

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IG/L043-1

## Filing at a Glance

Company: Transamerica Life Insurance Company  
Product Name: LTCR02  
State: Arkansas  
TOI: LTC03I Individual Long Term Care  
Sub-TOI: LTC03I.001 Qualified  
Filing Type: Form/Rate  
Date Submitted: 05/14/2012  
SERFF Tr Num: AEGB-128311144  
SERFF Status: Closed-Approved  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: LTCR02  
  
Implementation: On Approval  
Date Requested:  
Author(s): Paula Sachs, Suzanne Schaake, Sam Hunt  
Reviewer(s): Donna Lambert (primary)  
Disposition Date: 12/18/2012  
Disposition Status: Approved  
Implementation Date:  
  
State Filing Description:

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## General Information

Project Name: LTC Rider for TransAce 2012 - non-IC  
Project Number: L043-1  
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:  
Submission Type: New Submission  
Overall Rate Impact:

Deemer Date:  
Submitted By: Paula Sachs

Filing Description:  
ATTN: Long Term Care division

RE: Transamerica Life Insurance Company  
LTCR02 – Long Term Care Rider  
LTCR02 OC – Outline of Coverage  
RDB01 – Residual Death Benefit Endorsement  
LTC 0312T – Supplemental Application for Long Term Care Rider  
Readability Certification  
Sample specifications page  
Explanation of Variables

Status of Filing in Domicile: Not Filed  
Date Approved in Domicile:  
Domicile Status Comments: Iowa does not require prior approval  
Market Type: Individual  
Individual Market Type:  
Filing Status Changed: 12/18/2012  
State Status Changed: 12/18/2012  
Created By: Paula Sachs  
Corresponding Filing Tracking Number: 3Y111310

Enclosed please find the referenced rider, endorsement, outline of coverage and supplemental application for your department's review and approval. Once approved, we intend to use the rider and related materials with flexible premium adjustable life policy 1-12605107, approved by your department on January 10, 2012 under SERFF tracking number AEGB-127866968.

### Long Term Care Rider – LTCR02

This Rider is intended to be a federally tax-qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended. This Long Term Care Rider will provide a Monthly Long Term Care Benefit by way of an acceleration of the death benefit provided by the underlying policy, when the Insured has incurred expenses for Qualified Long Term Care Services. The maximum Monthly Long Term Care Benefit payable for any Calendar Month will be equal to the lesser of A or B where:

A. is 2% of Long Term Care Specified Amount, at commencement of benefits; and  
B. is the per diem amount allowed by the Health Insurance Portability and Accountability Act times the number of days in the Calendar Month.

Benefits are payable up to the Long Term Care Specified Amount, which is equal to the face amount of the underlying policy.

### Residual Death Benefit Endorsement – RDB01

The Residual Death Benefit Endorsement provides a benefit equal to the lesser of 10% of the lowest Face Amount of the Base

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

Policy from its inception, less any outstanding Policy Loans; or \$10,000. Benefits under this endorsement will be payable instead of the death benefit that would otherwise be payable if it is more than such death benefit and:

1. The Insured dies during a Calendar Month for which a Monthly Long Term Care Benefit is due under the Long Term Care Rider; or
2. The Insured dies after we have paid the Rider Maximum Amount under the Long Term Care Rider.

The Residual Death Benefit Endorsement will always be issued with the Long Term Care Rider.

#### Outline of Coverage – LTCR02 OC

This form will be used in the sales process, to convey to a proposed owner, the scope of coverage provided by the rider, as well as to disclose limitations and exceptions of such coverage.

#### Supplemental Application – LTC 0312T

This form will be used as a supplement to the application filled out for the underlying policy. It must be completed if the Long Term Care Rider is elected for the proposed insured.

We intend to use the form in a traditional manner whereby the Owner/Applicant signs the application in ink and submits the application to the Company.

We also plan to make this form available electronically. It is our intent to use this supplemental application form in a variety of electronic environments, including a laptop and web based application process. Regardless of the application process used, we intend to adopt measures to secure both the integrity of the document once signed, and the confidentiality of any information transmitted, including transmission of information via a secured socket layer/secured line. The information contained in the application will be transmitted to our administrative office electronically as well as the electronic signature of the Owner/Applicant. Current technology will be used to ensure that the confidential information is not compromised. All processes used will comply with the Uniform Electronic Transactions act, and to the extent applicable, the Federal ESIGN Act.

We hereby certify that any electronic signature we obtain will be linked to the date on the electronic application in such a manner that the electronic signature is invalidated if any of the data on the application is changed. We also certify that such electronic signature intended for use with this application will not be affixed to or duplicated on any other document.

Once signed via the electronic process, the document will not vary in any significant way as compared to the application in its printed format. A copy of the application supplement, identical to the filed form, will be printed and made part of any policy issued.

Please feel free to contact me at (213) 741-7101 or via e-mail at paula.sachs@transamerica.com if you have any questions or need any additional information to complete your review of this filing. Thank you for your attention to this submission.

## Company and Contact

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IG/L043-1

**Filing Contact Information**

Paula Sachs, Senior Analyst Paula.Sachs@transamerica.com  
 1150 South Olive Street 213-741-7101 [Phone]  
 Contract Development LAT-24-  
 0305  
 Los Angeles, CA 90015

**Filing Company Information**

Transamerica Life Insurance Company CoCode: 86231 State of Domicile: Iowa  
 4333 Edgewood Road, NE Group Code: 468 Company Type:  
 Cedar Rapids, IA 52499 Group Name: State ID Number:  
 (319) 355-7888 ext. [Phone] FEIN Number: 39-0989781

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$250.00  
 Retaliatory? No  
 Fee Explanation: \$50 per form - four forms plus \$50 for rates  
 Per Company: No

Company	Amount	Date Processed	Transaction #
Transamerica Life Insurance Company	\$250.00	05/14/2012	59143553

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State: Arkansas  
 TOI/Sub-TOI: LTC03I Individual Long Term Care/LTC03I.001 Qualified  
 Product Name: LTCR02  
 Project Name/Number: LTC Rider for TransAce 2012 - non-IC/L043-1

Filing Company: Transamerica Life Insurance Company

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	12/18/2012	12/18/2012
Approved	Donna Lambert	07/16/2012	07/16/2012
Approved	Donna Lambert	06/08/2012	06/08/2012
Approved	Donna Lambert	05/16/2012	05/22/2012

## Objection Letters and Response Letters

### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Donna Lambert	05/16/2012	05/16/2012
Pending Industry Response	Donna Lambert	05/15/2012	05/15/2012

### Response Letters

Responded By	Created On	Date Submitted
Paula Sachs	05/17/2012	05/17/2012
Paula Sachs	05/15/2012	05/15/2012

## Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Addition of new policy form for rider	Paula Sachs	12/18/2012	12/18/2012
Form	Long Term Care Rider	Paula Sachs	07/13/2012	07/13/2012
Supporting Document	Health - Actuarial Justification	Paula Sachs	06/06/2012	06/06/2012

## Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to re-open to extend rider's use	Note To Reviewer	Paula Sachs	12/17/2012	12/17/2012

**SERFF Tracking #:**

AEGB-128311144

**State Tracking #:****Company Tracking #:**

LTCR02

**State:**

Arkansas

**Filing Company:**

Transamerica Life Insurance Company

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.001 Qualified

**Product Name:**

LTCR02

**Project Name/Number:**

LTC Rider for TransAce 2012 - non-IC/L043-1

## Filing Notes

<b>Subject</b>	<b>Note Type</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Request to re-open	Note To Reviewer	Paula Sachs	07/11/2012	07/11/2012
Waiting for Revision	Note To Filer	Donna Lambert	06/06/2012	06/06/2012
Request to Amend	Note To Filer	Donna Lambert	05/23/2012	05/23/2012
Request to Amend	Note To Reviewer	Paula Sachs	05/23/2012	05/23/2012

**State:** Arkansas

**Filing Company:** Transamerica Life Insurance Company

**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified

**Product Name:** LTCR02

**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Disposition

Disposition Date: 12/18/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Transamerica Life Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	Yes
Supporting Document	Health - Actuarial Justification	Replaced	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Explanation of Variables and certification	Approved	Yes
Supporting Document	Sample specifications page	Approved	Yes
Supporting Document	Addition of new policy form for rider		Yes
Form (revised)	Long Term Care Rider	Approved	Yes
Form	Long Term Care Rider	Replaced	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Outline of Coverage	Replaced	Yes
Form	Residual Death Benefit Endorsement	Approved	Yes

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

Schedule	Schedule Item	Schedule Item Status	Public Access
Form (revised)	Supplemental Application	Approved	Yes
Form	Supplemental Application	Replaced	Yes
Rate	Long Term Care Rider	Approved	Yes

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Disposition

Disposition Date: 07/16/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Transamerica Life Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	Yes
Supporting Document	Health - Actuarial Justification	Replaced	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Explanation of Variables and certification	Approved	Yes
Supporting Document	Sample specifications page	Approved	Yes
Supporting Document	Addition of new policy form for rider		Yes
Form (revised)	Long Term Care Rider	Approved	Yes
Form	Long Term Care Rider	Replaced	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Outline of Coverage	Replaced	Yes
Form	Residual Death Benefit Endorsement	Approved	Yes

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

Schedule	Schedule Item	Schedule Item Status	Public Access
Form (revised)	Supplemental Application	Approved	Yes
Form	Supplemental Application	Replaced	Yes
Rate	Long Term Care Rider	Approved	Yes

**State:** Arkansas

**Filing Company:** Transamerica Life Insurance Company

**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified

**Product Name:** LTCR02

**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Disposition

Disposition Date: 06/08/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Transamerica Life Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	Yes
Supporting Document	Health - Actuarial Justification	Replaced	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Explanation of Variables and certification	Approved	Yes
Supporting Document	Sample specifications page	Approved	Yes
Supporting Document	Addition of new policy form for rider		Yes
Form (revised)	Long Term Care Rider	Approved	Yes
Form	Long Term Care Rider	Replaced	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Outline of Coverage	Replaced	Yes
Form	Residual Death Benefit Endorsement	Approved	Yes

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

Schedule	Schedule Item	Schedule Item Status	Public Access
Form (revised)	Supplemental Application	Approved	Yes
Form	Supplemental Application	Replaced	Yes
Rate	Long Term Care Rider	Approved	Yes

**State:** Arkansas  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

**Filing Company:** Transamerica Life Insurance Company

## Disposition

Disposition Date: 05/22/2012

Implementation Date:

Status: Approved

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Transamerica Life Insurance Company	%	%				%	%

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved	Yes
Supporting Document	Health - Actuarial Justification	Replaced	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Explanation of Variables and certification	Approved	Yes
Supporting Document	Sample specifications page	Approved	Yes
Supporting Document	Addition of new policy form for rider		Yes
Form (revised)	Long Term Care Rider	Approved	Yes
Form	Long Term Care Rider	Replaced	Yes
Form (revised)	Outline of Coverage	Approved	Yes
Form	Outline of Coverage	Replaced	Yes
Form	Residual Death Benefit Endorsement	Approved	Yes

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

Schedule	Schedule Item	Schedule Item Status	Public Access
Form (revised)	Supplemental Application	Approved	Yes
Form	Supplemental Application	Replaced	Yes
Rate	Long Term Care Rider	Approved	Yes

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**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/16/2012
Submitted Date	05/16/2012
Respond By Date	06/18/2012

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Dear Paula Sachs,

### **Introduction:**

#### **Objection 1**

- Supplemental Application, LTC 0312T (Form)

Comments: I'm sorry I missed this yesterday. Please revise the fraud warning to more closely mirror 23-66-503, specifically, include the language ". . . is guilty of a crime and may be subject to fines and confinement in prison." I can then approve this filing.

### **Conclusion:**

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Donna Lambert

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**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IG/L043-1

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	05/15/2012
Submitted Date	05/15/2012
Respond By Date	06/15/2012

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Dear Paula Sachs,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

- Outline of Coverage, LTCR02 OC (Form)

*Comments: In section 9 of the Outline, please include the list of benefits on page 2 of the Rider in its Rider Benefit section.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*

*Donna Lambert*

**State:** Arkansas  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Filing Company:** Transamerica Life Insurance Company  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 05/17/2012  
 Submitted Date 05/17/2012

Dear Donna Lambert,

### Introduction:

Thank you for your comments

### Response 1

#### Comments:

The application has been revised as requested

### Related Objection 1

Applies To:

- Supplemental Application, LTC 0312T (Form)

Comments: I'm sorry I missed this yesterday. Please revise the fraud warning to more closely mirror 23-66-503, specifically, include the language ". . . is guilty of a crime and may be subject to fines and confinement in prison." I can then approve this filing.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Supplemental Application	LTC 0312T AR	AEF	Initial		52.400	LTC 0312T AR.pdf	Date Submitted: 05/17/2012 By: Paula Sachs
<i>Previous Version</i>								
1	Supplemental Application	LTC 0312T	AEF	Initial		52.400	LTC 0312T.pdf	Date Submitted: 05/14/2012 By: Paula Sachs

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

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State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

*No Rate/Rule Schedule items changed.*

**Conclusion:**

*I hope you now have everything you need to complete your review of this filing.*

*Sincerely,*

*Paula Sachs*

**State:** Arkansas  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

**Filing Company:** Transamerica Life Insurance Company

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 05/15/2012  
 Submitted Date 05/15/2012

Dear Donna Lambert,

### Introduction:

Thank you for your very prompt response to this submission.

### Response 1

#### Comments:

As directed, we have added the list of benefits from page 2 of the rider to section 9 of the outline.

### Related Objection 1

Applies To:

- Outline of Coverage, LTCR02 OC (Form)

Comments: In section 9 of the Outline, please include the list of benefits on page 2 of the Rider in its Rider Benefit section.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Outline of Coverage	LTCR02 OC AR	OUT	Initial		52.700	TransACE LTC rider outline of coverage AR.pdf	Date Submitted: 05/15/2012 By: Paula Sachs
<i>Previous Version</i>								
1	Outline of Coverage	LTCR02 OC	OUT	Initial		52.700	TransACE LTC rider outline of coverage.pdf	Date Submitted: 05/14/2012 By: Paula Sachs

No Rate/Rule Schedule items changed.

**SERFF Tracking #:**

AEGB-128311144

**State Tracking #:**

**Company Tracking #:**

LTCR02

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**State:**

Arkansas

**Filing Company:**

Transamerica Life Insurance Company

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.001 Qualified

**Product Name:**

LTCR02

**Project Name/Number:**

LTC Rider for TransAce 2012 - non-IC/L043-1

**Conclusion:**

*I hope you now have all the information necessary to complete your review. If you do have any additional questions, feel free to contact me. Thanks again for your quick response.*

*Sincerely,*

*Paula Sachs*

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

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Filing Company:

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TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

## Amendment Letter

Submitted Date: 12/18/2012

Comments:

We would like to make the LTC rider available for use with UL07 AR.

Changed Items:

*No Form Schedule Items Changed.*

*No Rate Schedule Items Changed.*

### Supporting Document Schedule Item Changes

Satisfied - Item:	Addition of new policy form for rider
Comments:	
Attachment(s):	
Add UL07 AR to LTCR02 filing.pdf	

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

## Amendment Letter

Submitted Date: 07/13/2012

Comments:

Thank you for re-opening this filing. The previously approved rider has been revised so that the definition of Physician is consistent with our other company(ies) various LTC riders and policies. No other changes have been made to the rider, or to any other forms or attachments in this filing.

Your patience is greatly appreciated.

Changed Items:

### Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Long Term Care Rider	LTCR02	CERA	Initial		50.300	TransACE LTC rider 07-13.pdf	Date Submitted: 07/13/2012 By:
<i>Previous Version</i>								
1	Long Term Care Rider	LTCR02	CERA	Initial		50.300	TransACE LTC rider.pdf	Date Submitted: 05/14/2012 By: Paula Sachs

No Rate Schedule Items Changed.

No Supporting Documents Changed.

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

## Amendment Letter

Submitted Date: 06/06/2012

Comments:

Attached is the revised actuarial memo. My apologies for the delay.

Changed Items:

*No Form Schedule Items Changed.*

*No Rate Schedule Items Changed.*

### Supporting Document Schedule Item Changes

Satisfied - Item:	Health - Actuarial Justification
Comments:	Revised memo includes changes to Commissions and Underwriting sections. Also, references to "policy" have been changed to "rider" as applicable; and references to "monthly" charges have been changed to "annual" for consistency with the rate files.
Attachment(s):	
Actuarial memo - RDB Endorsement.pdf LTCR02 Actuarial Memorandum_053112.pdf	
<i>Previous Version</i>	
<i>Satisfied - Item:</i>	<i>Health - Actuarial Justification</i>
<i>Comments:</i>	
<i>Attachment(s):</i>	
<i>LTCR02 Actuarial Memorandum.pdf</i> <i>Actuarial memo - RDB Endorsement.pdf</i>	

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**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Note To Reviewer

**Created By:**

Paula Sachs on 12/17/2012 06:31 PM

**Last Edited By:**

Paula Sachs

**Submitted On:**

12/17/2012 06:32 PM

**Subject:**

Request to re-open to extend rider's use

**Comments:**

We would like to extend the use of this rider form to a newly-approved UL policy form. Please let me know if this can be handled through a revision to an existing filing or if a new filing is required. Thank you for your attention.

---

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Note To Reviewer

**Created By:**

Paula Sachs on 07/11/2012 01:19 PM

**Last Edited By:**

Paula Sachs

**Submitted On:**

07/11/2012 01:19 PM

**Subject:**

Request to re-open

**Comments:**

Our company would like to change the definition of Physician in our Long Term Care Rider for UL so that it matches the definition we will be using for our Indexed UL. If possible, would you please re-open this filing so I can replace the approved rider with the newer version. No other changes are being made. Thank you for your patience. If you have any questions, please feel free to give me a call at 213-741-7101 (Pacific Time).

Paula Sachs

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**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Note To Filer

**Created By:**

Donna Lambert on 06/06/2012 09:31 AM

**Last Edited By:**

Donna Lambert

**Submitted On:**

06/06/2012 09:31 AM

**Subject:**

Waiting for Revision

**Comments:**

Could you please let me know when you will be sending the revised actuarial memo?

**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Note To Filer

**Created By:**

Donna Lambert on 05/23/2012 02:40 PM

**Last Edited By:**

Donna Lambert

**Submitted On:**

05/23/2012 02:40 PM

**Subject:**

Request to Amend

**Comments:**

I have reopened the filing.

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**State:** Arkansas **Filing Company:** Transamerica Life Insurance Company  
**TOI/Sub-TOI:** LTC031 Individual Long Term Care/LTC031.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

## Note To Reviewer

**Created By:**

Paula Sachs on 05/23/2012 09:04 AM

**Last Edited By:**

Paula Sachs

**Submitted On:**

05/23/2012 09:05 AM

**Subject:**

Request to Amend

**Comments:**

The issue ages shown in the actuarial memo and explanation of variables form are incorrect. Can you please re-open this filing so I can make this correction?

Sorry for the inconvenience. Thanks for your help.

**State:** Arkansas  
**TOI/Sub-TOI:** LTC03I Individual Long Term Care/LTC03I.001 Qualified  
**Product Name:** LTCR02  
**Project Name/Number:** LTC Rider for TransAce 2012 - non-IC/L043-1

**Filing Company:** Transamerica Life Insurance Company

## Form Schedule

Lead Form Number: LTCR02								
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved 07/16/2012	Long Term Care Rider	LTCR02	CERA	Initial		50.300	TransACE LTC rider 07-13.pdf
2	Approved 07/16/2012	Outline of Coverage	LTCR02 OC AR	OUT	Initial		52.700	TransACE LTC rider outline of coverage AR.pdf
3	Approved 07/16/2012	Residual Death Benefit Endorsement	RDB01	CERA	Initial		51.100	Residual Death Benefit Endorsement.pdf
4	Approved 07/16/2012	Supplemental Application	LTC 0312T AR	AEF	Initial		52.400	LTC 0312T AR.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



Transamerica Life Insurance Company  
[Home Office: Cedar Rapids, IA  
Administrative Office:  
4333 Edgewood Rd NE  
Cedar Rapids, IA 52499  
1-800-TLC-HOST]  
[www.transamerica.com](http://www.transamerica.com)

**LONG TERM CARE RIDER**  
**Attached to and made a part of the policy issued by**  
**TRANSAMERICA LIFE INSURANCE COMPANY**  
**Cedar Rapids, Iowa**

**This Rider is intended to be a federally tax-qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended.** If a change to this Rider is required in order to conform to changes in the requirements of the Internal Revenue Code, we will send you an amendment describing the change and you will be given a choice of accepting or rejecting the amendment. If you reject such an amendment, you must give us written notice, and your refusal may result in this Rider no longer being tax-qualified or other adverse tax consequences. As with any tax matter, you should consult your tax advisor to evaluate any tax impact of rejecting any such amendment.

**The charges for this Rider may be distributions for income tax purposes. If you have any questions regarding the tax implications of this Rider, please consult with your tax advisor.**

We have issued this Rider as a part of the policy to which it is attached. Except as otherwise specifically set forth below, it is subject to all of the terms of the policy.

**RENEWABILITY**

This Rider will remain in force subject to this Rider's provisions, as long as the policy to which it is attached remains in force and the required charges for this Rider are paid.

**30-DAY RIGHT TO REVIEW THIS RIDER**

You have 30 days from the day you receive this Rider to review it and return it to us if you decide not to keep it. You do not have to tell us why you are returning the Rider. Within 30 days of when it is received, simply return it to us at our Administrative Office or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any Rider charge deducted from the policy's Accumulation Value, within 30 days after our receipt of the returned Rider. The Rider will be void as if it had never been issued. If you wish to cancel the Rider without canceling the policy, you must return the policy and this Rider to us so that we can send you back the policy without this Rider.

**IMPORTANT CAUTION ABOUT THE APPLICATION**

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

**No Cash Value:** This Rider has no cash value. You cannot borrow against this Rider or pledge it as collateral for a loan.

**Notice to Buyer:** This Rider may not cover all of the costs associated with long term care incurred during the period of coverage. You are advised to review all Rider limitations carefully.

**THIS RIDER DOES NOT PROVIDE MEDICARE SUPPLEMENT COVERAGE.** If the Insured is eligible for Medicare, review the "Guide to Health Insurance for People with Medicare" available from us.

This Rider uses terms that have specific meanings within this Rider. Most of these terms are defined in the General Definitions section of this Rider. Some of the definitions may be in the policy to which this Rider is attached. Definitions related to eligibility for benefits are in the Eligibility for the Payment of Benefits section of this Rider.

## GUIDE TO RIDER PROVISIONS

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### RIDER BENEFIT

Subject to the provisions, exclusions and limitations of this Rider and the policy to which it is attached, we will pay a Monthly Long Term Care Benefit when the Insured has incurred expenses for Qualified Long Term Care Services as set forth in this Rider.

Benefits are payable if the Insured has incurred expenses for one or more of the following types of Qualified Long Term Care Services:

1. Long Term Care Facility confinement;
2. Home Health Care Services;
3. Home Care Services;
4. Adult Day Care in an Adult Day Care Center;
5. Hospice Care by a Hospice Care Provider; or
6. Respite Care.

The amount of the Monthly Long Term Care Benefit is described in the Benefits section of this Rider.

In order to receive benefits under this Rider, you must provide us with both a Plan of Care acceptable to us and Proof of Loss documentation. This documentation must show (1) that the Insured has received one or more of the Qualified Long Term Care Services described above and (2) that the Qualified Long Term Care Services received were consistent with the requirements of the current Plan of Care, in terms of both type of services and frequency.

This Rider provides coverage for mental and nervous conditions, including Alzheimer's disease, Parkinson's disease and senile dementia in accordance with the terms of this Rider if the Insured is certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual.

### ELIGIBILITY FOR THE PAYMENT OF BENEFITS

Subject to all of the terms of this Rider, you are eligible for benefits under this Rider if the Insured is a Chronically Ill Individual.

**Chronically Ill Individual** means an individual who has been certified by a Licensed Health Care Practitioner as:

1. being unable to perform, without **Substantial Assistance** from another individual, at least 2 out of the 6 **Activities of Daily Living (ADLs)** for an expected period of at least 90 days due to a loss of functional capacity; or
2. requiring **Substantial Supervision** to protect the Insured from threats to health and safety due to **Severe Cognitive Impairment**.

**Substantial Assistance** means either Hands-On Assistance or Standby Assistance:

1. Hands-on Assistance means the physical assistance (minimal, moderate or maximal) of another person without which the Insured would be unable to perform the Activity of Daily Living.
2. Standby Assistance is the presence of another person within arm's reach that is necessary to prevent, by physical intervention, injury to the Insured while the Insured is performing the Activity of Daily Living.

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

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

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

**Severe Cognitive Impairment (including the term "Severely Cognitively Impaired")** means a severe loss or deterioration in intellectual capacity that is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:

1. short-term or long-term memory;
2. orientation as to people, places or time;
3. deductive or abstract reasoning; and
4. judgment as it relates to safety awareness.

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

## **LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS**

### **Conditions**

In order for benefits to be payable under this Rider:

1. The Insured must satisfy the requirements set forth in the Eligibility for the Payment of Benefits section;
2. All Qualified Long Term Care Services must begin while this Rider is in force;
3. All charges must be incurred for services rendered or goods provided while this Rider is in force;
4. The Insured must satisfy the Elimination Period;
5. All care and services must be in accordance with accepted medical and nursing standards of practice; and
6. All care and services must be consistent with the Insured's current Plan of Care. You must provide us with both a Plan of Care acceptable to us and Proof of Loss documentation.

### **Limitations**

The following limitations apply to this Rider:

1. All benefits are subject to the Rider Maximum Amount.
2. Benefits are payable as specified in the Benefits section of this Rider.
3. We will not pay benefits during the Elimination Period.
4. Benefits are subject to the General Exclusions and Limitations of this Rider.

## **ELIMINATION PERIOD**

This Rider has an Elimination Period of 90 days. This means that we will not pay benefits under this Rider for any period before the Insured has incurred expenses, on each of 90 separate days during which this Rider is in effect, for Qualified Long Term Care Services that would otherwise be covered under this Rider. These days of care or services need not be continuous. The Elimination Period has to be satisfied only once while this Rider is in effect. You must provide us with Proof of Loss in order to satisfy the Elimination Period.

We will give the Insured credit toward the Elimination Period for days of confinement, care or services covered under this Rider, even if they are paid or payable by Medicare.

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

## GENERAL DEFINITIONS

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

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

If licensure, registration, or certification is not required by the state, it is that part (or separate center) of a facility that provides Adult Day Care and meets all of the following requirements:

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

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

**Home Care Agency.** An entity that provides care and services in the Insured's home and meets all of the following criteria:

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

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

**Home Care Services.** Services that are provided by skilled or unskilled persons who work under the supervision of a Home Care Agency. These services are provided in the Insured's home. Home Care Services include the following:

1. Personal Care Attendant Services;
2. reporting changes in the Insured's condition and needs, and completing appropriate records; and
3. Homemaker Services.

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

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

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

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

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

**Immediate Family.** An individual's spouse (including common law spouse) or Partner and anyone who is related to the individual or his or her spouse or Partner (including adopted, in-law and step-relatives). This includes a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.

**Insured.** The person who is the Insured under the policy to which this Rider is attached.

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

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

A Long Term Care Facility must:

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

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

In those states where there is no facility that is licensed, certified or registered to provide inpatient care for persons who are in need of assistance with Activities of Daily Living or are Severely Cognitively Impaired, a facility must meet all of the requirements in items # 1-4 listed above. In addition, it must meet all of the following requirements in order to qualify as a Long Term Care Facility:

5. provides the following information in writing to each resident:
  - (a) a tenant services contract or agreement in place for each resident; and
  - (b) admission and transfer/discharge requirements;
6. provides a minimum of 10 beds; and
7. has staff on site 24-hours-a-day to provide personal care.

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

Long Term Care Facility does not include a hospital, except for a separate and distinct wing or section of a hospital, if such wing or section, including the Insured's assigned bed, is appropriately licensed, certified, or

registered to provide the level of care defined above. Also, Long Term Care Facility does not include: an independent living apartment or unit; hotel; motel; retirement home; or any dwelling similar to these.

**Long Term Care Specified Amount.** The Long Term Care Specified Amount is equal to the base policy's Face Amount. It may be reduced if the policy's Face Amount is reduced. The Long Term Care Specified Amount as of the Policy Date is shown in the Policy Data. The total amount of benefits paid under this Rider may not exceed the Long Term Care Specified Amount.

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

**Nurse.** A person who is duly licensed as either:

1. a Registered Nurse (RN);
2. a Licensed Practical Nurse (LPN); or
3. a Licensed Vocational Nurse (LVN).

The term Nurse does NOT include:

1. you or the Insured; or
2. a member of your Immediate Family or the Insured's Immediate Family.

**Partner.** An adult who is not related to the Insured by blood or marriage under the laws of the state in which this Rider was issued; who has resided with the Insured continuously for at least two years; and both the Insured and Partner hold themselves out to the public as life partners. Partner is used to describe these legally-sanctioned relationships, which may include domestic partners and/or civil union partners.

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

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

**Physician.** A doctor of medicine or osteopathy as set forth in Section 1861(r)(1) of the Social Security Act, as amended, who is legally qualified and authorized to practice medicine and surgery within the United States by the jurisdiction in which he or she performs such function or action.

The term Physician does not include:

1. you or the Insured;
2. a member of your Immediate Family or the Insured's Immediate Family; or
3. anyone who has a financial interest in, or is an employee of, a facility, agency, or center administering the Plan of Care.

**Plan of Care.** A written, systematic, standardized and comprehensive assessment of the Insured's physical and cognitive abilities by a Licensed Health Care Practitioner, based on a face-to-face evaluation of the Insured. The Plan of Care must specify the type, frequency and providers of all the services that the Insured requires. The services also must be consistent with the assessment done to develop the Plan of Care. The Plan of Care may include services not covered by this Rider. No more than one Plan of Care may be in effect at a time.

The Plan of Care must include the date, if any, by which the Insured is expected to recover from his or her illness or injury. The Plan of Care must be prescribed, approved and signed by a Licensed Health Care Practitioner. It must be updated or confirmed in writing at least once every 12 months or more frequently as we may require. We will not require an update or written confirmation more frequently than once each 90 days.

We reserve the right to discuss the Plan of Care with the Licensed Health Care Practitioner to verify that the Plan of Care is appropriate and consistent with generally accepted standards of care for a Chronically Ill Individual.

If possible, a copy of the Plan of Care should be sent to us before the care and services are received. Otherwise, it must be provided to us at the time the first claim under the Plan of Care is submitted. Unless otherwise stated in this Rider, the Plan of Care must be submitted no later than 90 days after the care and services begin. It must

document by assessment that the Insured met the requirements set forth in the Eligibility for the Payment of Benefits section of this Rider during that 90-day period.

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

**Proof of Loss.** Information or documents satisfactory to us to enable us to determine whether benefits are payable under your Rider. We will pay benefits only after we have received all necessary Proofs of Loss. You must either provide us with this information or authorize its release to us.

**Qualified Long Term Care Services.** This means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services, which:

1. are required by a Chronically Ill Individual; and
2. are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Qualified Long Term Care Services do not include any care, confinement or services set forth in the General Exclusions and Limitations section of this Rider.

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

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

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

**Volunteer Caregiver.** The unpaid person who has the primary responsibility of caring for the Insured in the Insured's home. A person who is paid to care for the Insured is not a Volunteer Caregiver.

## BENEFITS

**Payment of Benefits.** Once the Elimination Period has been satisfied and the claim is approved by us, we will pay the Monthly Long Term Care Benefit. You must file additional Proofs of Loss for each subsequent Calendar Month for which you wish to receive benefits.

Before we make a payment, we will first apply any benefit amount to any Required Premium due at that time, then to any interest due on any policy loans to the extent such interest due exceeds the policy's Net Cash Value. The remaining benefits will be paid to you. Benefits are payable in U.S. Dollars.

If there is an irrevocable beneficiary or an assignee on the policy, we will require consent from that party or parties before we begin paying benefits under this Rider.

**Monthly Long Term Care Benefit.** The maximum Monthly Long Term Care Benefit payable for any Calendar Month will be equal to the lesser of A or B where:

- A. is 2% of Long Term Care Specified Amount, at commencement of benefits; and
- B. is the per diem amount allowed by the Health Insurance Portability and Accountability Act times the number of days in the Calendar Month.

You may request a Monthly Long Term Care Benefit amount less than the above maximum, but the monthly benefit must be at least \$500. Choosing a lesser amount could extend the period during which benefits may be payable. Once selected, the Monthly Long Term Care Benefit amount will remain in effect for the remainder of the current calendar year. You may change your election for subsequent calendar years by giving us written notice at least 30 days before the beginning of that calendar year.

If benefits are payable for only part of a Calendar Month, we will prorate the Monthly Long Term Care Benefit at the beginning of a period of care or at the end. Prorate means we will divide the monthly benefit by the actual number of days in the month, then multiply that number times the number of days during the month for which you are eligible to receive benefit payments.

**Maximum Lifetime Rider Benefit.** If the total of the benefits paid under this Rider equals or exceeds the Rider Maximum Amount, benefit payments under this Rider will cease. The Rider Maximum Amount is equal to the Long Term Care Specified Amount minus any outstanding Policy Loan.

**Lapse Protection.** While Rider benefits are being paid, the policy will not Lapse due to the policy's Net Cash Value not being sufficient to pay the Monthly Deduction due.

**Extension of Benefits.** If this Rider terminates for any reason while you are receiving benefits under this Rider and while the Insured is confined in a Long Term Care Facility, benefits will be continued until the earlier of the following: the date the Insured is discharged from the Long Term Care Facility; or the date when the benefits paid under this Rider equal or exceed the Rider Maximum Amount.

### RIDER CHARGES

On each Monthly Policy Date while this Rider is in effect, we will charge you a Monthly Deduction for this Rider. The Monthly Deduction for this Rider is equal to the product of A times B where:

- A is the Long Term Care Specified Amount, divided by 1000; and
- B is the Monthly Deduction Rate per \$1,000 of Long Term Care Specified Amount.

The Monthly Deduction Rate for this Rider is shown in the Policy Data in the Table of Guaranteed Monthly Deduction Rates per \$1,000 of Long Term Care Specified Amount.

**Waiver of Rider Monthly Deductions.** We will not charge Monthly Deductions for this Rider for any policy month while we are paying benefits under this Rider. However, other policy and Rider charges will continue to apply.

### GRACE PERIOD

The Grace Period for this Rider is 65 days. If any amount due is not paid within thirty (30) days from the date that it was due, we will send a notice to you, the Insured and the person or persons designated by you to receive such notice at the addresses provided to us. Notice will be given by first class United States mail, postage prepaid. You will have an additional 35 days to pay the amounts due after we have mailed the Notice. During the Grace Period this Rider will stay in effect.

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

**Added Protection Against Termination; Reinstatement.** If this Rider Lapses while the Insured is Chronically Ill as set forth in the Eligibility for the Payment of Benefits section, this Rider may be reinstated. To have this Rider reinstated, the Policy must be reinstated in accordance with its Reinstatement provisions with the exception of its insurability conditions, which shall be waived if all the following conditions are met:

1. We must receive a written request for reinstatement in our Administrative Office within 180 days after the date this Rider Lapses; and
2. We must receive a Licensed Health Care Practitioner's written certification that, at the time this Rider Lapsed, the Insured had been diagnosed, using generally accepted medical diagnostic methods and tests, as being a Chronically Ill Individual; and
3. We must receive all unpaid, overdue Rider charges for this Rider.

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

**Reinstatement.** In situations other than the Added Protection Against Termination; Reinstatement provision, we will consider this Rider for reinstatement as described in the Reinstatement provision in the policy. Before we reinstate this Rider, we may require evidence of insurability specific to the coverage provided by this Rider.

## INTERACTION OF POLICY PROVISIONS AND THIS RIDER

**Accelerated Death Benefit.** Benefits paid under this Rider are considered an acceleration of the death benefit.

**Effect on Death Benefit.** If the Insured dies, the amount of the benefits paid under this Rider will be deducted from the policy's death benefit.

**Effect on Cash Value.** The amount of the benefits paid under this Rider will be deducted from the policy's Net Cash Value and will also reduce the amount available for any future policy loans or Partial Surrenders under the policy.

**Effect on Surrender Values when the policy includes an endorsement providing an enhanced surrender value.** If the policy is surrendered during the option periods provided in an endorsement enhancing its surrender value, any such enhanced surrender value will be reduced by the amount of the benefits paid under this Rider.

**Policy Face Amount Changes.** Transactions that reduce the face amount of the policy will also result in a dollar-for-dollar reduction in the Long Term Care Specified Amount.

**Loans and Partial Surrenders.** Loans and partial surrenders will not be permitted while benefits are being paid under this Rider.

**Effect of Reaching the Rider Maximum Amount.** After we have paid the Rider Maximum Amount:

1. No further premium payments will be accepted.
2. We will not charge any further Monthly Deductions.
3. All Riders other than this Rider will terminate.
4. If the policy includes an Insurance on Children Rider, coverage may be converted in accordance with that Rider's Conversion provision.
5. Interest will continue to be credited to the Accumulation Value if it is not less than zero.
6. You must pay interest on any Policy Loans as it becomes due or the policy may terminate.

**Effect of a Terminal Illness Accelerated Death Benefit Endorsement on this Rider.** If your policy includes an endorsement providing an accelerated death benefit in the event of a terminal illness ("Terminal Illness ADB Endorsement"), the Insured may qualify for benefits under both the Terminal Illness ADB Endorsement and this Rider. If the Insured qualifies for benefits under both the Terminal Illness ADB Endorsement and this Rider and if a claim is made under both the Terminal Illness ADB Endorsement and this Rider, a benefit will be paid under the Terminal Illness ADB Endorsement first. A payment under the Terminal Illness ADB Endorsement will reduce the policy's face amount and the Long Term Care Specified Amount will be reduced by the same amount. Once payment under the Terminal Illness ADB Endorsement is made, any payments under this Rider will be made based on the newly reduced Long Term Care Specified Amount.

We will not pay benefits under both the Terminal Illness ADB Endorsement and this Rider simultaneously. If a claim is made under the Terminal Illness ADB Endorsement while benefits are being paid under this Rider, we will stop paying benefits under this Rider when we pay benefits under the Terminal Illness ADB Endorsement. The maximum accelerated death benefit used to calculate the amount of the terminal illness accelerated death benefit will be reduced by the amount of the benefits paid under this Rider. Once payment under the Terminal Illness ADB Endorsement is made, if the Insured still qualifies for benefits under this Rider, any payments under this Rider will be made based on the newly reduced Long Term Care Specified Amount.

**Policy Threshold Reset.** If Rider benefit payments cease because the Insured no longer qualifies for benefits under this Rider, and the policy's No-Lapse Guarantee Endorsement or Death Benefit Protection Endorsement, if any, is in effect, the Policy Threshold will be reset to zero if it is less than zero at that time.

## GENERAL EXCLUSIONS AND LIMITATIONS

Qualified Long Term Care Services do not include care, confinement or services:

1. resulting from alcoholism, or drug addiction or chemical dependency unless as a result of medication used as prescribed by a Physician;
2. resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
3. due to participation in a felony, riot or insurrection;

4. for which no charge is normally made in the absence of insurance;
5. received outside the fifty (50) United States and the District of Columbia, or Canada; or
6. performed by a member of your Immediate Family or the Insured's Immediate Family. A member of your Immediate Family or the Insured's Immediate Family can provide covered care or services if he or she is a regular employee of an organization that is engaged in providing the Qualified Long Term Care Services. The organization he or she works for must receive the payment for the care or service. Your Immediate Family or the Insured's Immediate Family member must receive no compensation other than the normal compensation for employees in his or her job category.

Non-Duplication of Benefits. Qualified Long Term Care Services do not include care, confinement or services:

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

unless the costs incurred and paid exceed the amount covered by one of these entities, policies or programs.

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

Qualified Long Term Care Services do not include care, confinement or services received by the Insured that are not included in the Insured's Plan of Care.

## **CLAIMS INFORMATION**

This section explains: when to notify us of a claim; what to send to us; where to send it; how we pay benefits; and other claims-related rights and obligations under this Rider.

### **Notifying Us of a Claim.**

Notice of Claim. Early notification to our Claims Department will help us make a timely review of a claim. You should let us know immediately or in advance whenever possible, when the Insured needs care or services that may be covered by this Rider. You may reach us on the toll-free number on the first page of this Rider, or you may choose to send us written notice instead.

Notice must be received by us at our Administrative Office within 60 days of the date the covered loss starts or as soon as is reasonably possible. The notice should include at least: Your name, the name of the Insured, policy number, and the address to which the claim form should be sent.

### **How to File a Claim.**

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

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

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

1. the Insured's name, address, Social Security number, and policy number;
2. the type of benefits for which claim is being made;
3. the names and addresses of the medical professionals and care providers who are aware of the Insured's condition or have provided care covered by this Rider;
4. the diagnosis; and
5. the time periods for which benefits are being claimed.

Assessment of the Insured's Condition. Before we approve a claim for benefits under this Rider, an assessment may be performed by a Licensed Health Care Practitioner we select. This assessment may be performed in person. The Licensed Health Care Practitioner will assess the Insured's condition and prognosis for recovery.

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

#### **When to File a Claim.**

Proof of Loss. You must give us written Proof of Loss within 90 days after the end of the Elimination Period in order to satisfy the Elimination Period requirements. You must send the Proof of Loss to our Administrative Office. We will require a certification by a Licensed Health Care Practitioner that the Insured was a Chronically Ill Individual during the Elimination Period. It must include documentation that during the Elimination Period, the Insured received Qualified Long Term Care Services for which the Insured incurred a charge.

In order to help us determine the Insured's eligibility for the payment of benefits, we may require that you provide us with various documents, such as, but not limited to:

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

In addition, we reserve the right to conduct an assessment of the Insured's condition as described above before we approve a claim for benefits under this Rider.

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

#### **How and When Claims are Paid.**

Time of Payment of Claim. Benefits under this Rider are payable after services have been rendered and charges have been incurred for such services. We will not pay benefits based on advance billing for services or care to be rendered in the future.

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

If we fail to follow the process outlined above, we will pay interest at the rate of 1% per month on the amount of the claim that should have been paid but that remains unpaid 45 business days after the later of:

1. our receipt of the claim with respect to subsection A above; or
2. our receipt of all requested additional information with respect to subsection B above.

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

**How to Appeal a Claim Determination.**

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

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

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

**GENERAL PROVISIONS**

**Consideration.** We have issued this Rider in consideration of the application (including any supplemental application) and payment of the initial premium shown in the Policy Data. A copy of the application and any supplemental application is attached to the policy.

**Effective Date.** The effective date of coverage under this Rider will be the Rider Date shown in the Policy Data.

**Representations.** All statements submitted in the application for this Rider by or on behalf of the Insured will be considered representations and not warranties.

**Incontestability.** If a claim arises from a condition that manifests itself when coverage under this Rider has been in force less than six months, we may rescind the coverage or deny an otherwise valid claim upon a showing of misrepresentation that is material to our decision to issue you the coverage.

If a claim arises from a condition that manifests itself when coverage under this Rider has been in force for at least six months but less than two years, we may rescind the Rider or deny an otherwise valid claim upon a showing of misrepresentation that is both material to our decision to issue you the coverage and which pertains to the condition for which benefits are sought.

If a claim arises from a condition that manifests itself after coverage under this Rider has been in force for two years or more, we may only rescind the Rider upon a showing that you and/or the Insured knowingly and intentionally misrepresented relevant facts relating to the Insured's health.

If this Rider is reinstated, the original contestability periods will continue to apply. In addition, new contestability periods will apply with respect to statements made in any application for reinstatement.

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

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

**Termination of this Rider.** This Rider will terminate on the earliest of the following:

1. on the monthly policy date on or next following the date we receive your written request to terminate this Rider;
2. upon termination (including any rescission) of the policy; or
3. when the Insured dies.

Signed for the Company at Cedar Rapids, Iowa, on the Rider Date, which is the Policy Date unless we inform you in writing of a different date.



[  
[Secretary] ]



[  
[President] ]



Transamerica Life Insurance Company  
[Home Office: Cedar Rapids, IA  
Administrative Office:  
4333 Edgewood Rd NE  
Cedar Rapids, IA 52499  
1-800-TLC-HOST]  
[www.transamerica.com](http://www.transamerica.com)

**LONG TERM CARE INSURANCE  
OUTLINE OF COVERAGE  
Rider Form LTCR02**

**Notice to buyer:** The captioned Long Term Care Rider may not cover all of the costs associated with long-term care incurred during the period of coverage. You are advised to review all Rider terms, conditions and limitations carefully.

**Caution:** The issuance of the Long Term Care Rider is based on our issuance of the policy to which the Rider is attached; and on your responses to the questions on your application for the policy and the application supplement for the Rider. Copies of the application for the policy and the application supplement are attached to the policy. If your answers to any of the questions on the application or application supplement are incorrect or untrue, the company has the right (in addition to any rescission rights described in the policy) to deny benefits or rescind the Rider. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us at the address shown above.

1. The Long Term Care Rider is attached to an individual life insurance policy.
2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the Rider. You should compare this outline of coverage to outlines of coverage for other long term care riders or policies available to you. This is not an insurance contract, but only a summary of coverage. Only the underlying life insurance policy and Rider contain governing contractual provisions. This means that the life insurance policy and Rider set forth in detail the rights and obligations of you, the Insured (if other than yourself) and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY AND RIDER CAREFULLY!**
3. **FEDERAL TAX CONSEQUENCES.** The Rider is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended. If a change to the Rider is required in order to conform to changes in the requirements of the Internal Revenue Code, we will send you an amendment describing the change and you will be given a choice of accepting or rejecting the amendment. If you reject such an amendment, you must give us written notice, and your refusal may result in the Rider no longer being tax-qualified or other adverse tax consequences. As with any tax matter, you should consult your tax advisor to evaluate any tax impact of rejecting any such amendment.
4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED.**  
(a) **Renewability** – THE RIDER IS NONCANCELLABLE. This means that, subject to the Rider's termination provision, the Rider will remain in force as long as the policy to which it is attached remains in force and the required charges for the Rider are paid. Transamerica Life Insurance Company cannot change any of the terms of the Rider on its own and cannot change the Monthly Deductions you pay for the Rider. (b) **Waiver of Rider Charges** – While benefits under the Rider are being paid, the Long Term Care Rider charges will be waived. However, charges for the underlying policy and/or any other Riders providing additional benefits will continue to be assessed.
5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGES. We do not have the right to increase the Rider Monthly Deductions.**
6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED.** You have 30 days from the day you receive the Rider to review it and return it to us if you decide not to keep it. You do not have to tell us why you are returning the Rider. Within 30 days of when it is received, simply return it to us at our Administrative Office

or to the agent/insurance producer through whom it was purchased. We will refund the full amount of any Rider charge deducted from the policy's Accumulation Value, within 30 days after our receipt of the returned Rider. The Rider will be void as if it had never been issued. If you wish to cancel the Rider without canceling the policy, you must return the policy and the Rider to us so that we can send you back the policy without the Rider.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. That booklet is called the "Guide to Health Insurance for People with Medicare." Neither Transamerica Life Insurance Company nor its agents/insurance producers represent Medicare, the federal government or any state government.
8. **LONG TERM CARE COVERAGE.** Contracts of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital such as: (a) a Long Term Care Facility; (2) an Adult Day Care Center; (3) a Hospice Care Facility; or (4) the home.

The Rider provides coverage in the form of a fixed indemnity benefit for long term care expenses, subject to the Rider limitations and elimination period requirements.

#### 9. **BENEFITS PROVIDED BY THE RIDER.**

Benefits are payable if the Insured has incurred expenses for one or more of the following types of Qualified Long Term Care Services:

1. Long Term Care Facility confinement;
2. Home Health Care Services;
3. Home Care Services;
4. Adult Day Care in an Adult Day Care Center;
5. Hospice Care by a Hospice Care Provider; or
6. Respite Care.

Subject to the conditions, limitations and exclusions in the Rider, the amount of the benefit payable for any Calendar Month is an amount equal to the lesser of A or B where:

- A is 2% of Long Term Care Specified Amount, at commencement of benefits; and  
B is the per diem amount allowed by the Health Insurance Portability and Accountability Act times the number of days in the Calendar Month.

You may request a monthly benefit amount less than the above maximum. Choosing a lesser amount could extend the period during which benefits may be payable. You may change your election 30 days before the beginning of any calendar year.

If the Insured satisfies the Elimination Period and meets the Eligibility for the Payment of Benefits requirements for only part of a Calendar Month, we will prorate the Long Term Care Benefit payment at the beginning of a period of care or at the end. Prorate means we will divide the monthly Long Term Care Benefit by the actual number of days in the month, then multiply that number times the number of days during the month for which you are eligible to receive benefit payments.

Long Term Care Rider benefits are an acceleration of the policy's death benefit and will reduce any proceeds payable at surrender of the policy or upon the Insured's death.

**ELIGIBILITY FOR THE PAYMENT OF BENEFITS.** Long Term Care benefits may be payable under the Rider if the Insured is a Chronically Ill Individual and (1) has satisfied the 90-day Elimination Period; (2) has received Qualified Long Term Care Services covered under the Rider and such services are specified in a Plan of Care; and (3) a current Plan of Care and written Proof of Loss have been approved by us.

**Elimination Period.** The Rider has an Elimination Period of 90 days. This means that we will not

pay benefits under the Rider for any period before the Insured has incurred expenses, on each of 90 separate days during which the Rider is in effect, for Qualified Long Term Care Services that would otherwise be covered under the Rider. These days of care or services need not be continuous. The Elimination Period has to be satisfied only once while the Rider is in effect. You must provide us with Proof of Loss in order to satisfy the Elimination Period.

We will give the Insured credit toward the Elimination Period for days of confinement, care or services covered under the Rider, even if they are paid or payable by Medicare.

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

**Chronically Ill Individual** means an individual who has been certified by a Licensed Health Care Practitioner as being unable to perform, without Substantial Assistance from another individual, at least 2 out of the 6 Activities of Daily Living (ADLs) for an expected period of at least 90 days due to a loss of functional capacity; or requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

**Severe Cognitive Impairment (including the term “Severely Cognitively Impaired”)** means a severe loss or deterioration in intellectual capacity that is measured by clinical evidence and standardized tests as part of an evaluation that reliably measures impairment in the Insured's:

1. short-term or long-term memory;
2. orientation as to people, places or time;
3. deductive or abstract reasoning; and
4. judgment as it relates to safety awareness.

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

**Activities of Daily Living (ADLs)** means the following activities: Bathing, Continence, Dressing, Eating, Toileting and Transferring.

**10. GENERAL EXCLUSIONS AND LIMITATIONS.** Qualified Long Term Care Services do not include care, confinement or services:

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

**Non-Duplication of Benefits.** Qualified Long Term Care Services do not include care, confinement or services:

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

unless the costs incurred and paid exceed the amount covered by one of these entities, policies or programs.

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

We will not pay benefits under the Rider if Qualifying Long Term Care Services received by the Insured are not included in the Insured's Plan of Care.

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of Long Term Care services will likely increase over time, you should consider whether and how the benefits of the Rider should be used. The Rider does not include inflation protection coverage. Increases and decreases to the policy's death benefit resulting from the exercise of your rights under that policy, including your right to make policy loans and withdrawals, will cause a change in the maximum Monthly Long Term Care Rider Benefit Amount as well as the policy's death benefit.
12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The Rider provides coverage for mental and nervous conditions as long as the Insured is certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in the Rider. Covered illnesses include, but are not limited to, Alzheimer's Disease, Parkinson's Disease, senile dementia and related degenerative and dementia-based illnesses.
13. **LONG TERM CARE RIDER CHARGE.** The Guaranteed Monthly Deduction Rates per \$1000 of Long Term Care Specified Amount are as shown in the accompanying illustration.
14. **ADDITIONAL FEATURES.** Interaction of policy provisions and the Rider:

**Medical Information.** Issuance of the Rider requires that we are provided with and evaluate medical information about the Insured. This is generally known as medical underwriting.

**Policy Face Amount Changes.** Transactions that reduce the face amount of the policy, other than payment of Long Term Care Rider benefits, also will result in a dollar-for-dollar reduction in the Long Term Care Specified Amount.

**Loans and Partial Surrenders.** Loans and partial surrenders will not be permitted while benefits are being paid under the Rider.

**Long Term Care Rider's Effect on Surrender Values under any endorsement providing an enhanced surrender value.** If the policy is surrendered during the option periods provided in such an endorsement, any enhanced surrender value will be reduced by the amount of the Long Term Care Rider benefits paid.

**Terminal Illness Accelerated Death Benefit Endorsement Effect on the Rider.** If your policy includes an endorsement providing an accelerated death benefit in the event of a terminal illness ("Terminal Illness ADB Endorsement") the Insured may qualify for benefits under both the Terminal Illness ADB Endorsement and the Long Term Care Rider. If the Insured qualifies for benefits under both the Terminal Illness ADB Endorsement and the Long Term Care Rider and if a claim is made under both the Terminal Illness ADB Endorsement and the Long Term Care Rider, a benefit will be paid under the Terminal Illness ADB Endorsement first. A payment under the Terminal Illness ADB Endorsement will reduce the policy face amount and the Long Term Care Specified Amount will be reduced by the same amount. Once payment under the Terminal Illness ADB Endorsement is made, any payments under the Long Term Care Rider will be made based on the newly reduced Long Term Care Specified Amount.

We will not pay benefits under both the Terminal Illness ADB Endorsement and the Long Term Care Rider simultaneously. If a claim is made under the Terminal Illness ADB Endorsement while benefits are being paid under the Long Term Care Rider, we will stop paying benefits under the Long Term Care Rider when we pay benefits under the Terminal Illness ADB Endorsement. The maximum accelerated death benefit used to calculate the amount of the Terminal Illness Accelerated Death Benefit will be reduced by any Long Term Care Rider Benefits paid out. Once payment under the Terminal Illness ADB Endorsement is made, and the Insured qualifies for benefits under the Long Term Care Rider, any payments under the Long Term Care Rider will be made based on the newly reduced Long Term Care

Specified Amount.

**Policy Threshold Reset.** If Rider benefit payments cease because the Insured no longer qualifies for benefits under the Rider, and the policy's No-Lapse Guarantee Endorsement or Death Benefit Protection Endorsement, if any, is in effect, the Policy Threshold will be reset to zero if it is less than zero at that time.

15. **CONTACT THE STATE AGENCY LISTED IN A *SHOPPER'S GUIDE TO LONG-TERM CARE INSURANCE* IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE RIDER.**



Transamerica Life Insurance Company  
[Home Office: Cedar Rapids, IA  
Administrative Office:  
4333 Edgewood Rd NE  
Cedar Rapids, IA 52499  
1-800-TLC-HOST]  
[www.transamerica.com](http://www.transamerica.com)

### Residual Death Benefit Endorsement

**Transamerica Life Insurance Company** has issued this Endorsement as a part of the policy to which it is attached. Except as otherwise specifically set forth below, it is subject to all of the terms of the policy and of the Long Term Care Rider attached to the policy.

#### Amount of the Residual Death Benefit

The **Residual Death Benefit** is equal to the lesser of:

1. 10% of the lowest Face Amount of the Base Policy from its inception, less any outstanding Policy Loans; or
2. \$10,000.

#### Payment of the Residual Death Benefit

Upon the death of the Insured while the policy is in force, we will pay the Residual Death Benefit instead of the death benefit that would otherwise be payable if it is more than such death benefit and:

1. The Insured dies during a Calendar Month for which a Monthly Long Term Care Benefit is due under the Long Term Care Rider; or
2. The Insured dies after we have paid the Rider Maximum Amount under the Long Term Care Rider.

#### Termination

This Endorsement will terminate on the earliest of the following:

1. The date the policy is surrendered;
2. The date the policy terminates for any reason;
3. The date you request termination of the Long Term Care Rider.

Signed for Transamerica Life Insurance Company at [Cedar Rapids, Iowa], and effective on the Policy Date of the policy to which this endorsement is attached unless we advise you in writing of a different date.

[ ]

[Secretary]

[ ]

[President]



Transamerica Life Insurance Company  
 Home Office: [Cedar Rapids, Iowa 52499]  
 Administrative Office: [4333 Edgewood Road NE  
 Cedar Rapids, IA 52499]

**Supplemental  
 Application for  
 Long Term Care Rider  
 (LTCR)**

This is a supplement to the Application for Life Insurance for the proposed Insured. Please complete if LTC Rider is being elected.			
<input type="checkbox"/> <b>New Application</b>		<input type="checkbox"/> <b>Reinstatement</b> (Check the applicable box.)	
<b>Section 1 Proposed Insured and Owner Information</b>			
	First Name	M.I.	Last Name
Proposed Insured:	_____		Date of Birth (MM/DD/YYYY) _____
Owner: (if other than the proposed Insured)	_____		_____
<b>Section 2 Protection Against Unintended Lapse</b>			
I, the Owner, understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. (Check the applicable box.)			
<input type="checkbox"/> I designate the following person to receive notice prior to cancellation of my rider for nonpayment of premium (complete information below):		<input type="checkbox"/> I elect <b>NOT</b> to designate a person to receive this notice. I may change my election at a future date.	
First Name	M.I.	Last Name	
Address (Cannot be a P.O.Box)	City	State	Zip Code
<b>Section 3 Health Questions - In this section, "You" means the proposed Insured.</b>			
1. During the last 12 months, have you ever:			
a) required assistance or supervision of any kind to perform any every day activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring or toileting?			<input type="checkbox"/> Yes <input type="checkbox"/> No
b) used a catheter, chair lift, crutches, dialysis, motorized scooter, oxygen equipment, quad or three-pronged cane, respirator, walker or wheelchair?			<input type="checkbox"/> Yes <input type="checkbox"/> No
c) been advised to enter or resided in a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), or rehabilitation facility, or attended an adult day care facility, or required home health care?			<input type="checkbox"/> Yes <input type="checkbox"/> No
2. During the last 3 years, have you ever used insulin to treat Diabetes, or have you ever been diagnosed or treated for Diabetes WITH COMPLICATIONS (such as Neuropathy, Retinopathy, Nephropathy, Heart Disease, Stroke or Peripheral Vascular Disease)?			
			<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you EVER been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following condition(s):			
Alzheimer's disease or Dementia			<input type="checkbox"/> Yes <input type="checkbox"/> No
Amputation due to disease			<input type="checkbox"/> Yes <input type="checkbox"/> No
ALS (Lou Gehrig's disease)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis with narcotic pain medication			<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple Strokes/CVA's/TIA's			<input type="checkbox"/> Yes <input type="checkbox"/> No
Organ Transplant (other than Corneal)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple Sclerosis			<input type="checkbox"/> Yes <input type="checkbox"/> No
Huntington's Chorea			<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular Dystrophy			<input type="checkbox"/> Yes <input type="checkbox"/> No
Myasthenia Gravis			<input type="checkbox"/> Yes <input type="checkbox"/> No
Organic Brain Syndrome			<input type="checkbox"/> Yes <input type="checkbox"/> No
Osteoporosis with fractures			<input type="checkbox"/> Yes <input type="checkbox"/> No
Parkinson's disease			<input type="checkbox"/> Yes <input type="checkbox"/> No
Polymyositis			<input type="checkbox"/> Yes <input type="checkbox"/> No
Scleroderma			<input type="checkbox"/> Yes <input type="checkbox"/> No
Memory loss			<input type="checkbox"/> Yes <input type="checkbox"/> No
Unplanned weight loss greater than 15 pounds within the last 2 years			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease?			
			<input type="checkbox"/> Yes <input type="checkbox"/> No

**If Questions 1, 2, 3 or 4 were answered yes, the rider is not available for the proposed Insured and this application supplement should not be completed or submitted.**

5. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions:
- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Disorientation                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Used a Straight Cane            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Chest pain                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Transient Ischemic Attack (TIA) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of Balance                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Loss of Strength                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Tremors                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dizziness                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
6. Do you have a handicap sticker, handicap placard, or handicap license plate? (Give reason below.)  Yes  No
7. In the last 24 months, have you had to limit or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies? (Give reason below.)  Yes  No

**Give details for all yes answers to questions 5, 6, & 7. For every medication there should be a condition and for most conditions there should be a medication or treatment.**

Question #	Nature of Condition/Date of Diagnosis	Date Last Treated/Medication Taken	Name of Physician Seen/Physician's Address

8. Have you ever received any long term care benefits, disability income benefits or Social Security Disability benefits? If the answer is yes, provide details in Section 5, Remarks.  Yes  No
9. Within the past 5 years, have you ever been declined for long term care insurance including long term care insurance provided by rider to a life insurance or other policy? List company name, date and reason in Section 5, Remarks.  Yes  No

**Section 4 Existing and Pending Coverage - In this section, "You" means the proposed Insured. (Provide details of yes answers below.)**

1. Are you covered by Medicaid?  Yes  No
2. Are you covered under any other long term care insurance policy, contract or rider in force?  Yes  No
3. Has any of your long term care insurance, including coverage by riders, lapsed, been surrendered or otherwise terminated in the past 24 months?  Yes  No
4. Is the coverage applied for intended to replace any long term care, medical or health or disability insurance coverage?  Yes  No
5. Are there any other life insurance policies currently in force on your life which provide similar long term care or accelerated death benefit coverage?  Yes  No
6. Do you currently have another long term care policy or certificate in force (including health care service contract, health maintenance organization contract)? If yes, please give details in Section 5, Remarks.  Yes  No
7. Did you have a long term care insurance policy or certificate in force in the last 12 months? If yes, with which company? And if that policy lapsed, when did it lapse? Please provide details in Section 5, Remarks.  Yes  No
8. Do you intend to replace any in force medical or health insurance coverage with this policy? If yes, please provide details in Section 5, Remarks and complete the required replacement form.  Yes  No

**If yes to questions 5-8, please provide details.** If more space is needed, please use the Supplemental Information form.

Name and Address of Insurance Company	Policy/Certificate Number	Type and Amount of Benefits	Lapse Date	Currently In Force?		Being Replaced?	
				Yes	No	Yes	No
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 5	Remarks

**I, the proposed Insured, and I, the Owner if different, hereby represent** that all statements and answers given in this application supplement are true and complete to the best of my/our knowledge and belief. **I/we agree** that: (1) this application supplement, and the Application shall be the basis for any contract issued; (2) the coverage I/we are applying for provides benefits for the proposed Insured only; and (3) no waiver or modification shall be binding upon Transamerica Life Insurance Company ("the Company") unless in writing and signed by the President or a Vice President and the Secretary or an Assistant Secretary.

**Caution: If your answers on this application supplement and/or on the Application for the life insurance policy to which the LTC Rider will be attached are incorrect or untrue, Transamerica Life Insurance Company may have the right to deny benefits or rescind coverage.**

**I understand** that benefits under the Long Term Care Rider are provided through an accelerated death benefit option, and that if I exercise the accelerated death benefit option, any beneficiary I designate will receive a reduced death benefit.

**I certify** that I have received the Outline of Coverage, HIPAA Privacy Notice, the Disclosure Notices for the MIB and Fair Credit Reporting, and if eligible for Medicare, the "Guide to Health Insurance for People with Medicare."

**Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

**X** \_\_\_\_\_  
Signature of proposed Insured

\_\_\_\_\_  
Date (MM/DD/YYYY)

**X** \_\_\_\_\_  
Signature of Owner (if other than proposed Insured)

\_\_\_\_\_  
Date (MM/DD/YYYY)

**X** \_\_\_\_\_  
Signature of Licensed Agent/Insurance Producer

\_\_\_\_\_  
Date (MM/DD/YYYY)

**AGENT/INSURANCE PRODUCER'S REPORT**

<b>Insurance Producer's Report</b>				
1. Did you personally interview the proposed Insured, ask all the questions and witness the signatures?				<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Did you see or hear or were you advised of any physical impairment of the proposed Insured with regard to walking, speaking, any form of tremor or any signs of confusion or disorientation?				<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Did you review the current long term care, medical or health or disability insurance coverage of the proposed Insured and find that the coverage applied for is appropriate for the applicant's needs?				<input type="checkbox"/> Yes <input type="checkbox"/> No
4. To the best of your knowledge, is the insurance applied for intended to replace any other long term care, medical or health or disability insurance coverage in force with this or any other company?				<input type="checkbox"/> Yes <input type="checkbox"/> No
5. To the best of your knowledge, is the information provided in this application true and complete?				<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Does the proposed Insured live alone?				<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>LIST ANY OTHER HEALTH INSURANCE COVERAGE YOU HAVE SOLD ON THE PROPOSED INSURED</b>				
(1) List policies or other coverage sold that are still in force; and				
(2) List policies or other coverage sold within the last five (5) years that are no longer in force.				
Insurance Company	Policy/Certificate Number	Type and Amount of Benefits	In Force	Lapse Date
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	
			<input type="checkbox"/> Yes <input type="checkbox"/> No	

Licensed Agent/Insurance Producer: \_\_\_\_\_  
Last First

Licensed Agent/Insurance Producer ID #: \_\_\_\_\_  
(Up to 10 Digits)

\_\_\_\_\_  
Signature of Licensed Agent/Insurance Producer Date (MM/DD/YYYY)

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

### Rate Information

Rate data applies to filing.

Filing Method:

Approval

Rate Change Type:

Neutral

Overall Percentage of Last Rate Revision:

%

Effective Date of Last Rate Revision:

Filing Method of Last Filing:

### Company Rate Information

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
Transamerica Life Insurance Company	%	%				%	%

**SERFF Tracking #:**

AEGB-128311144

**State Tracking #:****Company Tracking #:**

LTCR02

**State:**

Arkansas

**Filing Company:**

Transamerica Life Insurance Company

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.001 Qualified

**Product Name:**

LTCR02

**Project Name/Number:**

LTC Rider for TransAce 2012 - non-IC/L043-1

## Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1	Approved 07/16/2012	Long Term Care Rider	LTCR02	New		LTCR02 Rates.pdf

**Transamerica Life Insurance Company  
Long Term Care Rider: LTCR02**

Age/Dur	Male / Standard / Non-Smoker				Male / Standard / Smoker				Male / Preferred / Non-Smoker				Male / Preferred / Smoker			
	25,000	100,000	250,000	1,000,000	25,000	100,000	250,000	1,000,000	25,000	100,000	250,000	1,000,000	25,000	100,000	250,000	1,000,000
16	3.55	1.11	0.52	0.4	3.04	0.88	0.77	0.7	3.81	1.23	0.79	0.37	3.27	0.79	0.66	0.6
17	3.55	1.18	0.55	0.5	2.72	1.05	0.94	0.86	3.82	1.29	0.83	0.45	3.01	0.92	0.79	0.73
18	3.51	1.14	0.65	0.59	2.61	1.22	1.11	1.02	3.83	1.26	0.85	0.53	2.79	1.05	0.92	0.85
19	3.55	1.14	0.74	0.69	2.78	1.4	1.28	1.2	3.84	1.26	0.9	0.6	2.83	1.18	1.06	0.98
20	3.55	1.21	0.83	0.78	2.94	1.58	1.45	1.36	3.85	1.26	0.81	0.68	2.93	1.32	1.19	1.11
21	3.56	1.29	0.93	0.87	3.12	1.76	1.63	1.54	3.87	1.3	0.88	0.75	3.03	1.45	1.32	1.24
22	3.55	1.35	1	0.95	3.27	1.92	1.79	1.69	3.86	1.34	0.95	0.81	3.12	1.57	1.44	1.35
23	3.55	1.4	1.07	1.02	3.4	2.05	1.92	1.82	3.85	1.37	1	0.87	3.18	1.67	1.54	1.45
24	3.51	1.43	1.12	1.07	3.48	2.16	2.03	1.92	3.8	1.38	1.04	0.91	3.21	1.75	1.62	1.53
25	3.51	1.46	1.16	1.11	3.54	2.25	2.12	2	3.78	1.39	1.07	0.94	3.23	1.82	1.69	1.59
26	3.45	1.47	1.19	1.14	3.56	2.31	2.18	2.06	3.7	1.39	1.1	0.97	3.21	1.86	1.73	1.63
27	3.4	1.47	1.21	1.16	3.56	2.35	2.21	2.1	3.62	1.39	1.11	0.99	3.18	1.89	1.76	1.66
28	3.33	1.46	1.22	1.16	3.52	2.36	2.23	2.11	3.53	1.37	1.12	0.99	3.13	1.9	1.77	1.67
29	3.25	1.44	1.21	1.16	3.47	2.36	2.22	2.11	3.44	1.35	1.11	0.99	3.06	1.9	1.77	1.67
30	3.17	1.41	1.2	1.15	3.4	2.34	2.21	2.09	3.34	1.31	1.1	0.99	2.98	1.89	1.76	1.66
31	3.12	1.37	1.18	1.13	3.32	2.32	2.18	2.07	3.26	1.28	1.08	0.97	2.89	1.87	1.74	1.64
32	3	1.32	1.15	1.1	3.22	2.27	2.13	2.02	3.15	1.22	1.05	0.95	2.78	1.83	1.71	1.6
33	2.88	1.25	1.1	1.05	3.06	2.18	2.04	1.94	3.05	1.17	1.02	0.92	2.64	1.77	1.64	1.55
34	2.72	1.17	1.04	0.99	2.86	2.05	1.92	1.82	2.92	1.1	0.96	0.87	2.47	1.68	1.56	1.47
35	2.57	1.08	0.97	0.92	2.63	1.88	1.76	1.66	2.8	1.01	0.9	0.82	2.27	1.58	1.45	1.36
36	2.51	1.18	1.04	0.98	2.84	2.06	1.95	1.86	2.75	1.08	0.94	0.87	2.43	1.7	1.58	1.49
37	2.3	1.28	1.11	1.04	3.02	2.23	2.12	2.03	2.74	1.13	0.98	0.93	2.58	1.82	1.71	1.61
38	2.34	1.35	1.17	1.08	3.16	2.35	2.25	2.16	2.64	1.18	1.01	0.97	2.68	1.92	1.81	1.72
39	2.02	1.41	1.21	1.11	3.26	2.45	2.35	2.26	2.51	1.21	1.03	1	2.75	2	1.89	1.8
40	2.05	1.46	1.24	1.14	3.31	2.51	2.41	2.33	2.52	1.23	1.04	1.02	2.79	2.05	1.94	1.86
41	2.05	1.47	1.24	1.15	3.28	2.5	2.4	2.32	2.22	1.24	1.04	1.04	2.77	2.05	1.95	1.87
42	2.03	1.47	1.24	1.14	3.19	2.44	2.35	2.27	2.13	1.24	1.05	1.04	2.7	2.02	1.91	1.84
43	2.01	1.46	1.24	1.15	3.12	2.39	2.3	2.23	2.04	1.24	1.06	1.05	2.63	1.98	1.88	1.81
44	1.98	1.43	1.24	1.15	3	2.31	2.22	2.14	1.93	1.25	1.08	1.05	2.53	1.91	1.81	1.75
45	1.91	1.37	1.25	1.15	2.79	2.14	2.06	1.99	1.8	1.27	1.12	1.05	2.35	1.78	1.69	1.63
46	2.28	1.61	1.4	1.32	3.16	2.42	2.33	2.25	2.18	1.53	1.26	1.17	2.64	2	1.91	1.85
47	2.61	1.81	1.53	1.45	3.45	2.63	2.55	2.45	2.52	1.78	1.37	1.27	2.87	2.17	2.08	2
48	2.91	1.99	1.65	1.56	3.68	2.79	2.71	2.61	2.85	2.01	1.47	1.35	3.05	2.31	2.21	2.13
49	3.18	2.15	1.73	1.65	3.86	2.91	2.83	2.72	3.16	2.23	1.54	1.42	3.19	2.4	2.3	2.22
50	3.42	2.28	1.79	1.7	3.97	2.97	2.88	2.77	3.44	2.42	1.59	1.47	3.28	2.44	2.34	2.26
51	3.42	2.35	1.79	1.72	3.76	2.9	2.84	2.74	3.53	2.55	1.6	1.48	3.08	2.38	2.3	2.23
52	3.39	2.39	1.78	1.71	3.47	2.76	2.73	2.64	3.59	2.67	1.59	1.48	2.83	2.26	2.21	2.15
53	3.46	2.46	1.75	1.68	3.27	2.59	2.55	2.47	3.78	2.8	1.56	1.46	2.68	2.14	2.08	2.03
54	3.48	2.5	1.68	1.6	2.96	2.35	2.31	2.23	3.93	2.91	1.51	1.41	2.45	1.95	1.89	1.84
55	3.4	2.5	1.54	1.45	2.65	2.09	2.04	1.98	4.01	2.97	1.4	1.31	2.22	1.75	1.69	1.64
56	3.78	2.81	1.81	1.67	3.3	2.56	2.5	2.42	4.38	3.19	1.53	1.47	2.72	2.12	2.05	1.99
57	4.07	3.06	1.99	1.83	3.73	2.88	2.8	2.71	4.68	3.38	1.63	1.59	3.05	2.37	2.29	2.23
58	4.31	3.26	2.14	1.96	4.07	3.14	3.06	2.96	4.94	3.56	1.73	1.69	3.34	2.6	2.51	2.44
59	4.48	3.41	2.22	2.04	4.31	3.34	3.26	3.15	5.14	3.73	1.82	1.78	3.54	2.77	2.68	2.61
60	4.59	3.5	2.25	2.09	4.45	3.48	3.41	3.29	5.3	3.9	1.92	1.86	3.68	2.9	2.81	2.73
61	4.75	3.77	2.47	2.36	4.71	3.83	3.8	3.73	5.6	4.26	2.14	2.1	3.76	3.1	3.04	3.02
62	4.86	4.03	2.66	2.6	4.83	4.1	4.1	4.08	5.84	4.56	2.32	2.31	3.76	3.26	3.23	3.25
63	5.31	4.32	2.84	2.78	5.22	4.29	4.28	4.23	6.39	4.87	2.5	2.47	4.09	3.41	3.35	3.36
64	5.65	4.52	2.93	2.86	5.1	4.11	4.08	4.01	6.83	5.11	2.6	2.57	4.09	3.33	3.26	3.24
65	5.87	4.64	2.95	2.84	4.95	3.88	3.83	3.72	7.17	5.28	2.64	2.59	4.03	3.18	3.11	3.04
66	6.32	5.01	3.38	3.3	5.99	4.76	4.69	4.56	6.85	5.05	2.96	2.87	4.84	3.88	3.8	3.71
67	6.62	5.29	3.88	3.71	6.78	5.43	5.36	5.21	6.39	4.78	3.19	3.07	5.48	4.43	4.35	4.24
68	6.62	5.33	4.25	3.97	7.23	5.82	5.74	5.58	5.8	4.43	3.26	3.11	5.89	4.8	4.72	4.6
69	6.66	5.37	4.69	4.31	7.83	6.32	6.23	6.07	5.23	4.11	3.33	3.25	6.43	5.26	5.17	5.05
70	6.11	4.95	4.73	4.24	7.64	6.17	6.08	5.91	5.99	4.92	4.5	4.44	6.13	4.99	4.89	4.77
71	6.46	5.51	5.32	4.87	9.34	7.74	7.7	7.31	6.42	5.28	5.05	4.99	7.44	6.27	6.16	5.97
72	7.38	6.55	6.34	5.92	11	9.45	9.46	8.88	7.17	5.97	5.86	5.8	8.78	7.67	7.58	7.28
73	8.76	7.53	7.26	6.84	11.65	9.83	9.78	9.07	8.37	6.74	6.62	6.53	9.5	8.12	7.98	7.57
74	9.7	8.12	7.85	7.43	12.27	10.08	9.99	9.3	9.22	7.32	7.13	7.02	10.03	8.36	8.19	7.77
75	9.32	7.53	7.38	6.98	12.45	9.89	9.73	9.4	9.09	7.19	6.85	6.73	10.02	8.08	7.92	7.69
76	15.48	11.99	11.13	10.3	17.63	14.03	13.75	13.37	15.71	12.05	11.79	10.48	14.52	11.74	11.49	11.22
77	21.53	16.46	15.02	13.67	22.28	17.74	17.36	16.98	22.11	16.84	16.62	14.14	18.46	14.92	14.6	14.35
78	26.24	19.99	18.12	16.16	26.12	20.77	20.32	19.98	27.48	20.86	20.65	17	21.61	17.47	17.09	16.88
79	31.22	23.95	21.84	19.13	28.95	23.03	22.55	22.22	32.98	25.14	24.9	20.09	23.82	19.26	18.86	18.66
80	34.72	26.94	24.83	21.19	30.71	24.46	24.03	23.64	37.18	28.5	28.16	22.22	24.99	20.26	19.87	19.65
81	37.6	30.78	27.53	23.98	34.67	26.45	27.64	27.48	39.78	31.19	31.09	24.81	26.95	21.9	22.1	22.09
82	41.47	35.71	30.88	27.5	39.41	29.04	31.92	31.96	42.94	34.42	34.49	27.95	29.1	23.81	24.48	24.67
83	47.8	41.38	34.22	31.02	48.78	33.05	37.28	37.32	48.13	37.93	37.84	31.04	34.53	26.56	27.21	27.44
84	54.76	47.9	37.93	34.98	58.58	37.61	42.87	42.8	53.58	41.65	41.39	34.57	39.56	29.04	29.5	29.74
85	62.45	55.18	42.14	39.53	68.82	42.73	48.75	48.46	59.4	45.66	45.24	38.78	44.19	31.76	31.35	31.54
86	69.75	61.31	47.51	43.62	84.61	56.58	61.52	60.95	66.91	55.02	55.41	42.71	54.85	39.88	38.84	38.9
87	76.39	66.93	52.62	47.36	106.33	75.77	78.62	77.65	74.16	60.46	60.02	46.71	69.88	51.22	49.27	49.18
88	82.77	73.24	57.87	51.87	115.13	90.36	90.52	89.43	79.4	65.81	64.14	50.58	72.11	58	55.43	55.39
89	87.24	77.09	61.48	53.22	143.87	111.45	108.27	107.07	88.08	70.56	70.1	53.96	96.61	68.84	66.09	66.16

**Transamerica Life Insurance Company  
Long Term Care Rider: LTCR02**

Age/Dur	Female / Standard / Non-Smoker				Female / Standard / Smoker				Female / Preferred / Non-Smoker				Female / Preferred / Smoker			
	25,000	100,000	250,000	1,000,000	25,000	100,000	250,000	1,000,000	25,000	100,000	250,000	1,000,000	25,000	100,000	250,000	1,000,000
16	3.94	1.32	0.87	0.49	3.99	1.19	0.76	0.68	4.14	1.43	1.03	0.57	4.06	1.04	0.65	0.57
17	3.95	1.37	0.9	0.57	3.95	1.07	0.92	0.84	4.15	1.46	1.08	0.63	4	1	0.78	0.7
18	3.96	1.42	0.97	0.65	3.92	1.24	1.07	0.99	4.16	1.49	1.12	0.69	3.98	1.07	0.91	0.83
19	3.96	1.47	1.03	0.72	3.88	1.38	1.21	1.14	4.16	1.51	1.16	0.75	3.95	1.19	1.03	0.95
20	3.96	1.51	1.09	0.79	3.85	1.53	1.35	1.28	4.16	1.54	1.2	0.81	3.93	1.3	1.15	1.07
21	3.95	1.55	1.14	0.85	3.83	1.66	1.48	1.41	4.15	1.55	1.23	0.86	3.86	1.4	1.26	1.17
22	3.94	1.58	1.19	0.91	3.73	1.78	1.59	1.52	4.13	1.56	1.26	0.9	3.79	1.49	1.35	1.27
23	3.91	1.6	1.23	0.96	3.71	1.89	1.7	1.63	4.11	1.57	1.28	0.94	3.73	1.58	1.45	1.36
24	3.86	1.62	1.26	1	3.54	1.99	1.8	1.73	4.08	1.57	1.3	0.97	3.79	1.66	1.53	1.44
25	3.83	1.63	1.29	1.04	3.58	2.08	1.88	1.82	4.04	1.57	1.31	1	3.7	1.73	1.6	1.51
26	3.78	1.64	1.31	1.07	3.61	2.15	1.96	1.89	3.98	1.56	1.31	1.03	3.6	1.79	1.66	1.57
27	3.73	1.63	1.32	1.1	3.62	2.21	2.01	1.94	3.89	1.55	1.31	1.04	3.46	1.83	1.7	1.61
28	3.64	1.62	1.32	1.12	3.61	2.25	2.05	1.98	3.8	1.53	1.31	1.06	3.34	1.87	1.74	1.65
29	3.56	1.6	1.32	1.13	3.58	2.28	2.08	2.01	3.71	1.5	1.29	1.07	3.32	1.89	1.75	1.67
30	3.53	1.58	1.31	1.13	3.54	2.29	2.09	2.02	3.61	1.47	1.27	1.06	3.26	1.89	1.76	1.68
31	3.44	1.54	1.29	1.12	3.46	2.27	2.07	2	3.51	1.43	1.24	1.06	3.16	1.89	1.74	1.66
32	3.34	1.49	1.26	1.11	3.36	2.24	2.04	1.97	3.41	1.39	1.21	1.04	3.05	1.86	1.71	1.64
33	3.24	1.43	1.22	1.09	3.24	2.18	1.99	1.91	3.32	1.34	1.17	1.03	2.92	1.82	1.67	1.59
34	3.11	1.36	1.18	1.06	3.08	2.1	1.9	1.83	3.21	1.29	1.12	1	2.76	1.76	1.6	1.53
35	3.01	1.28	1.12	1.03	2.9	1.99	1.8	1.73	3.11	1.23	1.06	0.96	2.59	1.68	1.51	1.44
36	3.05	1.43	1.24	1.16	3.08	2.14	1.95	1.87	3.09	1.29	1.12	1.02	2.69	1.78	1.6	1.53
37	3.16	1.56	1.35	1.28	3.23	2.26	2.07	1.99	3.06	1.35	1.17	1.07	2.78	1.85	1.67	1.61
38	3.23	1.69	1.46	1.39	3.35	2.35	2.17	2.08	3.01	1.39	1.22	1.12	2.84	1.91	1.73	1.66
39	3.28	1.81	1.56	1.5	3.46	2.44	2.25	2.17	2.94	1.43	1.26	1.16	2.89	1.96	1.77	1.71
40	3.32	1.92	1.65	1.6	3.53	2.5	2.32	2.23	2.88	1.47	1.29	1.19	2.92	2	1.81	1.75
41	3.34	2.01	1.73	1.68	3.54	2.51	2.33	2.25	2.79	1.48	1.31	1.21	2.91	2	1.82	1.75
42	3.35	2.09	1.81	1.75	3.5	2.49	2.32	2.23	2.69	1.49	1.32	1.21	2.87	1.98	1.8	1.74
43	3.34	2.16	1.87	1.81	3.4	2.44	2.27	2.19	2.58	1.49	1.32	1.22	2.8	1.94	1.77	1.7
44	3.32	2.22	1.93	1.86	3.26	2.35	2.19	2.11	2.46	1.47	1.31	1.21	2.69	1.88	1.72	1.66
45	3.29	2.26	1.98	1.9	3.06	2.24	2.08	2.02	2.34	1.44	1.29	1.19	2.55	1.81	1.65	1.6
46	3.41	2.36	2.09	2	3.25	2.34	2.19	2.13	2.66	1.66	1.38	1.29	2.75	1.91	1.75	1.7
47	3.51	2.45	2.17	2.08	3.4	2.42	2.29	2.22	2.98	1.87	1.45	1.37	2.92	2	1.83	1.78
48	3.59	2.52	2.25	2.15	3.53	2.5	2.37	2.3	3.28	2.06	1.51	1.44	3.06	2.07	1.9	1.85
49	3.66	2.58	2.3	2.2	3.66	2.57	2.45	2.37	3.57	2.24	1.57	1.49	3.18	2.14	1.96	1.91
50	3.72	2.62	2.34	2.24	3.77	2.64	2.51	2.44	3.85	2.41	1.61	1.54	3.29	2.19	2.01	1.96
51	3.57	2.59	2.34	2.25	3.63	2.62	2.52	2.45	3.94	2.52	1.61	1.55	3.15	2.17	2.02	1.97
52	3.42	2.55	2.32	2.24	3.48	2.59	2.52	2.46	4	2.62	1.61	1.57	2.99	2.14	2	1.97
53	3.46	2.52	2.3	2.22	3.45	2.58	2.5	2.43	4.2	2.74	1.61	1.56	2.96	2.13	1.98	1.95
54	3.59	2.47	2.25	2.17	3.38	2.52	2.43	2.37	4.37	2.84	1.59	1.54	2.87	2.07	1.92	1.89
55	3.65	2.35	2.13	2.06	3.03	2.28	2.18	2.13	4.49	2.89	1.53	1.48	2.59	1.89	1.75	1.72
56	3.91	2.62	2.38	2.32	3.64	2.7	2.58	2.51	4.87	3.13	1.7	1.65	3.04	2.2	2.05	2.02
57	4.13	2.85	2.6	2.55	4.14	3.06	2.91	2.84	5.21	3.33	1.85	1.8	3.42	2.47	2.31	2.27
58	4.23	3.06	2.79	2.75	4.51	3.34	3.17	3.1	5.49	3.52	1.97	1.92	3.71	2.69	2.52	2.48
59	4.47	3.25	2.96	2.92	4.75	3.54	3.35	3.28	5.73	3.67	2.06	2.01	3.92	2.85	2.68	2.63
60	4.63	3.41	3.1	3.06	4.89	3.66	3.48	3.4	5.91	3.8	2.12	2.08	4.06	2.98	2.79	2.75
61	4.59	3.65	3.36	3.31	5.34	4.11	3.95	3.89	5.83	4.04	2.64	2.47	4.31	3.25	3.08	3.06
62	4.58	3.88	3.57	3.52	5.7	4.49	4.36	4.33	5.8	4.23	3.11	2.83	4.51	3.5	3.35	3.34
63	4.99	4.18	3.81	3.73	6.48	4.94	4.79	4.71	6.2	4.49	3.63	3.18	5.13	3.84	3.65	3.62
64	5.33	4.42	3.98	3.89	6.93	5.18	5.03	4.93	6.57	4.69	4.08	3.48	5.55	4.08	3.86	3.82
65	5.64	4.6	4.09	3.99	7.33	5.4	5.19	5.13	6.91	4.83	4.5	3.74	5.94	4.34	4.09	4.03
66	6.58	5.38	4.82	4.39	8.25	6.15	6.11	5.85	7.04	5.03	4.73	3.89	6.89	5.04	4.79	4.73
67	7.38	6.06	5.44	4.7	9.05	6.8	6.78	6.47	7.07	5.1	4.83	3.91	7.69	5.63	5.38	5.31
68	8.03	6.6	5.94	4.88	9.59	7.24	7.23	6.91	6.96	5.05	4.81	3.8	8.27	6.08	5.83	5.75
69	8.53	7.04	6.35	4.97	9.94	7.55	7.49	7.24	6.73	4.88	4.67	3.57	8.68	6.41	6.17	6.09
70	8.8	7.31	6.57	4.88	10.07	7.67	7.53	7.38	7.51	5.64	5.46	4.24	8.63	6.39	6.11	6.03
71	9.76	8.17	7.65	6.07	11.66	9.18	9.09	8.84	8.43	6.61	6.48	4.98	9.9	7.81	7.58	7.47
72	10.53	8.94	8.62	7.13	12.55	10.23	10.19	9.91	9.21	7.46	7.37	5.63	10.7	8.9	8.7	8.58
73	11.86	9.81	9.6	8.17	14.56	11.64	11.53	11.21	10.5	8.34	8.24	6.25	12.39	10.17	9.91	9.75
74	12.95	10.47	10.31	8.97	16.16	12.72	12.56	12.18	11.56	9.01	8.87	6.66	13.73	11.09	10.79	10.59
75	13.77	10.9	10.77	9.52	17.45	13.55	13.32	12.88	12.37	9.43	9.22	6.85	14.79	11.72	11.36	11.15
76	17.31	14.1	13.57	12.44	19.94	16	15.76	15.28	15.67	12.21	11.69	9.8	17.02	13.89	13.6	13.27
77	20.47	16.9	16.08	15.08	21.64	17.73	17.47	16.95	18.61	14.71	13.94	12.5	18.57	15.43	15.2	14.78
78	23.22	19.25	18.29	17.41	22.52	18.7	18.43	17.9	21.15	16.83	15.94	14.94	19.43	16.34	16.13	15.67
79	25.59	21.18	20.22	19.45	22.81	19.01	18.73	18.21	23.28	18.61	17.69	17.13	19.66	16.61	16.39	15.91
80	27.48	22.73	21.85	21.2	22.3	18.54	18.26	17.72	24.88	20.03	19.14	19.01	19.01	16.03	15.75	15.34
81	29.37	24.21	23.68	23.16	25.08	21.6	21.74	21.12	25.86	21.38	19.82	20.18	21.1	18.65	18.6	18.14
82	31.64	26.11	25.82	25.44	28.5	25.17	25.78	25.04	27.07	22.92	20.56	21.48	23.64	21.71	21.8	21.24
83	36.62	28.92	28.6	28.32	36.29	30.3	31.08	29.98	30.7	24.85	21.67	23.59	29.71	26.01	25.82	25
84	42.1	32.72	32.48	32.35	44.74	35.73	36.76	35.25	34.61	27.61	24.85	27.79	36.12	30.54	29.98	28.84
85	48.42	38.43	38.88	39.5	54.38	41.79	43.23	41.2	39.1	33.49	28.84	32.57	43.3	35.62	34.55	33.04
86	56.4	46.27	44.95	44.48	60.44	52.11	53.38	50.74	46.16	39.14	34.26	36.81	48.68	43.23	41.89	39.96
87	65.58	55.19	52.86	51.52	69.5	65.97	66.81	63.42	54.17	45.37	41.18	42.96	56.25	53.24	51.54	49.01
88	74.56	64.75	61.15	59.23	77.02	78.88	78.93	74.79	61.57	54.21	49.72	50.94	60.48	61.97	60.16	57.07
89	86.32	74.69	69.37	66.67	86.48	99.36	97.97	92.9	71.62	60.67	55.28	55.43	71.22	76.27	74.66	70.89

SERFF Tracking #:

AEGB-128311144

State Tracking #:

Company Tracking #:

LTCR02

State:

Arkansas

Filing Company:

Transamerica Life Insurance Company

TOI/Sub-TOI:

LTC03I Individual Long Term Care/LTC03I.001 Qualified

Product Name:

LTCR02

Project Name/Number:

LTC Rider for TransAce 2012 - non-IC/L043-1

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	07/16/2012
Comments:			
Attachment(s):			
AR Regulation 19 Certification.pdf			
AR Regulation 49 Certification.pdf			
Certification of Readability.pdf			
		Item Status:	Status Date:
Bypassed - Item:	Application	Approved	07/16/2012
Bypass Reason:	The application supplement intended for use with this rider is attached to the forms tab of this filing		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved	07/16/2012
Bypass Reason:	The outline of coverage for this rider is attached to the forms tab of this filing		
		Item Status:	Status Date:
Satisfied - Item:	Explanation of Variables and certification	Approved	07/16/2012
Comments:			
Attachment(s):			
Explanation of Variables.pdf			
Explanation of Variability Certification.pdf			
		Item Status:	Status Date:
Satisfied - Item:	Sample specifications page	Approved	07/16/2012
Comments:			
Attachment(s):			
TransAce LTC rider data page.pdf			

**SERFF Tracking #:**

AEGB-128311144

**State Tracking #:**

**Company Tracking #:**

LTCR02

**State:**

Arkansas

**Filing Company:**

Transamerica Life Insurance Company

**TOI/Sub-TOI:**

LTC03I Individual Long Term Care/LTC03I.001 Qualified

**Product Name:**

LTCR02

**Project Name/Number:**

LTC Rider for TransAce 2012 - non-IC/L043-1

**Item Status:**

**Status Date:**

Satisfied - Item:

Addition of new policy form for rider

Comments:

Attachment(s):

Add UL07 AR to LTCR02 filing.pdf

**TRANSAMERICA LIFE INSURANCE COMPANY**

**Home Office: Cedar Rapids, Iowa**

**REGULATION 19 CERTIFICATION**

**Forms: LTCR02 with RDB01 and underlying policy form 1-12605107**

We certify that, to the best of our knowledge and belief, this submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements of the Insurance Division of the State of Arkansas.

*Cheryl Bock*

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Cheryl Bock  
Assistant Vice President

April 20, 2012  
Date

**TRANSAMERICA LIFE INSURANCE COMPANY**

**Home Office: Cedar Rapids, Iowa**

**REGULATION 49 CERTIFICATION**

**Forms: LTCR02 with RDB01 and underlying policy form 1-12605107**

We certify that, for policies issued in Arkansas on the above-referenced form numbers, we will deliver the Life and Health Guaranty Fund Notice required by Regulation 49.

*Cheryl Bock*

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Cheryl Bock  
Assistant Vice President

April 20, 2012  
Date

# TRANSAMERICA LIFE INSURANCE COMPANY

## CERTIFICATION OF READABILITY

<u>Form Name</u>	<u>Form Number</u>	<u>Flesch Score</u>
Long Term Care Rider	LTCR02	50.3
Residual Death Benefit Endorsement	RDB01	51.1
Long Term Care Rider Outline of Coverage	LTCR02 OC	52.7
Supplemental Application	LTC 0312T	52.4

It is hereby certified that each form listed above meets the minimum reading ease score required by the state in its standards for Long Term Care forms. Each form also complies with rules and regulations as to size of print, format and arrangement.



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Cheryl Bock  
Assistant Vice President

April 20, 2012  
Date

# Explanation of Variables

## Long Term Care Rider and related forms

### Long Term Care Rider LTCR02

Page 1 - The company's Home Office address, Administrative Office address and phone number are shown as variable as they may change in the future.

Page 1 - The phone number at the bottom of the page will be modified to reflect the appropriate state insurance department's contact information.

Page 13 - The officers executing the rider may change which may result in a change of title and corresponding change in signature.

### Residual Death Benefit Endorsement RDB01

The company's Home Office address, Administrative Office address and phone number are shown as variable as they may change in the future.

The officers executing the endorsement may change which may result in a change of title and corresponding change in signature.

### Outline of Coverage LTCR02 OC

The company's Home Office address, Administrative Office address and phone number are shown as variable as they may change in the future.

### Supplemental Application LTC0312T

The company's Home Office address and Administrative Office address are shown as variable as they may change in the future.

### Long Term Care Rider - data page

Insured: This will be personalized with the name of the individual covered by the rider.

Issue Age: The age of the individual covered by the rider. Age range is 16-80.

LTC Class of Risk: This rider will be made available to persons in the following risk classes: Standard Smoker, Standard Non-Smoker, Preferred Non-Smoker, Rated Smoker and Rated Non-Smoker. The LTC Class of Risk may differ from the class of risk of the underlying policy.

Rider Date: Since the rider is only made available to new issues, the rider date will always be the same as the policy date of the underlying policy.

LTC Specified Amount: An amount equal to the face amount of the underlying policy. Face amounts and the corresponding LTC Specified Amount range from \$25,000 through \$1,000,000.

Rider Monthly Deduction Rates: MDs will vary based on issue age, sex, risk class of the insured.

Page number: The page number on the LTC Rider data page will depend on the number additional pages required based on other benefits included in the underlying policy.

**TRANSAMERICA LIFE INSURANCE COMPANY**

**STATEMENT OF VARIABILITY CERTIFICATION**

**Rider Form: LTCR02**

We certify that, if we make any changes in the variable information contained in the rider or its corresponding schedule pages, we will submit:

1. A revised Statement of Variability in accordance with Variability of Information requirements; and
2. Revised policy schedule pages.



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Cheryl Bock  
Assistant Vice President

April 20, 2012  
Date

POLICY DATA (CONTINUED)

THE CHARGE FOR ANY ADDITIONAL BENEFITS WHICH ARE PROVIDED BY RIDER IS SHOWN BELOW. ONLY A BRIEF DESCRIPTION IS GIVEN.

THE COMPLETE PROVISIONS ARE INCLUDED IN THE RIDER.

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 RIDER NUMBER    ADDITIONAL BENEFIT  
 LTCR02            LONG TERM CARE (LTC) RIDER  
                       INSURED: [JOHN TRANSAMERICA]  
                       ISSUE AGE: [35]  
                       LTC CLASS OF RISK: [STANDARD NON-SMOKER]  
                       RIDER DATE: [JULY 1, 2012]  
                       LTC SPECIFIED AMOUNT: [\$25,000]

TABLE OF GUARANTEED MONTHLY DEDUCTION RATES PER \$1,000 OF  
 LTC SPECIFIED AMOUNT

POLICY YEAR	RIDER MONTHLY DEDUCTION RATE	POLICY YEAR	RIDER MONTHLY DEDUCTION RATE	POLICY YEAR	RIDER MONTHLY DEDUCTION RATE
1	[0.214166666	30	0.214166666	59	0.214166666
2	0.214166666	31	0.214166666	60	0.214166666
3	0.214166666	32	0.214166666	61	0.214166666
4	0.214166666	33	0.214166666	62	0.214166666
5	0.214166666	34	0.214166666	63	0.214166666
6	0.214166666	35	0.214166666	64	0.214166666
7	0.214166666	36	0.214166666	65	0.214166666
8	0.214166666	37	0.214166666	66	0.214166666
9	0.214166666	38	0.214166666	67	0.214166666
10	0.214166666	39	0.214166666	68	0.214166666
11	0.214166666	40	0.214166666	69	0.214166666
12	0.214166666	41	0.214166666	70	0.214166666
13	0.214166666	42	0.214166666	71	0.214166666
14	0.214166666	43	0.214166666	72	0.214166666
15	0.214166666	44	0.214166666	73	0.214166666
16	0.214166666	45	0.214166666	74	0.214166666
17	0.214166666	46	0.214166666	75	0.214166666
18	0.214166666	47	0.214166666	76	0.214166666
19	0.214166666	48	0.214166666	77	0.000000000
20	0.214166666	49	0.214166666	78	0.000000000
21	0.214166666	50	0.214166666	79	0.000000000
22	0.214166666	51	0.214166666	80	0.000000000
23	0.214166666	52	0.214166666	81	0.000000000
24	0.214166666	53	0.214166666	82	0.000000000
25	0.214166666	54	0.214166666	83	0.000000000
26	0.214166666	55	0.214166666	84	0.000000000
27	0.214166666	56	0.214166666	85	0.000000000
28	0.214166666	57	0.214166666	86	0.000000000]
29	0.214166666	58	0.214166666		

FOR ALL POLICY YEARS AFTER THOSE SHOWN, THE RIDER MONTHLY DEDUCTION RATE IS  
 0.000000000.

December 18, 2012

Ms. Donna Lambert  
Arkansas Department of Insurance

RE: Transamerica Life Insurance Company  
AEGB-128311144  
Long Term Care Rider LTCR02, et al

Dear Ms. Lambert,

We requested the re-opening of this rider filing so that we will be able to attach the approved rider to a universal life policy recently approved by your Department.

<u>POLICY FORM NUMBER</u>	<u>SERFF TRACKING NUMBER</u>	<u>APPROVAL DATE</u>
UL07 AR	AEGB-128711590	10/24/2012

Please let me know when the previously approved rider can be available for this policy. If you have any questions or need any additional information regarding this request, feel free to contact me at (213) 741-7101 or via e-mail at paula.sachs@transamerica.com. Thank you in advance for your time and attention.



Paula Sachs, HIA, ALHC, FLMI, ACS  
Contract Development