Transamerica Life Insurance Company, the Company, we, us, or our** – The Insurer that underwrites this coverage.

## ELIGIBILITY AND EFFECTIVE DATE

Effective Dates and Coverage Type are shown on the Schedule of Benefits. Coverage will start on such date at 12:01 AM at the main place of business of the Policyholder. Effective Dates for all persons added to coverage after this Certificate is issued will be reflected by an endorsement to the Certificate. The Insured may select from three Coverage Types: Individual, Single Parent Family, or Family.

**Coverage Type** – You, as the Insured, may select:

1. Individual coverage for you only; or
2. Single Parent Family coverage for you and your Children; or
3. Family coverage for you, your Spouse or Other Adult Dependent, and your Children.

**Employee or Member Eligibility** - To be eligible for insurance, you must:

1. Meet eligibility requirements as selected on the Policyholder's Application; and
2. Satisfactorily answer all eligibility and other questions on the Application; and
3. Provide Evidence of Insurability satisfactory to us, if we ask for it; and
4. Be in Active Service.

**Employee or Member Effective Date** - Your insurance will take effect on the Effective Date of the Policy if:

1. You completed an Application on or before said Effective Date; and
2. You are in Active Service; and
3. Your first premium is paid and received by us.

If you are not eligible for this coverage on the Policy Effective Date, your coverage will take effect on the first day of the month which coincides with or next follows the date you first become eligible and are approved for coverage. Additionally, your first premium must have been received by us, and all provisions listed in the Employee or Member Eligibility provision above, must be met.

**Dependent Eligibility** - If Dependent coverage is available, a Dependent will be eligible for such coverage on the later of the following dates:

1. The day you become eligible for coverage; or
2. The day he or she first meets the definition of Dependent.

You may elect Dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
2. Providing Evidence of Insurability satisfactory to us, if we ask for it; and
3. Completing any required form for payroll deduction, if applicable.

You must complete an Application for enrollment of a Spouse or Other Adult Dependent, or Child, and pay any required premium within 31 days of the date your Dependent meets these eligibility criteria. If such Application is not made within that 31-day period, your Dependent will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Any eligible Dependent who does not become a Covered Person on your Effective Date may be added to this Certificate subject to:

1. The completion of an Application;
2. Satisfaction of any Evidence of Insurability requirements; and
3. Payment of any additional premium, if required.

If you and your Spouse or Other Adult Dependent are both eligible as an employee or member, the Children may be insured as Dependents of either you or your Spouse or Other Adult Dependent, but not both.

**Dependent Effective Date** - The Effective Date of coverage for each eligible Dependent will be on the first day of the month that coincides with or next follows:

1. Our acceptance of the Application; and
2. Our receipt of the first premium.

However, if on such date your coverage has not yet taken effect, the Effective Date for Dependent coverage will be the same as your Effective Date.

**Newborn Child or Newly-Adopted Child Effective Date** - Coverage for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on the day he or she is born, the day the Child is placed for adoption or the day a court enters an order appointing you the legal guardian of the Child, as long as you have Single Parent Family or Family coverage in force on that date.

If this Certificate was issued as Individual coverage, the Child will be automatically covered for 31 days. In order to continue the Child's coverage:

1. You must notify us by the end of the 31-day period of the addition of such Child; and
2. You must elect either the Single Parent Family or Family coverage, and pay any applicable additional premium.

## BENEFITS

**Critical Illness Benefit** – If a Covered Person is diagnosed with the First Occurrence of a Critical Illness, we will pay a lump sum benefit equal to the Benefit Amount multiplied by the applicable percentage shown in the Schedule of Benefits. The positive diagnosis must be made after the Effective Date of this Certificate and while this Certificate is in force.

If the total sum of the Critical Illness Benefit paid in a Category is less than 100% of the Benefit Amount, we will pay upon the diagnosis of a different type of Critical Illness within the same Category. This lump sum benefit is equal to the Benefit Amount multiplied by the applicable percentage shown in the Schedule of Benefits, not to exceed 100% of benefits within the same Category.

The cumulative Critical Illness Benefit paid will not exceed 100% of the Benefit Amount within each applicable Category.

**Lifetime Maximum Benefit** - The total benefits paid under this Certificate, including any attached Riders, will not exceed the Lifetime Maximum Benefit listed in the Schedule of Benefits for each Covered Person.

**Benefit Payments** - Benefit payments will be made directly to you. Proof of any Critical Illness diagnosis must be submitted to us. Dependents are covered at a percentage of the Benefit Amount as stated in the Schedule of Benefits.

## EXCLUSIONS

We do not cover losses caused by, or as a result of, the:

1. Conditions other than those due to a covered Critical Illness.
2. Covered Person participating or attempting to participate in an illegal activity.
3. Covered Person intentionally causing self-inflicted injury.
4. Covered Person committing or attempting to commit suicide, whether sane or insane.
5. Covered Person's involvement in any period of armed conflict.
6. Surgeries performed outside the United States or its Territories.

Under no condition will we pay any benefits for losses or medical expenses incurred prior to the Effective Date.

We may reduce or deny a claim or void the Certificate for loss incurred by a Covered Person:

1. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected our acceptance of the risk; or
2. At any time for fraudulent misstatements in the Application.

## PREMIUMS

All premiums are payable on or before the date they are due.

We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 31-day advance written notice to the Policyholder, or to you if the Portability Option is in effect. If an increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee.

## TERMINATION OF INSURANCE

Subject to the Portability Option, your insurance will cease on the earliest of:

1. The date of your death;
2. The date on which you cease to be eligible for coverage;
3. The last date for which premium payment has been made to us, subject to the Grace Period;
4. The date on which you terminate employment;
5. The date the Policy terminates, subject to the Portability Option; or
6. The date you send us a written notice that you want to cancel coverage.

The insurance on a Dependent will cease on the earliest of:

1. The date of your death;
2. The date your coverage terminates;
3. The last date for which premium payment has been made to us, subject to the Grace Period;
4. The date the Dependent no longer meets the definition of Dependent;
5. The date the Certificate is modified so as to exclude Dependent coverage; or
6. The date you send us a written notice that you want to cancel coverage on your Dependent.

We will have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Certificate.

## PORTABILITY OPTION

While you are alive, if you lose eligibility for this insurance for any reason other than nonpayment of premiums, you will have the option to continue this Certificate (including any Riders, if applicable) by paying the premiums directly to us at our Administrative Office within 31 days after this insurance terminates. We will bill you for these premiums after you notify us to continue this coverage. The premiums you pay directly to us may exceed the premiums that were paid through the Policyholder due to increased administrative costs for direct billing. If you stop paying the premiums under this option, this coverage will cease, subject to the terms of the Grace Period.

This Portability Option is only available for the Insured and the Insured's Dependents; it is not available for the Insured's Dependents without the Insured.

## CLAIMS PROVISIONS

**Claim Forms** - Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision.

**Claims Procedure** - Due Proof of Loss must be submitted to us at our Administrative Office. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

**Notice of Claim** - Written notice of claim must be given to us at our Administrative Office, or to our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

**Payment of Claim Benefits** - All benefits payable under the Policy will be paid to you. Any benefits that are not paid at your death will be paid to your Spouse or Other Adult Dependent, or to your estate if there is no Spouse or Other Adult Dependent. We may pay up to \$1,000.00 of such benefit to one of your relatives at our discretion. Such payment fully discharges us to the extent of the payment.

**Proof of Loss** - Satisfactory written Proof of Loss must be given to us at our Administrative Office. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of such loss.

Failure to furnish such proof within such time will not invalidate nor reduce any claim if it was not reasonably possible to furnish such proof and that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the time of loss, unless the claimant was legally incapacitated.

**Time of Payment of Claims** - Benefits for a covered loss will be paid immediately after we have received satisfactory written Proof of Loss.

## GENERAL PROVISIONS

**Changes to this Certificate** - Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

**Clerical Error**- A clerical error by us will not invalidate insurance otherwise in force, nor continue insurance otherwise not validly in force.

**Conformity with State Laws** - A provision of the Policy and/or Certificate that conflicts with a law of the governing jurisdiction is hereby changed to meet the minimum standards of that law.

**Entire Contract** - The Entire Contract consists of the Policy, this Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, and your Application.

**Grace Period** - A Grace Period of 31 days will be allowed for each premium payment after the first premium is paid. Coverage will stay in force during this time. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid. You must still pay all unpaid premium. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If coverage is canceled during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which coverage was in force. Benefits may be reduced by the amount of any due, but unpaid premiums.

**Legal Action** - No legal action may be brought to recover under the Policy and/or Certificate:

1. Within 60 days after written Proof of Loss has been furnished as required; or
2. More than three years from the time written Proof of Loss is required to be furnished.

**Misstatement of Age** - If the Covered Person's age has been misstated, the Covered Person's true age will be used to adjust the premium or adjust the benefits paid.

**Misstatement of Tobacco Use Status** - If the Covered Person's tobacco use status has been misstated on the Application for this insurance coverage, the Covered Person's true tobacco use status will be used to adjust the premium or adjust the benefits paid.

**No Dividends Payable** - This Certificate does not participate in the profits or surplus earnings of our Company.

**Other Insurance With Us** - If you have more than one Critical Illness policy or certificate with us, only the one chosen by you will remain in effect. We will refund all premiums paid for any other such coverage for the period of time duplicate coverage was in effect.

**Physical Examinations and Autopsy** - We have the right to have a Covered Person examined by a Physician of our choice as often as reasonably needed while a claim is pending. We will pay for such examination. In case of death, we may request an autopsy where it is not forbidden by law.

**Time Limit on Certain Defenses**

Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during your lifetime for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts would be subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

**When Notice is to be Given by Us** – Any notice to you will be sent to your last known address.

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
Administrative Office: [1400 Centerview Drive, PO Box 8063, Little Rock, AR 72203-8063]  
(Hereinafter called "the Company," "we," "us," or "our")

## ARKANSAS AMENDMENT

This Amendment is part of the contract to which it is attached. The contract is amended as follows for the contracts issued in the State of Arkansas.

The following notice is added to the cover page of the contract:

If we at Transamerica Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1904  
(501) 371-2640

## DEFINITIONS

The second paragraph of the definition of **Child** in the Contract is amended to read:

Child also includes a Child who is incapable of self-support due to a mental retardation or physical handicap. If a Child has reached Age 26, but is incapable of self-support because of mental retardation or physical impairment, we will continue the Child's coverage under the following conditions:

1. The Child must be incapacitated;
2. We must receive proof of incapacity prior to the time that coverage would otherwise terminate. If proof, that the Child was incapacitated from the date the Child attained the limiting age is not submitted before or at the time Proof of Loss is submitted for a claim, benefits will not be extended past the date the Child attained the limiting age.
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains Age 26; and
4. Your coverage must remain in force.

## ELIGIBILITY AND EFFECTIVE DATE

The following provision is added to the **Eligibility and Effective Date** section of the Contract:

**Newborn Child or Newly-Adopted Child Effective Date** - Coverage for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on:

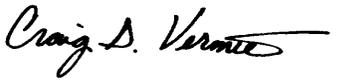
1. The day he or she is born. The Child will be automatically covered for 90 days.
2. The date you file a petition to adopt the Child if you apply for coverage within 60 days after the filing of the petition of adoption. However, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the Child.
3. The day a court enters an order appointing you the legal guardian of the Child, as long as you have Single Parent Family or Family coverage in force on that date.

If this Certificate was issued as Individual coverage, the Child will be automatically covered for the times shown in the above paragraph. In order to continue the Child's coverage:

1. You must notify us by the end of the period shown above of the addition of such Child; and
2. You must elect either the Single Parent Family or Family coverage, and pay any applicable additional premium.

This Amendment does not waive, alter, or extend any conditions or provisions of the contract except to the extent shown. It is subject to all the terms and limitations of the contract. This Amendment takes effect and expires concurrently with the contract to which it is attached.

This Amendment is signed for the Company at our Home Office to take effect on the contract's Effective Date.

  
[General Counsel and Secretary]

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]

Administrative Office: [1400 Centerview Drive, PO Box 8063, Little Rock, AR 72203-8063]  
(Hereinafter called "the Company," "we," "us," or "our")

## CANCER BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail.

### DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

**Bone Marrow Transplant** – The irreversible failure of a Covered Person's bone marrow for which a Physician has determined that the replacement of such Covered Person's bone marrow with bone marrow from the Covered Person, or another human donor is Necessary.

**Clinical Diagnosis** - A Clinical Diagnosis of Cancer is based on the study of symptoms.

**Cancer** - For purposes of this Rider, the word "Cancer" includes Skin Cancer, Carcinoma In Situ, Invasive Cancer, or Prostate Cancer with TNM Classification of T1, as defined herein.

- **Skin Cancer** - Basal cell epithelioma or squamous cell carcinoma. Skin Cancer does not include malignant melanoma or mycosis fungoides, which are not considered skin cancers under this Rider for the purpose of paying benefits.
- **Carcinoma In Situ** - Cancer that is in the natural or normal place, confined to the site of origin without having invaded neighboring tissue.
- **Invasive Cancer** - A Cancer which is evidenced by the presence of a malignant tumor characterized by uncontrolled and abnormal growth and spread of malignant cells, and the invasion of tissue. Leukemia, Hodgkin's Disease (except Stage 1 Hodgkin's Disease), and malignant melanoma will be considered Invasive Cancer.

Invasive Cancer does not include:

1. Pre-malignant conditions or conditions with malignant potential;
  2. Prostatic Cancers which are histologically described as TNM Classification T1 (including T1(a) or T1(b), or of other equivalent or lesser classification); and
  3. Any malignancy associated with the diagnosis of HIV.
- **Prostate Cancer with TNM Classification of T1**- Microscopic tumors of the prostate that are neither palpable nor visible on transrectal ultrasonography.

**Critical Illness** – Under this Rider, Bone Marrow Transplant and Cancer, as defined, will be included under the Critical Illness Benefit in the contract, subject to the benefit amounts as listed under Category 3 in the Schedule of Benefits:

**First Occurrence** - A Cancer that was diagnosed for the very first time and is the first Cancer ever diagnosed within Category 3. (Diagnosis can occur after death, if the death is due to a Cancer.) For purposes of this Rider, we will consider the first Skin Cancer diagnosis after the Effective Date as the First Occurrence. A Bone Marrow Transplant will be considered a First Occurrence the first time the Physician has determined that the Bone Marrow Transplant is Necessary. This First Occurrence must occur while this Rider is in force.

**Initial Positive Diagnosis/Initially Positively Diagnosed** - Cancer must be diagnosed by a Pathological or Clinical Diagnosis. An Initial Positive Diagnosis is the first time a Covered Person has received a Pathological Diagnosis based on the medical criteria as accepted by the American Board of Pathology or the Osteopathic Board of Pathology for the Cancer being investigated. We will accept a Clinical Diagnosis in lieu of a Pathological Diagnosis only when:

1. A Pathological Diagnosis cannot be made because it is medically inappropriate or life-threatening;
2. There is medical evidence to support the diagnosis; and
3. A Physician is treating a Covered Person for Cancer.

**Necessary** – There is medical evidence to support the treatment.

**Pathological Diagnosis** - A Pathological Diagnosis of Cancer is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system. This type of diagnosis must be done by a certified pathologist whose diagnosis of malignancy is in keeping with the standards set up by the American Board of Pathology.

## **BENEFITS**

This Rider adds the Category 3 Cancer coverage to the list of Critical Illnesses that are shown on the Schedule of Benefits of the contract to which this Rider is attached.

**Cancer or Bone Marrow Transplant Benefit** – If a Covered Person is diagnosed with the First Occurrence of Cancer or determined to have a First Occurrence for a Bone Marrow Transplant, we will pay a lump sum benefit equal to the Benefit Amount multiplied by the applicable percentage shown in the Schedule of Benefits provided that the Positive Diagnosis or Necessary transplant is made after the Effective Date of the contract and while this coverage is in force.

If the total Cancer or Bone Marrow Transplant Benefit paid in Category 3 is less than 100% of the Benefit Amount, we will pay a lump sum benefit equal to the Benefit Amount multiplied by the applicable percentage shown in the Schedule of Benefits upon the diagnosis of a different type of Cancer or Bone Marrow Transplant within the same Category. The cumulative Cancer or Bone Marrow Transplant Benefit paid within Category 3 will not exceed 100% of the Benefit Amount.

We will only pay for loss as a direct result of Cancer or Bone Marrow Transplant as defined herein. Proof of Positive Diagnosis or Necessary transplant must be submitted with each new claim.

## **EFFECTIVE DATE**

This Rider becomes effective on the same date as the contract's Effective Date unless we inform the Insured in writing of a different date.

## **EXCLUSIONS**

We will not pay for any disease or incapacity that has been caused, complicated, worsened, or affected by, or as a result of Cancer or its treatment.

Under no condition will we pay any benefits for losses or medical expenses incurred prior to the Rider Effective Date.

We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:

1. During the first 2 years from the Rider Effective Date for any misstatements in the Application which would have materially affected our acceptance of the risk; or
2. At any time for fraudulent misstatements in the Application.

## **TERMINATION**

This Rider will end on the earliest of:

1. The date the contract ends.
2. The date the contract or Rider lapses for failure to pay premium, subject to the Grace Period.
3. The date stated in the Policyholder's written request to end this Rider.

Termination of the contract and/or Rider by us will not affect any claim or loss which commenced while the contract and/or Rider were in force.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

[ *Craig D. Verme* ]

[General Counsel and Secretary]

[ *Granda Casey* ]

[President]

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
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## RECURRENT CRITICAL ILLNESS BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail.

### DEFINITIONS

**Critical Illness** – An illness, disease, or condition as covered under the contract.

**Recurrent Critical Illness** - A Critical Illness that is not eligible for payment under the Critical Illness Benefit in the contract as a First Occurrence.

### BENEFITS

This Rider provides a Recurrent Critical Illness benefit per Covered Person as follows:

A recurrence of the same type of Critical Illness is not eligible for the Recurrent Critical Illness Benefit, unless:

1. The diagnosis for the prior occurrence was at least 12 months from the most recent diagnosis; and
2. The Covered Person has been Treatment Free for at least 12 months.

If a Covered Person is diagnosed with a Recurrent Critical Illness, we will pay a lump sum benefit subject to any applicable maximum benefit payment limitation, provided that the positive diagnosis is made after the Effective Date and while this Rider is in force. The lump sum benefit equals the percentage shown for this Rider times the Benefit Amount times the applicable percentage as shown in the Schedule of Benefits.

The total Recurrent Critical Illness Benefit paid within each Category will not exceed the percentage shown for this Rider in the Schedule of Benefits times the Benefit Amount.

### EFFECTIVE DATE

This Rider becomes effective on the same date as the contract's Effective Date unless we inform the Insured in writing of a different date.

### EXCLUSIONS

Under no condition will we pay any benefits for losses incurred prior to the Rider Effective Date.

We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:

1. During the first 2 years from the Rider Effective Date for any misstatements in the Application which would have materially affected our acceptance of the risk; or
2. At any time for fraudulent misstatements in the Application.

### TERMINATION

This Rider will end on the earliest of:

1. The date the contract ends.
2. The date the contract or Rider lapses for failure to pay premium, subject to the Grace Period.
3. The date stated in the Policyholder's written request to end this Rider.

Termination of the contract and/or Rider by us will not affect any claim or loss which commenced while the contract and/or Rider were in force.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

[ *Craig D. Vermeir* ]

[General Counsel and Secretary]

[ *Jenna Casey* ]

[President]

# TRANSAMERICA LIFE INSURANCE COMPANY

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## WELLNESS BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail.

### BENEFITS

**Wellness Benefit** - We will pay the amount shown on the Schedule of Benefits per Calendar Year for each Covered Person when a charge is incurred for one of the below-listed health screening tests. This benefit is limited to one payment per Calendar Year per Covered Person. The Lifetime Maximum shown in the Schedule of Benefits does not apply to this Rider.

Health Screening Tests - The annual health screening tests payable under this benefit are listed as follows:

Biopsy	Flexible sigmoidoscopy
Blood test for triglycerides	Hemocult stool analysis
Bone marrow testing	Mammography
Breast ultrasound	Pap test
CA 125 (blood test for ovarian cancer)	PSA (prostate-specific antigen tests)
CA 15-3 (blood test for breast cancer)	Serum cholesterol test to determine HDL/LDL level
CEA (blood test for colon cancer)	Serum Protein Electrophoresis (blood test for myeloma)
Chest X-ray	Stress test on a bicycle or treadmill
Colonoscopy	Thermography
Fasting blood glucose test	

Health screening tests must be performed under the supervision of or recommended by a Physician, and a charge must be incurred. Satisfactory proof of the charges incurred for the health screening tests must be submitted with each new claim. Under no condition will we pay any benefits for losses incurred prior to the Rider Effective Date.

### EFFECTIVE DATE

This Rider becomes effective on the same date as the contract's Effective Date unless we inform the Insured in writing of a different date.

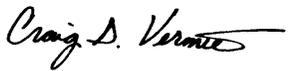
### TERMINATION

This Rider will end on the earliest of:

1. The date the contract ends.
2. The date the contract or Rider lapses for failure to pay premium, subject to the Grace Period.
3. The date stated in the Policyholder's written request to end this Rider.

Termination of the contract and/or Rider by us will not affect any claim or loss which commenced while the contract and/or Rider were in force.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

[  ]  
[General Counsel and Secretary]

[  ]  
[President]

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
Administrative Office: [1400 Centerview Drive, PO Box 8063, Little Rock, AR 72203-8063]  
(Hereinafter called "the Company," "we," "us," or "our")

## INTENSIVE CARE BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail.

### DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

**Actual Charge(s)** – The amount actually paid by or on behalf of the Covered Person and accepted by the provider as payment for the particular goods or services provided.

**Hospital** - A licensed institution that has on its premises or in facilities available to the Hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:

1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour nursing service by graduate registered nurses; and
4. A patient's written history and medical records.

We will consider a government or charity Hospital as any other Hospital.

The term "Hospital" does not include an institution or that part of an institution operated as:

1. A place for rehabilitation;
2. A place for rest, or for the aged;
3. A nursing or convalescent home;
4. A long term nursing unit or geriatrics ward; or
5. An extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

**Hospital Confinement, Confinement, or Confined** - That period of time the Covered Person is admitted into a medical facility on an inpatient basis in excess of 23 hours. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, or a freestanding surgical facility or outpatient facility. Successive Confinements separated by 30 days or less will be considered as one Confinement.

**Intensive Care Unit ("ICU")** – A specially designated area of a Hospital that provides the highest level of medical care restricted to those patients who are critically ill or critically injured. It must be separate and apart from the surgical recovery room and other rooms, wards, or beds normally used for patient Confinement. It must also:

1. Be provided with constant and continuous nursing care by nurses assigned on a full-time basis exclusive to such unit; and
2. Be under the full-time direction or supervision of either a Physician or a standing committee of the Hospital's medical staff; and
3. Contain special life-saving equipment.

ICU includes intensive cardiac and coronary care units, neonatal ICUs, and burn ICUs, if such units meet the conditions in this definition. ICU does not include any of the following lesser treatment units: private or semi-private rooms, private monitored/telemetry rooms, observation units, surgical recovery units, or other lesser treatment units.

**Period of Intensive Care Confinement** – A period of Hospital Confinement when the Covered Person is confined to the ICU or a Step Down Unit, and charged the Intensive Care or Step Down Unit rate for each day of such Confinement. If 30 days or less separates two Periods of Intensive Care Confinement, the second Period of Intensive Care Confinement will be considered a continuation of the first.

**Step Down Unit** – A specially designed area of the Hospital that provides medical care restricted to those patients who are critically ill or critically injured, providing a level of care just under that of an Intensive Care Unit. Step Down Unit includes: progressive care units; subacute intensive care units; and intermediate care units. This does not include lesser treatment units, such as: private or semi-private rooms; private monitored/telemetry rooms; observation units; or surgical recovery units.

## BENEFITS

The following benefits are payable as shown below.

**Daily Indemnity** - We will pay the amount shown on the Schedule of Benefits for this Rider for each day the Covered Person is Confined in an ICU. We will pay 50% of this Daily Indemnity Benefit for treatment in a Step Down Unit when the Covered Person is Confined on an inpatient basis. During any one Period of Intensive Care Confinement, our payments will not exceed 45 days for sickness or injury.

We will pay only one daily indemnity benefit per 24-hour period. The Lifetime Maximum shown in the Schedule of Benefits does not apply to this Rider.

**Ambulance** - We will pay the Actual Charges for transportation by a licensed ambulance service, not to exceed twice the daily indemnity benefit amount for one 24-hour period of ICU Confinement as shown on the Schedule of Benefits for this Rider. Transportation must be to a Hospital for admission to an ICU or a Step Down Unit for a covered Confinement.

Ambulance transportation in excess of 100 miles from the point of origin must be to the nearest Hospital which contains an ICU and provides necessary medical care.

Benefit payments will be made directly to you, unless you assign benefits. Proof of Loss must be submitted to us for each incurred expense.

## EFFECTIVE DATE

This Rider becomes effective on the same date as the contract's Effective Date unless we inform the Insured in writing of a different date.

## EXCLUSIONS

We will not pay any benefits for loss resulting from:

1. Specifically excluded diseases or conditions in the contract or in this Rider; or
2. An attempted suicide while sane or insane or an intentionally self-inflicted injury; or
3. Any act of war either declared or undeclared; or
4. Alcoholism or drug addiction; or
5. Mental or nervous disorders; or
6. An overdose of drugs, narcotics, hallucinogens, unless administered on the advice of a Physician; or
7. Intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a Physician; or
8. Injury received while engaging in an illegal occupation or activity.

Under no conditions will we pay any benefits for losses or medical expenses incurred prior to the Rider Effective Date.

We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:

1. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected our acceptance of the risk; or
2. At any time for fraudulent misstatements in the Application.

## TERMINATION

This Rider will end on the earliest of:

1. The date the contract ends.
2. The date the contract or Rider lapses for failure to pay premium, subject to the Grace Period.
3. The date stated in the Policyholder's written request to end this Rider.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

[ *Craig D. Vermeir* ]

[General Counsel and Secretary]

[ *Frenda Clancy* ]

[President]

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
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## INITIAL HOSPITALIZATION FOR ACCIDENTAL BODILY INJURY BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail.

### DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

**Accidental Bodily Injury** - An injury or injuries for which Necessary Treatment is received and benefits are provided. The injury or injuries must be sustained by a Covered Person and must be the direct cause of the loss, independent of disease or bodily infirmity. All such injuries, with any complications and any recurrences of complications arising from any one Covered Accident, will be deemed to be a single injury. Such injury or injuries must occur while this Rider is in force.

**Covered Accident** – An unforeseen occurrence which results in Accidental Bodily Injury and occurs while this coverage is in force and is not excluded in this Rider.

**Hospital** - A licensed institution that has on its premises or in facilities available to the Hospital on a contractually prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:

1. Laboratory, X-ray equipment, and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by or under the supervision of graduate registered nurses; and
4. A patient's written history and medical records.

We will consider a Government or Charity Hospital as any other Hospital.

The term "Hospital" does not include an institution or that part of an institution operated as:

1. A place for rehabilitation;
2. A place for rest or for the aged;
3. A nursing or convalescent home;
4. A long-term nursing unit or geriatrics ward; or
5. An Extended Care Facility for the care of convalescent, rehabilitative, or ambulatory patients.

**Hospital Confinement, Confinement, or Confined** - That period of time during which the Covered Person is admitted into a Hospital on an inpatient basis in excess of 23 hours as an overnight resident bed patient for the Necessary Treatment of a Covered Accident. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a freestanding surgical facility, or Outpatient facility.

Successive Confinements separated by 30 days or less will be considered as one Confinement.

**Necessary Treatment** - The medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service which is not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment, service, or expense which is experimental in nature is considered Necessary Treatment.

We may use a Peer Review Organization or other professional medical opinions to determine if health care services are:

1. Medically necessary;
2. Consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and

3. Provided in the most economical and medically appropriate site for treatment.

Expenses related to such services will not be considered Necessary Treatment if services are not considered to be:

1. Medically necessary; or
2. Consistent with professionally recognized standards of care with respect to quality, frequency, or duration.

### **BENEFITS**

While this coverage is in force, when a Covered Person is Hospital Confined for a Covered Accident, we will pay a lump sum benefit as shown on the contract's Schedule of Benefits for the initial hospitalization. Hospital Confinement must begin within 30 days of the Covered Accident.

This benefit is payable only once per Hospital Confinement per Covered Accident per Covered Person.

### **EFFECTIVE DATE**

This Rider becomes effective on the same date as the contract's Effective Date unless we inform the Insured in writing of a different date.

### **EXCLUSIONS**

1. Voluntarily taking, administering, absorbing, or inhaling poison, gas, or fumes;
2. Participating in any sport or sporting activity for wage, compensation, profit, or racing any type vehicle in an organized event;
3. War, or any act of war, whether declared or undeclared;
4. Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurred;
5. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
6. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
7. Intentionally self-inflicting a bodily injury or attempting suicide, while sane or insane;
8. Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.

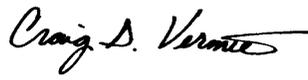
### **TERMINATION**

This Rider will end on the earliest of:

1. The date the contract ends;
2. The date the contract or Rider lapses for failure to pay premium, subject to the Grace Period; or
3. The date stated in the Policyholder's written request to end this Rider.

Termination of the contract and/or Rider by us will not affect any claim or loss which commenced while the contract and/or Rider were in force.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

[  ]

[General Counsel and Secretary]

[  ]

[President]

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
Administrative Office: [1400 Centerview Drive, PO Box 8063, Little Rock, AR 72203-8063]  
(Hereinafter called "the Company," "we," "us," or "our")

## ACCIDENT EMERGENCY TREATMENT BENEFIT RIDER

This Rider is issued in consideration of the Application and payment of any required premium. Except as shown in this Rider, the provisions of the contract to which this Rider is attached will prevail.

### DEFINITIONS

In addition to the definitions contained in the contract, the following definitions apply to this Rider.

**Accidental Bodily Injury** - An injury or injuries for which Necessary Treatment is received and benefits are provided. The injury or injuries must be sustained by a Covered Person and must be the direct cause of the loss, independent of disease or bodily infirmity. All such injuries, with any complications and any recurrences of complications arising from any one Covered Accident, will be deemed to be a single injury. Such injury or injuries must occur while this Rider is in force.

**Covered Accident** – An unforeseen occurrence which results in Accidental Bodily Injury and occurs while this coverage is in force and is not excluded in this Rider.

**Hospital** - A licensed institution that has on its premises or in facilities available to the Hospital on a contractually prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:

1. Laboratory, X-ray equipment, and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by or under the supervision of graduate registered nurses; and
4. A patient's written history and medical records.

We will consider a Government or Charity Hospital as any other Hospital.

The term "Hospital" does not include an institution or that part of an institution operated as:

1. A place for rehabilitation;
2. A place for rest or for the aged;
3. A nursing or convalescent home;
4. A long-term nursing unit or geriatrics ward; or
5. An Extended Care Facility for the care of convalescent, rehabilitative, or ambulatory patients.

**Necessary Treatment** - The medical treatment which is consistent with currently accepted medical practice. Any confinement, operation, treatment, or service which is not a valid course of treatment recognized by an established medical society in the United States is not considered Necessary Treatment. No treatment, service, or expense which is experimental in nature is considered Necessary Treatment.

We may use a Peer Review Organization or other professional medical opinions to determine if health care services are:

1. Medically necessary;
2. Consistent with professionally recognized standards of care with respect to quality, frequency, and duration; and
3. Provided in the most economical and medically appropriate site for treatment.

Expenses related to such services will not be considered Necessary Treatment if services are not considered to be:

1. Medically necessary; or
2. Consistent with professionally recognized standards of care with respect to quality, frequency, or duration.

## BENEFITS

While this coverage is in force, if a Covered Person receives treatment for a Covered Accident, we will pay a lump sum amount shown in the contract's Schedule of Benefits for treatment received in a Hospital emergency room.

Treatment must be received within 96 hours of such Covered Accident for benefits to be payable. This benefit is payable once per Covered Accident per Covered Person.

## EFFECTIVE DATE

This Rider becomes effective on the same date as the contract's Effective Date unless we inform the Insured in writing of a different date.

## EXCLUSIONS

We will not pay benefits for a Covered Person's accident that is caused by or occurs as a result of one of the following events:

1. Voluntarily taking, administering, absorbing, or inhaling poison, gas, or fumes;
2. Participating in any sport or sporting activity for wage, compensation, profit, or racing any type vehicle in an organized event;
3. War, or any act of war, whether declared or undeclared;
4. Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurred;
5. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly;
6. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
7. Intentionally self-inflicting a bodily injury or attempting suicide, while sane or insane;
8. Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.

## TERMINATION

This Rider will end on the earliest of:

1. The date the contract ends;
2. The date the contract or Rider lapses for failure to pay premium, subject to the Grace Period; or
3. The date stated in the Policyholder's written request to end this Rider.

Termination of the contract and/or Rider by us will not affect any claim or loss which commenced while the contract and/or Rider were in force.

This Rider is signed for the Company at our Home Office to take effect on the Rider Effective Date.

[  ]  
[General Counsel and Secretary]

[  ]  
[President]

[Logo]

Transamerica Life Insurance Company ("insurer")
Home Office: [Cedar Rapids, IA]
Administrative Office: [P.O. Box 8063
Little Rock, AR 72203-8063]

[Critical Illness
Employee]
Application

First Application [ ] Add Dependents - Certificate # [ ] Increase Coverage - Certificate # [ ]
Group Name [ABC Plumbing] Group Number [1234567] Location [Regional Plant]

Applicant (Last, First, M.I.) [Doe, John J.] [ ] Male [ ] Female Social Security No. [123-45-6789] Date of birth [04-20-1964] Home phone [(123) 456-7890]
Email Address [anyname@provider.com] [Do you agree to receive correspondence about your coverage electronically? [ ] Yes [ ] No] Have you used tobacco products in the last year? [ ] No [ ] Yes
Date of hire [08-10-2000] Avg hours worked per week [40] Occupation [Typesetter] Applicant ID [12345] Work phone/ext. [(123) 456-7891 ext. 222]
Home address [123 Any Street] City [Anytown] State [ST] Zip code [12345]

Table with 5 columns: Full name of dependents for which coverage is being applied for, Relationship to Applicant, Date of Birth, Social Security No., Used tobacco products in the last year?
[ ] No [ ] Yes
Does not apply to children

Payment Mode: [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Other [ ]

I Am Applying For: [ ] Individual [ ] Single Parent Family [ ] Family
Critical Illness Insurance [Plan [ ] ]
Table with 4 columns: [Policyholder Provided Benefit Amount\*], [Applicant Purchased Benefit Amount\*], [Applicant] Premium Per Payment Mode\*
Applicant \$ [10,000.00] \$ [10,000.00] \$ [14.00]
[Dependents (if applicable)] \$ [5,000.00] \$ [5,000.00]
[\*If increasing coverage, enter the TOTAL Benefit Amount and Premium.]

Eligibility Questions
1. [Are you actively at work on a full time basis and able to perform the regular duties of your occupation?] [Are you a member in good standing and able to perform the activities of a person of like age and gender?] [ ] Yes [ ] No
If "No", you [and your dependents] are not eligible for coverage.
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? [ ] Yes [ ] No
If "Yes", List name(s) [ ] , who will be excluded from coverage.

Evidence of Insurability Questions
3. Indicate height and weight for : Applicant / Spouse /
4. Has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease? [ ] Yes [ ] No
If "Yes", List name(s) [ ] , who will be excluded from coverage, unless included by special endorsement.
5. In the ten years prior to the application date, has any proposed insured been treated for, been diagnosed as having, or had any indication, sign, or symptom of having any heart (including heart attack), lung, brain, circulatory, respiratory, blood, vascular (including stroke), neurological, kidney, liver, pancreas, rheumatoid, or reproductive disorders, diabetes, optic neuritis, fibromyalgia, or chronic fatigue syndrome, had any medical or surgical procedures recommended (including major organ transplant) or advised by a physician but not done at this time, or, in the two years prior to the application date, been treated or counseled for alcohol or drug abuse? [ ] Yes [ ] No
If "Yes", List name(s) [ ] , who will be excluded from coverage, unless included by special endorsement.
6. Does any proposed insured have high blood pressure that is controlled by more than two medications? [ ] Yes [ ] No
If "Yes", List name(s) [ ] , who will be excluded from coverage, unless included by special endorsement.

**[Only answer if the coverage you are applying for includes the Cancer Rider**

7. In the ten years prior to the application date, has any proposed insured been diagnosed as having or been treated for any form of internal cancer, or malignancy (excluding basal cell skin cancer) which includes leukemia, Hodgkin's Disease, carcinoma, sarcoma, lymphoma, or malignant tumors?

[  Yes  No ]

If "Yes", List name(s) \_\_\_\_\_, who will be excluded from coverage, unless included by special endorsement.

8. In the past 12 months, has any proposed insured been recommended for any medical treatment that has not yet been completed, undergone a biopsy or other diagnostic test, or is now scheduled for such to determine whether any form of cancer or malignancy exists, other than a regular Pap Smear, Mammogram, Colonoscopy, or PSA test?

[  Yes  No ]

If "Yes", List name(s) \_\_\_\_\_, who will be excluded from coverage, unless included by special endorsement.

[Please provide details of all "Yes" answers to questions [4, 5, 6, 7, and 8]. Use additional paper if needed.  
For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.]

Question #	Name	Please list: Illness, Injury, Condition, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

[Is the insurance being applied for intended to replace any existing health or accident and sickness insurance coverage? [  Yes  No ]

If "Yes", list name of company \_\_\_\_\_, Policy/certificate # \_\_\_\_\_, complete the replacement form(s) provided by your agent and return with this application.]

**[For residents of [CA, GA, MA, and MN] only:**

Are all proposed insureds covered under major medical, hospital, or medical expense insurance, or an HMO contract? [  Yes  No ]

[If "No", list names \_\_\_\_\_, who will be excluded from coverage.

Coverage will not be issued to anyone who does not have comprehensive medical coverage. If applicant answers "No", no coverage will be issued.]

**[For [ID, MA, MT, NH and NJ] applicants only:**

Did you receive an Outline of Coverage describing the insurance you are applying for, which is required? [  Yes  No ]

I have read or had read to me the completed application.

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

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, 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 that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work on the effective date (according to the insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office.

I understand that completion of this application in no way implies that I will be accepted for insurance coverage.

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

Applicant's Signature \_\_\_\_\_ Spouse's Signature (if applicable) \_\_\_\_\_

**AGENT'S STATEMENTS AND AGREEMENTS:**

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application. [I also certify that this insurance [  does  does not] replace any existing health, accident and sickness, or disability insurance coverage.]

Licensed Representative's Name \_\_\_\_\_ Licensed Representative's Signature \_\_\_\_\_ Agent # \_\_\_\_\_

SERFF Tracking Number: AEGG-127016862 State: Arkansas  
 Filing Company: Transamerica Life Insurance Company State Tracking Number: 47915  
 Company Tracking Number:  
 TOI: H07G Group Health - Specified Disease - Sub-TOI: H07G.001 Critical Illness  
 Limited Benefit  
 Product Name: Group Critical Illness Insurance Policy  
 Project Name/Number: /CPCI0400

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	02/23/2011
<b>Comments:</b>		
<b>Attachment:</b> Readability Certification 1-19-2011.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	02/23/2011
<b>Comments:</b> Group Policyholder Application, form C-PH-01-00, was approved by your Department on 9/21/2010, SERFF Tracking # AEGG-126792395.		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Explanation of Variability	Approved-Closed	02/23/2011
<b>Comments:</b>		
<b>Attachment:</b> CCI-VARIABLES2010-00 Explanation of Variables - 2311.pdf		

## 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 Secretary
Signature	Officer's Title
Officer's name: Patsy J. Napier	Date: January 19, 2011

**GROUP CRITICAL ILLNESS INDEMNITY 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>
Group Master Policy for Critical Illness Indemnity Insurance	CPCI0400	3150	2107	81	54
Certificate for Critical Illness Indemnity Insurance	CCCI0400	6345	4244	197	59
Cancer Benefit Rider	CRCAN400	1540	1030	42	56
Intensive Care Rider	CRICU400	1604	1073	48	58
Recurrent Critical Illness Benefit Rider	CRRCI400	622	416	18	57
Wellness Benefit Rider	CRWEL400	422	282	15	61
Initial Hospitalization for Accidental Bodily Injury Rider	CRINJ400	1508	1009	46	58
Accident Emergency Treatment Benefit Rider	CREMT400	1402	938	44	59
Certificate Application	CCI-AP-04-00	1290	863	34	55

**TRANSAMERICA LIFE INSURANCE COMPANY  
GROUP CRITICAL ILLNESS INDEMNITY INSURANCE  
EXPLANATION OF VARIABLES**

**FORMS:** CPCI0400, CCCI0400, CRCAN400, CRRCI400, CRWEL400, CRICU400, CRINJ400, CREMT400, CCI-AP-04-00

**Bracketed text is either intended to be a) in or out of the forms; or b) variable as 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 reserves the right to correct at any time any and all typographical errors that do not impact benefits or intent of language.**

**Group Master Policy – CPCI0400**

The policyholder can select from the various benefit options, including the optional riders, to put together a Group Critical Illness Indemnity Policy that fits the needs of their employees or members.

Cover Page - The company's home office, the address and customer service phone number of the Administrative Office are variable in the event the home office address or administrative office of the policy changes.

The Policyholder through Governing Jurisdiction brackets are case specific for that Policyholder.

The signature and officer title brackets reflect the future potential that an officer name or title may change.

**Certificate of Insurance – CCCI0400**

Cover Page - The company's home office location, the address and customer service phone number of the administrative office are variable in the event the home office address or administrative office of the certificate changes.

The signature and officer title brackets reflect the future potential that an officer name or title may change.

**Certificate Schedule of Benefits**

The information contained above Coverage Type is all case-specific for the Certificateholder.

Coverage Type – Individual; Single Parent Family (Insured and Dependent Children Only); Family (Insured and all Dependents)

Rate Class – Nontobacco, Tobacco, or Uni-tobacco

The following ranges will apply:

Issue Ages – Adults – 18 and older  
Children – Birth to Age 26

Insured Benefit Amounts - \$1,000.00 to \$250,000.00

If the Policyholder contributes to the benefit amount, the breakdown of what amount is provided by the Policyholder and the remaining amount purchased by the Insured is listed.

Dependent Benefit Amount – \$500 - \$125,000 (50% of the Insured Benefit Amount) per Covered Dependent

If the Policyholder contributes to the benefit amount, the breakdown of what amount is provided by the Policyholder and the remaining amount purchased by the Insured for the Covered Dependent is listed.

Type of Coverage – Reflects all benefits and riders, including any that are optional. The optional benefits/riders are bracketed to be either "in" or "out."

Optional Benefit Riders - Each bracketed rider is optional and will be shown on the Schedule of Benefits if issued.

Recurrent Critical Illness Benefit Rider will be offered in a range of 25%, 50%, or 75% of the Benefit Amount

Wellness Benefit Rider will be a dollar amount benefit range from \$25 - \$500.

The bracketed Policyholder Provided statement will only be listed if the Policyholder is contributing to this benefit; , which case, the Insured Purchased statement would also appear.

Intensive Care Benefit Rider (ICU) will be a dollar amount daily indemnity benefit per day of ICU Confinement in the range from \$100 - \$2,000. The bracketed Policyholder Provided statement will only be listed if the Policyholder is contributing to this benefit, in which case, the Insured Purchased statement would also appear.

Initial Hospitalization for Accidental Bodily Injury Benefit Rider will be a dollar amount per one Hospital Confinement per Covered Accident per Covered Person in the range from \$500 - \$20,000.

Accident Emergency Treatment Benefit Rider will be a dollar amount per Covered Accident per Covered Person in the range of \$50 - \$5,000.

**Optional Benefit Riders - CRCAN400, CRRCI400, CRWEL400, CRICU400, CRINJ400, CREMT400**

The Optional Benefit Riders all have variable bracketing for the addresses of the Home Office and Administrative Office as well as the named officers and their titles to facilitate any future change.

**Application - CCI-AP-04-00**

This form is a print on demand form. It is bracketed in order to provide the maximum amount of flexibility for the benefits and underwriting criteria selected by the Policyholder.

The logo is bracketed in case our Transamerica Life Insurance Company logo should ever change. The address information is variable in case it should ever change location. The name is bracketed in case a product name is included.

The boxed text contains John Doe information in brackets.

Two types of underwriting are possible: (1) Guaranteed Issue for those who are purchasing an agreed upon amount of insurance – first two questions (eligibility questions) only; and (2) Simplified Issue – questions 1-6 must be answered. Simplified Issue - questions 7 - 8 are only answered if the Cancer Benefit Rider is included.

This application may also be used for late enrollees.

The application form may be used for internet solicitation. If the application is to be used on the internet, no substantive changes will be made to the format and no changes will be made to the actual application language. For the applicant's signature, a PIN or other electronic signature will be required to be captured three times: (1) Applicant's Statements and Agreements; (2) Representation of Applicant; and (3) Authorization to Release Medical Information. A PDF must be submitted to the Administrative Office and should include a checkmark on the Applicant's initials line and should include to the right a notion "Signature by PIN."



# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [Cedar Rapids, IA 52499]  
Administrative Office: [1400 Centerview Drive, PO Box 8063, Little Rock, AR 72203-8063]  
(Hereinafter called "the Company," "we," "us," or "our")

## ARKANSAS AMENDMENT

This Amendment is part of the contract to which it is attached. The contract is amended as follows for the contracts issued in the State of Arkansas.

The following notice is added to the cover page of the contract:

If we at Transamerica Life Insurance Company fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department  
Consumer Services Division  
1200 West Third Street  
Little Rock, AR 72201-1904  
(501) 371-2640

## DEFINITIONS

The second second paragraph of the definition of **Child** in the Contract is amended to read:

Child also includes a Child who is incapable of self-support due to a mental retardation or physical handicap. If a Child has reached Age 26, but is incapable of self-support because of mental retardation or physical impairment, we will continue the Child's coverage under the following conditions:

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate. We must receive proof of the Child's incapacity. If proof, that the Child was incapacitated from the date the Child attained the limiting age is not submitted before or at the time Proof of Loss is submitted for a claim, benefits will not be extended past the date the Child attained the limiting age.
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains Age 26; and
4. Your coverage must remain in force.

## ELIGIBILITY AND EFFECTIVE DATE

The following provision is added to the **Eligibility and Effective Date** section of the Contract:

**Newborn Child or Newly-Adopted Child Effective Date** - Coverage for a newborn, a newly adopted Child, or a Child for whom you are appointed the legal guardian, will become effective automatically on:

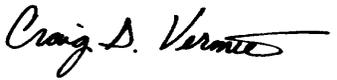
1. The day he or she is born. The Child will be automatically covered for 90 days.
2. The date you file a petition to adopt the Child if you apply for coverage within 60 days after the filing of the petition of adoption. However, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 days after the birth of the Child.
3. The day a court enters an order appointing you the legal guardian of the Child, as long as you have Single Parent Family or Family coverage in force on that date.

If this Certificate was issued as Individual coverage, the Child will be automatically covered for the times shown in the above paragraph. In order to continue the Child's coverage:

1. You must notify us by the end of the period shown above of the addition of such Child; and
2. You must elect either the Single Parent Family or Family coverage, and pay any applicable additional premium.

This Amendment does not waive, alter, or extend any conditions or provisions of the contract except to the extent shown. It is subject to all the terms and limitations of the contract. This Amendment takes effect and expires concurrently with the contract to which it is attached.

This Amendment is signed for the Company at our Home Office to take effect on the contract's Effective Date.

  
[General Counsel and Secretary]