

SERFF Tracking Number: AEGG-128262168 State: Arkansas
Filing Company: Transamerica Life Insurance Company State Tracking Number:
Company Tracking Number:
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
Product Name: Blanket Disability Income
Project Name/Number: Blanket Disability Income/CPBDI100

Filing at a Glance

Company: Transamerica Life Insurance Company

Product Name: Blanket Disability Income SERFF Tr Num: AEGG-128262168 State: Arkansas

TOI: H11G Group Health - Disability Income SERFF Status: Closed-Approved- State Tr Num:
Closed

Sub-TOI: H11G.002 Short Term Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Author: Patsy Napier

Reviewer(s): Rosalind Minor

Date Submitted: 04/16/2012

Disposition Date: 04/17/2012

Disposition Status: Approved-
Closed

Implementation Date Requested: 06/15/2012

Implementation Date:

State Filing Description:

General Information

Project Name: Blanket Disability Income

Status of Filing in Domicile: Authorized

Project Number: CPBDI100

Date Approved in Domicile: 04/09/2012

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Group Market Type: Employer, Blanket

Overall Rate Impact:

Filing Status Changed: 04/17/2012

State Status Changed: 04/17/2012

Deemer Date:

Created By: Patsy Napier

Submitted By: Patsy Napier

Corresponding Filing Tracking Number: CPBDI100

Filing Description:

RE: TRANSAMERICA LIFE INSURANCE COMPANY

NAIC: 468-86231 FEIN: 39-0989781

NEW BLANKET HEALTH DISABILITY FILING

CPBDI1AR – Blanket Master Policy for Short Term Disability Income Insurance

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

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company or industry standards.

CPBDI1AR is a Blanket Short Term Disability Income Policy that will be available for issue to employers and labor unions as permitted under the laws of your state. These forms will be marketed to individual employees/members in a Worksite Marketing solicitation. This policy will provide self-administered, guaranteed-issue, Basic Disability coverage. The employees or members will not be required to complete an application. One hundred percent of the premiums will be paid by the policyholder. Basic Disability coverage is provided for losses occurring as the result of off-the-job injuries and/or sicknesses. The policy also provides benefits for partial disability, limited mental illness, and waiver of premium.

In addition to Basic Disability coverage, all eligible employees or members will have the opportunity to purchase Supplemental Disability coverage. If an Insured elects the Supplemental Disability Income Coverage, he or she will be requested to contribute toward cost of the coverage. Premiums for supplemental coverage will be paid to the policyholder by the employee or member on a pre-tax basis. All premiums will be remitted to us monthly by the policyholder.

We wish to extend the use of the Evidence of Insurability form, C-EI-01-00 approved on March 19, 2010 (SERFF Tracking Number AEGG-126537726) to this disability income insurance.

The Group Policyholder Application to be used in the solicitation of this policy is form C-PH-01-00, approved July 22, 2010, SERFF Tracking Number July 22, 2010. We wish to extend the use of the application to the policy form in this filing.

Please see the attached Explanation of Variables for the ranges of values we will use for text contained in brackets. Minor modifications in paper size, stock, ink, border, Company logo, signatures, and column formatting to accommodate system needs or internet format may occur.

To the best of our knowledge, this filing is complete and intended to comply with the insurance laws of your state. If you have any questions, please do not hesitate to contact me.

Sincerely,

Patsy J. Napier FLMI, AIRC, HIA, CCP
Senior Product Manager, Contract Compliance
Product Implementation Department
Transamerica Life Insurance Company
Telephone: 800-400-3042 x1271664

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Email: patsy.napier@transamerica.com

State Narrative:

Company and Contact

Filing Contact Information

Patsy Napier, Senior Contract Analyst pnapier@aegonusa.com
 PO Box 8063 501-227-1664 [Phone]
 Little Rock, AR 72203-8063 501-227-1097 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: AR filing fee - 1 form @ \$50.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Transamerica Life Insurance Company	\$50.00	04/16/2012	58008279

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/17/2012	04/17/2012

SERFF Tracking Number: *AEGG-128262168* *State:* *Arkansas*
Filing Company: *Transamerica Life Insurance Company* *State Tracking Number:*
Company Tracking Number:
TOI: *H11G Group Health - Disability Income* *Sub-TOI:* *H11G.002 Short Term*
Product Name: *Blanket Disability Income*
Project Name/Number: *Blanket Disability Income/CPBDI100*

Disposition

Disposition Date: 04/17/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum	Approved-Closed	No
Form	Blanket Master Policy for Short Term Disability Income Insurance	Approved-Closed	Yes

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Form Schedule

Lead Form Number: CPBDI100

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/17/2012	CPBDI1AR	Policy/Cont ract/Fratern al	Blanket Master Policy for Short Term Disability Income Certificate Insurance	Initial		52.370	CPBDI1AR - Blanket DI Policy 4-12- 2012.pdf

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: [4333 Edgewood Road NE, Cedar Rapids, IA 52499]
A Stock Company

Policyholder: [ABC Eligible Group]
Policyholder Address: [123 Any Street
Any City]
Policy Number: [0123456789]
Effective Date: [October 1, 2010]
Anniversary Date: [October 1]
Governing Jurisdiction: [Any State]

Transamerica Life Insurance Company ("the Company," "we," "us," and "our") agrees to pay the benefits described in this Policy, subject to all terms, conditions, and limitations. This Policy provides Basic Short Term Disability Income Insurance on the lives of all Eligible Persons of the Policyholder, in consideration of the statements made in the Policyholder Application and the payment of premiums.

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

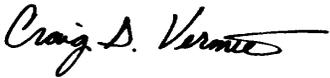
1. To be bound by the terms of this Policy; and
2. To pay all premiums to us according to the terms of this Policy.

This Policy is subject to the laws of the governing jurisdiction in which it is issued. This is not a policy of Workers' Compensation insurance.

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

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

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

[]

[General Counsel and Secretary]

[]

[President]

Blanket Master Policy
for Short Term Disability Income Insurance
Coverage for Off-the-Job Accidental Injuries and Sickness
Annually Renewable
Nonparticipating - No Annual Dividends

Administrative Office:
[1400 Centerview Drive, PO Box 8063
Little Rock, AR 72203-8063]

For Customer Service: [1-888-763-7474]

**MASTER POLICY
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INSURANCE SCHEDULE

This Insurance Schedule becomes effective on [October 1, 2010] and replaces any previous Insurance Schedule.

BENEFITS

Class: [1]	Description: [All Benefit-Eligible Employees]
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Basic Disability Coverage

Basic Benefit: [\$1,000 per month] [not to exceed [60%] of Monthly Compensation] [Monthly] Cost per [\$1,000]: \$[32.59]
Maximum Disability Period: [12 months]
Maximum Mental Illness Disability Period: [6 months] per period of disability with a lifetime maximum of 12 months of disability payments.
Accident Elimination Period: [14] days
Sickness Elimination Period: [14] days
Minimum Disability Benefit: [\$100]

[Supplemental Disability Coverage

[Supplemental Benefit: \$200 to \$600 per month in increments of \$200. [Monthly Cost per \$200: \$10.17]
The Basic and Supplemental Benefit total cannot exceed [60%] of Monthly Compensation.
Supplemental Disability Coverage must be paid for with pre-tax dollars.]]

Evidence of Insurability

Basic Disability Coverage does not require Evidence of Insurability.
[Supplemental Disability Coverage requires Evidence of Insurability if electing more than \$600 per month.]

Rate Guarantee

Rates are conditionally guaranteed for [2] Policy Years. Rates are subject to change if you request benefit changes.
Rates are also subject to change if the total number of Insureds changes by more than [10]%.]

Minimum Participation

[We require 100% of all Eligible Persons to be covered under the Basic Disability Coverage of this Policy.]

POLICYHOLDER RESPONSIBILITIES

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

1. Accurately record and maintain information for each Eligible Person concerning eligibility, name, salary and any changes thereto, benefit elections, amount of coverage, Age, Effective Date, termination dates, contributions, class, and any completed Evidence of Insurability Forms. For two years after this Policy terminates, you must allow us the opportunity to examine these records at any reasonable time during normal business hours.
2. Provide us with any information we need to process claims.
3. Remit premium payments each month along with a worksheet detailing your premium calculations.
4. Provide us with any completed Evidence of Insurability Forms prior to the Anniversary Dates so that we can underwrite to determine benefit eligibility when applicable.
5. Cooperate fully with us in preparing and/or delivering certificates and any disclosures or notices regarding this insurance to all Insureds under this Policy.

Inspection of Policy - You must make this Policy available for inspection by your Insureds at all reasonable times during normal business hours.

PREMIUMS, POLICY CHANGES, TERMINATION, AND REINSTATEMENT

Premiums – The premiums due will be the sum of the premiums due for all Insureds under this Policy. Premiums are due and payable to us by you on each premium due date. The first premium due date is this Policy's Effective Date. Subsequent premiums are due monthly.

Who May Change This Policy - The terms of this Policy, including premium rates, may be changed at any time by written agreement between you and us. The insurance provided by this Policy may be changed or canceled without the consent of any Insured and without prior notice to any Insured. Only our President, Vice President, Secretary, or an Assistant Secretary may make changes to this Policy and then only in writing. No agent or Policyholder has authority to change this Policy or to waive any of its provisions. All changes are subject to the laws of the governing jurisdiction.

When Policy Changes are Effective - Unless otherwise agreed upon in writing, the Effective Date of any change in benefits or premiums will be the Anniversary Date.

When This Policy Ends – This Policy will terminate on the earliest of the following events:

1. If any premium payable is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period;
2. If you submit a 60-day advance written request to us to terminate this Policy, this Policy will terminate on the date specified in such request;
3. If we give you a 60-day advance written notice that we intend to terminate this Policy, this Policy will terminate on the date specified in such notice;
4. If you fail to comply with any terms of this Policy, or fail to fulfill any obligations under or pertaining to this insurance, or fail to comply with or cooperate with us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this Policy will terminate on the 32nd day after we have given you written notice of our intent to terminate.

Termination of this Policy is without prejudice to claims that occur or commence prior to the date of termination.

Grace Period – You have a Grace Period of 31 days from each premium due date, except the first, in which to pay the premium then due. Coverage will continue during the Grace Period. You are liable for the premium during the Grace Period.

When Policy May Be Reinstated – At our sole discretion, we may reinstate this Policy which has terminated if you request us to do so.

DEFINITIONS

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

Accident or Accidental Injury - The sudden, unexpected, and unintended injury:

1. That is independent of any Sickness;
2. Over which the Insured has no control;
3. That results in a Total Disability that begins while the Insured's coverage is in force; and
4. The injury begins within 90 days of the Accident.

Active Service - To be considered in Active Service, the Eligible Person must be:

1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. Performing these duties at one of the places of business where he or she normally works or at some location directed by the employer.

The Eligible Person is considered to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day. The Eligible Person must also have been in Active Service on the last preceding regular work day.

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

Anniversary Date - The month and date of each Policy Year that is the same month and date as the Effective Date. When any date is referred to, the Effective Date will be at 12:01 AM at your address.

Application - The form completed and signed by you to apply for this Short Term Disability Income Insurance coverage.

Basic Disability Coverage - The disability coverage paid for by you and provided to the Insured at no cost.

Disability Benefits - The Basic Benefit shown on the Insurance Schedule plus the Supplemental Benefit selected by the Insured, if any, that is paid for periods of Total Disability as described in this Policy.

Effective Date - The date when coverage is in force.

Eligible Person - An employee or member that meets all of the eligibility requirements for becoming insured for Basic Disability Coverage.

Elimination Period - The number of days that must elapse before benefits become payable. The Insured must be continuously disabled during the Elimination Period. During an Elimination Period, benefits are not payable and do not accrue.

Family or Medical Leave of Absence - A leave of absence which is approved in writing by you or the Insured's employer, if not you, and which is subject to:

1. The federal Family and Medical Leave Act of 1993 (FMLA), and any amendments to it; or
2. Any similar state law requiring you or the Insured's employer, if not you, to grant family or medical leave.

Immediate Family Member - The Insured, the Insured's spouse, or the child, mother, father, brother, sister, or other close family member of the Insured or his or her spouse.

Insured - The Eligible Person covered under this Policy.

Monthly Compensation – means

1. One-twelfth (1/12) of the Insured's gross annual salary; or
2. One-twenty-fourth (1/24) of the preceding 24 months' salary if the Insured's salary is solely or partially based on commissioned sales, bonus or overtime earnings.

Partial Disability - The Insured must be able to perform one or more, but not all, of the material and substantial duties of his or her occupation on a full-time or part-time basis; or must be able to perform some or all of the duties of another occupation on a full-time or part-time basis.

Physician - A licensed practitioner of the healing arts who:

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

Policy - This document that describes the disability insurance coverage for your Insureds.

Policy Year - The 12-month period that starts from the Effective Date constitutes the first Policy Year. A new Policy Year begins on each Anniversary Date.

Policyholder, you, your, or yours - The entity named on this Policy's Cover Page.

Pre-existing Condition - A Sickness or physical condition for which the Insured:

1. Had treatment;
 2. Incurred expense;
 3. Took medication; or
 4. Received a diagnosis or advice from a Physician,
- during the 12-month period immediately before the Effective Date of the Insured's coverage.

The term "Pre-existing Condition" will also include a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment.

Regular Care and Attendance - The Insured is under the care of a Physician at least once a month or until the Physician determines that the Insured:

1. Has reached a state where continuous medical care is unnecessary; and
2. Is still Totally Disabled.

Sickness - Illness or disease which results in a Total Disability that begins while the Insured's coverage is in force and is the direct cause of the loss. Pregnancy will be covered as any other Sickness, subject to the Pre-existing Condition Limitation.

Supplemental Disability Coverage - The optional disability coverage which allows an Insured to increase his or her Disability Benefits. The Insured must contribute toward the cost of this coverage.

Total Disability or Totally Disabled - During the first 12 months that benefits are payable means the Insured is:

1. Unable to perform the material and substantial duties of his or her occupation;
2. Not engaged in any other occupation; and
3. Under the Regular Care and Attendance of a Physician for the covered Accident or Sickness causing such Total Disability.

After the first 12 months of disability, if applicable, Total Disability means the Insured is:

1. Unable to perform the material and substantial duties of any occupation for which he or she is reasonably qualified by education, training, or experience;
2. Not engaged in any other occupation; and
3. Under the Regular Care and Attendance of a Physician for the covered Accident or Sickness causing such Total Disability.

Transamerica Life Insurance Company, the Company, we, us, or our – The Insurer that underwrites this Short Term Disability Income Insurance coverage and pays the benefits upon a claim.

ELIGIBILITY REQUIREMENTS

To become an Insured under this Policy an Eligible Person:

1. Must be in Active Service on the day his or her coverage becomes effective;
2. Must meet the eligibility requirements listed on the Application; and
3. Must be a member of an eligible class as listed on the Insurance Schedule of this Policy.

INITIAL ENROLLMENT AND EFFECTIVE DATE

Basic Disability Coverage – An Eligible Person can enroll for Basic Disability Coverage when he or she first becomes an Eligible Person. The Eligible Person is not required to contribute toward the cost of Basic Disability Coverage. Coverage will become effective the first day of the month following the date he or she enrolls. If the Eligible Person is not in Active Service on the day coverage is scheduled to become effective, his or her coverage will become effective on the date he or she returns to Active Service.

Supplemental Disability Coverage – If available, an Eligible Person may elect Supplemental Disability Coverage within 31 days of becoming an Eligible Person and authorize the payment of contributions due for the amount of additional coverage elected. If the Insured fails to make an election within the 31-day period, he or she will not be permitted to enroll until the next Anniversary Date.

Coverage will become effective the first day of the month following the date he or she elects coverage. If the Eligible Person is not in Active Service on the day coverage is scheduled to become effective, coverage will become effective on the date he or she returns to Active Service.

Evidence of Insurability – Evidence of Insurability requirements are shown on the Insurance Schedule. If required, a completed Evidence of Insurability Form must be received prior to the Anniversary Date and approved by us before the associated coverage will become effective.

COVERAGE CHANGES

Annual Benefit Elections – Benefits are elected on an annual basis and will remain in effect for the Policy Year, subject to the terms of this Policy. Changes in benefit elections are not allowed during the Policy Year.

Coverage Options Subject to Change - Basic and Supplemental Disability Coverage options are subject to change on any Anniversary Date, as agreed upon between you and us.

Supplemental Disability Coverage Changes - An Insured may increase or decrease Supplemental Disability Coverage elections each Anniversary Date. Such changes will become effective on the Anniversary Date. If the Insured is not in Active Service on the Anniversary Date, any new or additional amounts will not take effect until he or she returns to Active Service.

DISABILITY BENEFITS

Disability Benefits will be paid if the Insured becomes Totally Disabled. Total Disability must:

1. Be due to a covered Accident or Sickness; and
2. Begin while the Insured's coverage is in force.

We will pay benefits for each period of Total Disability that continues beyond the Elimination Period. We will not pay benefits beyond the Maximum Disability Period stated on the Insurance Schedule.

If any monthly benefit is to be paid for less than a full month, the amount of benefit will be reduced pro-rata on the basis that one day's benefit equals one-thirtieth (1/30th) the Disability Benefit.

We will pay the Disability Benefit only for a period in which the Insured is under the Regular Care and Attendance of a Physician.

Disability Benefits will be paid for only one disability when:

1. More than one disability exists at the same time; or
2. A disability results from two or more causes.

Total Disability will be deemed to have commenced on the date the Insured first receives treatment from a Physician following continuous cessation of work.

Geographical Limitations - If an Insured becomes disabled outside the United States or its territories, Disability Benefit payments will be limited to two months. To continue to receive any additional benefit payments, the Insured must reside in the United States or its territories.

Family or Medical Leave of Absence - If the Insured is not in Active Service due to an approved FMLA leave, then this insurance may be continued, until the earliest of:

1. The end of the leave period required by federal or state law;
2. The date the Insured notifies you or his or her employer that he or she will not return; or

3. The date the Insured begins employment with another employer; provided we receive the required premium from you for the Insured's coverage. An approved leave of absence does not include layoff or termination of employment.

If the Insured goes on a leave of absence which is not subject to FMLA or any similar state law, the Insured's insurance may be continued until the end of the calendar month in which the leave began, provided we receive the required premium from you for the Insured's coverage for that month.

Subsequent Disabilities - Separate periods of disability resulting from unrelated conditions are considered a continuation of the previous disability, not a new disability, unless they are separated by at least seven calendar days, during which time the Insured returned to work.

Successive Disabilities - Those disabilities which result from the same or related causes for which benefits are payable under this Policy. Successive Disabilities will be considered one period of disability, unless the disabilities are separated by the Insured's return to:

1. Active Service; or
2. Any other occupation

for at least 90 consecutive days.

Any disability which begins after termination of coverage:

1. Will not be considered a Successive Disability; and
2. Will not be covered under this Policy.

PARTIAL DISABILITY BENEFIT

A Partial Disability Benefit will be paid if an Insured becomes Partially Disabled due to a covered Accident or Sickness. Payment of the Partial Disability Benefit is subject to the following conditions:

1. The Elimination Period for Total Disability must be satisfied.
2. Partial Disability Benefits will be payable beginning the first day following cessation of Total Disability.
3. The Partial Disability must be the result of the same Accident or Sickness which caused Total Disability.
4. The Partial Disability Benefit will be payable for a maximum period of six consecutive months. However, the combined period of time for which benefits are payable for Total Disability and Partial Disability may not exceed the Maximum Disability Period stated on the Insurance Schedule.
5. The Partial Disability Benefit will be equal to 50% of the Disability Benefit. However, the sum of the Partial Disability Benefit, the salary earned while receiving Partial Disability Benefits, and income from all other sources may not exceed 100% of the Insured's pre-disability Monthly Compensation. In this event, the Minimum Disability Benefit, if any, stated on the Insurance Schedule will not be payable.

MENTAL ILLNESS LIMITED BENEFIT

If an Insured is Totally Disabled due to a Mental Illness, regardless of the cause, Disability Benefits will be paid for the period up to the Maximum Mental Illness Disability Period shown on the Insurance Schedule provided:

1. The Insured is under the Regular Care and Attendance of a Physician; and
2. For the first 12 months after the date the Insured completes his or her Elimination Period, the Insured receives medical treatment (mental or medical examination alone not being considered treatment) from either:
 - a. A registered specialist in psychiatry;
 - b. A Physician administering treatment on the advice of a registered specialist in psychiatry who certifies that such treatment is medically necessary; or
 - c. A Physician, if in our opinion, a specialist in psychiatry is not required to certify that such treatment is medically necessary.

Mental Illness means a psychiatric or psychological condition such as:

1. Schizophrenia;
2. Depression;
3. Manic depressive or bipolar illness;
4. Anxiety;
5. Personality disorders;
6. Alcohol addiction;
7. Drug addiction; and/or
8. Adjustment disorders or other conditions, usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar modalities used in the treatment of the above conditions.

The term Mental Illness does not apply to dementia, if due to:

1. Stroke;
2. Trauma;
3. Viral infection;
4. Alzheimer's disease; or
5. Other such conditions not listed above which are not usually treated by a mental health provider using psychotherapy, psychotropic drugs, or other similar modalities.

WAIVER OF PREMIUM

If the Insured becomes Totally Disabled due to a covered Accident or Sickness, the Insured's coverage will be continued without payment of premium. Waiver of Premium will begin the next premium due date following the Insured's satisfaction of the Elimination Period or 90 days of continuous Total Disability, whichever is later. Premium must be paid from the beginning of Total Disability to the date Waiver of Premium begins.

Waiver of Premium will continue until the earliest of the:

1. End of the Insured's Total Disability;
2. End of the Maximum Benefit Period;
3. End of the period for which benefits would otherwise be payable;
4. Date this Policy terminates; or
5. Date the Insured's employment or relationship with you terminates as determined by you.

LIMITATIONS AND ADJUSTMENTS

The sum of the Disability Benefits paid to the Insured and the payments the Insured is entitled to receive from the sources described below, may not exceed the percentage of Monthly Compensation shown on the Insurance Schedule:

1. Group or individual insurance coverage or like coverage for persons in a group;
2. Federal Social Security Act (this includes benefits paid to the Insured and the Insured's dependents on account of the Insured's disability);
3. State or federal government disability or retirement plan or increases thereof which begin on or after the date of Total Disability;
4. Pension plan to which you or the Insured's employer contributes or makes payroll deductions;
5. Salary or wage continuance plans such as sick leave paid for by you or the Insured's employer which extend beyond the period stated in the Insurance Schedule;
6. Federal Old Age Benefits, or increases which begin on or after the date of Total Disability, under the Federal Social Security Act on the Insured's own behalf; and
7. Workers' Compensation or similar law.

With respect to items (2) and (6) only, unless the Insured shows proof to us that payments under these applicable programs or acts have been applied for but will not be paid, we:

1. Will assume each Insured who is covered under the Federal Social Security Act is receiving such payments; and
2. May require the Insured to reapply (but not more frequently than annually) once a Social Security denial has been received and all appeals have been pursued. Failure to reapply for benefits when required by us will result in our estimation of payment under those acts.

Benefits will not be reduced due to a cost of living increase in Social Security if the increase takes place while benefits are payable.

With respect to any and all of the above sources, if a lump sum payment is received by the Insured or his or her dependents for a period previously paid by us, any resulting overpayment by the Company will be due to us on a lump sum basis. If the Insured has the option of taking retirement benefits on a monthly basis but chooses to receive retirement benefits on a lump sum basis, we may assume he or she is receiving retirement benefits based upon the lowest monthly retirement plan benefit available to him or her prior to lump sum withdrawal.

After application or reapplication has been made for the above applicable income sources, in lieu of our estimating other income, the Insured may complete a reimbursement agreement provided by us. The agreement will allow us to provide benefits without estimation of other income and require the Insured to reimburse us for any overpayment as the result of retroactive awards.

The Disability Benefits payable will never be less than the Minimum Disability Benefit amount shown on the Insurance Schedule.

PRE-EXISTING CONDITION LIMITATION

There will be no Disability Benefit payable for a Pre-existing Condition until the Insured has been continuously covered under this Policy for 12 months, and has returned to performing the duties of his or her occupation for 30 continuous days after the first 12 months of coverage.

EXCLUSIONS

This Policy does not cover any loss, fatal or non-fatal, which occurs as a result of:

1. An intentionally self-inflicted injury while sane or insane;
2. Any act of war, declared or undeclared;
3. The Insured's commission of a felony;
4. The Insured operating, learning to operate or having any duty in the operation of any device or vehicle intended or designed for flight in the air including boarding, alighting or descending therefrom;
5. Accident or Sickness arising out of and in the course of any occupation, either full-time or part-time, for wage or profit. This exclusion applies even if Workers' Compensation is not paid for the on-the-job injury; or
6. An Accident sustained or Sickness contracted while in the service of the armed forces of any country.

TERMINATION OF COVERAGE

The Insured's coverage will end at 12:01 AM on the earliest of the following:

1. The date the Insured is no longer eligible for coverage;
2. The date the Insured retires;
3. The date the Insured ceases to be in Active Service;
4. The end of the last period for which premium has been paid, subject to the Grace Period;
5. The date this Policy is terminated.

Termination of this Policy or termination of the Insured's coverage will have no effect on the payment of benefits which begins before this Policy is terminated or before the Insured's coverage terminates. You are responsible for continuing to pay the premiums for the Insured until the notice of termination is received by us.

CLAIMS

Claim Forms - Claim forms should be used for filing proof of loss. The Policyholder will send such form to the claimant within 15 days of receipt of notice of claim. If the Policyholder fails to supply the proper claim forms within 15 days, the Insured can give written proof, setting forth the nature and extent of the loss, within the time stated in the Proof of Loss provision.

Claims Procedure - Due proof of the Insured's loss must be submitted to us at our Administrative Office. Claim forms may be obtained from the Policyholder.

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

Payment of Benefits - All benefits will be paid to the Insured. Accrued benefits that are not paid at the Insured's death will be paid to his or her beneficiary or estate. If a benefit is to be paid to the Insured's estate, or to an Insured who is not competent to give a valid release, we may pay up to \$500 of such benefit to one of the Insured's relatives who is deemed by us to be justly entitled to it. Such payment, made in good faith, fully discharges us to the extent of the payment.

Physical Examination - We have the right to have the Insured examined by a Physician of our choosing as often as is reasonably necessary while a claim is pending. We will pay for such examination.

Proof of Loss - Proof of loss must be given to us at our Administrative Office within 90 days after the loss. If it is not reasonably possible to give proof within that time, late proof may be accepted if given within one year from the date of loss. This one year limit will not apply in the absence of legal capacity.

Reimbursement of Overpayment - The benefits payable under this Policy will be adjusted by other sources of income listed in the Limitations and Adjustments section. If any income from a source stated in the Limitations and Adjustments section is received or granted retroactively, the Insured will be responsible for reimbursing us for any

resulting overpayment. Reimbursement will be only to the extent of the overpayment involved. Such reimbursement will be required in one lump sum payment at the time the Insured received the award.

Time of Payment of Claims - All accrued benefits for loss for which this Policy provides periodic payment will be paid each month, subject to written proof of loss. Any balance not paid when liability ends will be paid immediately upon receipt of written proof. Benefits for any other covered loss will be paid as soon as we receive written proof of such loss.

GENERAL PROVISIONS

Adjustments in the Event of Clerical Error - Clerical error will not void insurance otherwise validly in force, nor will it continue or make insurance valid that otherwise would cease or would never have been issued.

Change in Job Classification - On the date that Total Disability starts, if the Insured's job classification is different than the one used to determine premium, we will pay proportionately reduced benefits or refund excess premiums based on the rates then in effect for the correct classification, provided you have chosen to insure such job classification.

Conformity With State Statutes - Any provision of this Policy which is in conflict with the statutes of the governing jurisdiction is hereby amended to conform to the minimum requirements of such statutes.

Entire Contract - The Entire Contract consists of this Policy, any attached Amendments, Endorsements, or Riders, and your Application.

Legal Action - No legal action may be brought to recover under this Policy:

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

Misstatement of Age - If the Insured's age has been misstated, the Insured's true age will be used to determine all amounts to be paid for loss incurred by the Insured.

Money Payable - All sums payable by or to us will be paid in the lawful currency of the United States of America.

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

Policyholder is an Agent of the Insured - For all purposes related to the insurance issued under this Policy, you act as an agent of the Insured. You do not, therefore, act as our agent for any purposes related to insurance issued under this Policy.

Right to Contest - We will not use any statement, except fraudulent statements, to void or reduce benefits under this Policy after it has been in force for two years from the Effective Date. Any such statements would have to be in a signed form. All statements made are considered representations and not warranties. No such statement will be used in any contest, unless a copy of such statement has been furnished to you.

Time Effective - For any dates used in this Policy, the effective time will be 12:01 AM at your address.

When Notice is Given - Any notice to be given will be sent to the Insured at his or her last known address.

SERFF Tracking Number: AEGG-128262168 State: Arkansas
 Filing Company: Transamerica Life Insurance Company State Tracking Number:
 Company Tracking Number:
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.002 Short Term
 Product Name: Blanket Disability Income
 Project Name/Number: Blanket Disability Income/CPBDI100

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	04/17/2012
Comments:		
Attachment: DI Readability Certification or any st variation - Blanket 3-27-2012.pdf		

	Item Status:	Status Date:
Satisfied - Item: Application	Approved-Closed	04/17/2012
Comments: Group App - July 22, 2010, SERFF Tracking Number AEGG-126732538 Evidence of Insurability Form - March 19, 2010 (SERFF Tracking Number AEGG-126537726)		
Attachments: C-PH-01-00-jd-071510-FINAL.pdf C-EI-01-00-022210.pdf		

	Item Status:	Status Date:
Satisfied - Item: Explanation of Variability	Approved-Closed	04/17/2012
Comments:		
Attachment: Explanation of Variables without Cert 4-3-2012.pdf		

	Item Status:	Status Date:
Satisfied - Item: Actuarial Memorandum	Approved-Closed	04/17/2012
Comments:		
Attachment: TransDI Blanket policy form_Act Memo-generic March 2012.pdf		

Readability Certification

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

A. Option Selected

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

Forms and Form Numbers to Which Certification is Applicable:

See attached list

B. Test Option Selected

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

C. Standards for Certification

A checked block indicates standard has been achieved

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

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

	Assistant Vice President
Signature	Officer's Title
Officer's name: Douglas Simino	Date: March 27, 2012



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

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

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

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

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

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

- Eligibility for insurance:

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

Billing Information

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

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

District of Columbia and Louisiana

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

Florida

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.]

Kansas

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.]

Kentucky

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

North Carolina and Oregon

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.]

New Jersey

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

Oklahoma

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

Puerto Rico

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

Tennessee

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

Virginia

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

Vermont

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.]

All other states

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

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

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

Signature of Officer

Email Address

Print Name and Title of Officer

Signature of Licensed Agent

Email Address

Print Name of Licensed Agent

Agent Number

Insurance Selections

(Product and Rider availability subject to state approval)

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

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

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



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

Evidence of
 Insurability
 Form

Group Name		Group Number		Location	
Employee/Member Name (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	Effective Date
Home address		City		State	Zip code

Full Name of Covered Person(s) Requiring Underwriting Approval	Relationship to Employee/Member	Date of Birth	Height	Weight	Occupation

1. Is any Covered Person listed above currently disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Has any Covered Person listed above had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past ten years, has any Covered Person listed above been treated for, been diagnosed as having, or had any indication, sign or symptom of having any heart, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, reproductive, rheumatoid or neurological disorders, high blood pressure, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Has any Covered Person listed above been recommended for any medical treatment that has not yet been completed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Has any Covered Person listed above ever been recommended for an organ transplant, including bone marrow?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has any Covered Person listed above undergone a biopsy or other diagnostic test within the last 30 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide details of all "Yes" answers. Use additional paper if needed.
 For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

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

I represent that all statements and answers made on or attached to this form are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage.
 I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
 I also understand that coverage will become effective only if underwriting is approved by Transamerica Life Insurance Company.
 I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau, or other organization, institution or person, that has any records or knowledge of me or my family's health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information.
 I understand the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. I know that I may request to receive a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. I agree that this Authorization shall be valid for two years from the date shown below.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____ .
 Employee's Signature _____

Administrative Office Use Only: Request has been reviewed by the Administrative Office and is: Approved Declined Date: _____
 Reviewer Name: _____ Reviewer Signature: _____

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, Iowa

BLANKET SHORT TERM DISABILITY INCOME INSURANCE EXPLANATION OF VARIABLES

FOR FORMS: CPBDI100 or any state variation thereof.

Text that is intended to be variable is bracketed. Bracketed text is either intended to be: (1) in or out of the contract; (2) have variable ranges; or (3) be customized (specific sections only) to accommodate Policyholder requirements. Each variable bracketed text is described below. No change in the variable areas will be made which will be in conflict with the laws, rules and regulations of your state. In addition, no change in variability will be made which in any way expands the scope of the wording being changed. Transamerica Life Insurance Company ("Company") reserves the right to correct at any time any and all typographical errors that do not impact benefits or intent of language.

CPBDI100 – Blanket Short Term Disability Income Insurance Master Policy - Variations

Face Page

1. Home Office Address - The address is bracketed for any future address changes.
2. Officers' Signatures – The signatures are bracketed to take into consideration any future personnel changes.
3. Officers' Titles – The titles are bracketed to take into consideration any future changes in the officers' titles who are signing on behalf of the Company.
4. Administrative Office Address – The address is bracketed to take into consideration any future changes.
5. Customer Service Toll Free Number – The toll free number is bracketed to take into consideration any future changes to the telephone number.

Insurance Schedule (Page 3)

The insurance schedule included in this filing is an illustrative example of what information will be contained in the actual insurance schedule provided to the Policyholder. It contains information for a single class of Insureds. This information may be repeated for additional classes of Insureds for which a Policyholder is purchasing coverage. Coverage amounts are determined by the Policyholder. The rates will be determined by using rating information provided to us by the Policyholder.

6. Basic Benefit range is \$300 - \$10,000 per month not to exceed 20% - 80% of salary.
7. [Monthly] Cost per [\$1,000] will vary based on what frequency the Policyholder wishes to make their premium payments (weekly, bi-weekly, semi-monthly, monthly) and how the Basic Benefit is structured (per \$1,000, per \$200, per employee, or other similar statement.)
8. Maximum Disability Period range is 3 – 24 months.
9. Maximum Mental Illness Disability Period range is 1 – 12 months.
10. Accident Elimination Period range is 0 – 180 days.
11. Sickness Elimination Period range is 0 – 180 days.
12. Minimum Disability Benefit range is \$100 - \$300.
13. Supplemental Disability Coverage will either be in or out based on Policyholder selection.
14. Supplemental Benefit range is \$100 - \$10,000 per month in increments of \$100 - \$1,000.
15. Rate Guarantee is for 1 – 3 years.
16. Rates are subject to change if total number of Insureds changes by more than 10% - 50%.
17. Minimum Participation will always be 100% for the Basic Disability Coverage, but language may be added to this section to explain the participation requirement negotiated with the Policyholder on any Supplemental Disability Coverage.