

TRANSAMERICA LIFE INSURANCE COMPANY

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

About Your Insurance – This Certificate explains benefits provided under the Group Master Policy (“Policy”) issued to the Policyholder named on the Schedule of Benefits. The Policy is a legal contract between the Group Policyholder and the Company. **READ YOUR CERTIFICATE CAREFULLY.** Read it closely to become familiar with your coverage.

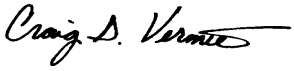
Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions and are capitalized.

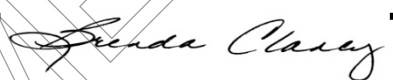
Important Notice – Benefits are payable only as described in this Certificate for a covered loss that occurs while the Covered Person is insured under the Policy.

The Policy may be amended or canceled as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to change.

The benefits for Dependents described in this Certificate, if available under the Policy, are applicable only if you are insured, apply for Dependent coverage, receive our approval of such Dependents, and pay the premium required for each Dependent.

This Certificate is signed for us at our Home Office to take effect on the same date coverage becomes effective.

[]
[General Counsel and Secretary]

[]
[President]

THIS CERTIFICATE IS NOT A MEDICARE SUPPLEMENT CERTIFICATE. If you are eligible for Medicare, review the [Guide to Health Insurance for People with Medicare](#) that is available from us.

IMPORTANT CANCELLATION INFORMATION – PLEASE REFER TO THE “TERMINATION OF INSURANCE” SECTION FOUND ON PAGE 8.

Group Certificate for Critical Illness Indemnity Insurance

**LIMITED BENEFIT – READ YOUR CERTIFICATE CAREFULLY
LUMP SUM BENEFIT FOR SPECIFIED CRITICAL ILLNESSES ONLY**

Administrative Office:
[1400 Centerview Drive, PO Box 8063
Little Rock, AR 72203-8063]
Customer Service: [1-888-763-7474]
E-Mail Address: [TEBcustresp @Transamerica.com]
Web Address: [www.transamericaemployeebenefits.com]

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SPECIMEN

SCHEDULE OF BENEFITS

POLICYHOLDER: [ABC ELIGIBLE GROUP]

POLICY EFFECTIVE DATE: [JANUARY 1, 2013]

INSURED: [JOHN DOE]

CERTIFICATE NUMBER: [123456789ABC]

COVERAGE TYPE: [FAMILY]

TOTAL PREMIUM: [\$52.50]

GOVERNING JURISDICTION: NORTH CAROLINA

AGE AT ISSUE: [35]

EFFECTIVE DATE: [JUNE 1, 2007]

RATE CLASS: [NONTOBACCO]

PREMIUM MODE: [MONTHLY]

[PREMIUMS ARE BASED UPON YOUR ATTAINED AGE AND INCREASE AT AGES 25, 30, 35, 40, 45, 50, 55, 60 AND 65]

CRITICAL ILLNESS	BENEFIT AMOUNT	
	<u>INSURED</u>	<u>DEPENDENT</u>
ALZHEIMER'S DISEASE	[\$300 - \$75,000]	[\$150 - \$75,000]
CORONARY ARTERY DISEASE REQUIRING ANGIOPLASTY/STENT	[\$50 - \$12,500]	[\$25 - \$12,500]
REQUIRING BYPASS GRAFTS	[\$250 - \$62,500]	[\$125 - \$62,500]
END STAGE RENAL FAILURE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
HEART ATTACK	[\$1,000 - \$250,000]	[\$500 - \$250,000]
MAJOR ORGAN FAILURE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
MISCELLANEOUS DISEASES FOR EACH DISEASE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
OTHER SPECIFIED ORGAN FAILURE (LOSS OF SIGHT, SPEECH, OR HEARING)	[\$1,000 - \$250,000]	[\$500 - \$250,000]
STROKE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
 [OPTIONAL BENEFIT RIDERS]		
[CANCER BENEFIT RIDER INVASIVE CANCER	[\$1,000 - \$250,000]	[\$500 - \$250,000]
BONE MARROW FAILURE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
CARCINOMA IN SITU	[\$250 - \$62,500]	[\$125 - \$62,500]
PROSTATE CANCER WITH TNM CLASSIFICATION OF T1	[\$250 - \$62,500]	[\$125 - \$62,500]
SKIN CANCER	[\$50 - \$12,500]	[\$25 - \$12,500]
 [OCCUPATIONAL HIV BENEFIT RIDER (INSURED ONLY-NO DEPENDENT COVERAGE)]		
	[\$1,000 - \$250,000]	
 [WELLNESS INDEMNITY BENEFIT RIDER (PER CALENDAR YEAR BENEFIT)]		
	[\$25 - \$500]	[\$25 - \$500]

BENEFIT AMOUNT

	<u>INSURED</u>	<u>[DEPENDENT]</u>
[RECURRENT CRITICAL ILLNESS BENEFIT RIDER		
ALZHEIMER'S DISEASE	[\$75 - \$75,000]	[\$37.50 - \$75,000]
CORONARY ARTERY DISEASE		
REQUIRING ANGIOPLASTY/STENT	[\$12.50 - \$12,500]	[\$6.25 - \$12,500]
REQUIRING BYPASS GRAFTS	[\$62.50 - \$62,500]	[\$31.25 - \$62,500]
END STAGE RENAL FAILURE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
HEART ATTACK	[\$1,000 - \$250,000]	[\$500 - \$250,000]
MAJOR ORGAN FAILURE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
MISCELLANEOUS DISEASES		
FOR EACH DISEASE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
OTHER SPECIFIED ORGAN FAILURE		
(LOSS OF SIGHT, SPEECH, OR HEARING)	[\$1,000 - \$250,000]	[\$500 - \$250,000]
STROKE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
[INVASIVE CANCER	[\$1,000 - \$250,000]	[\$500 - \$250,000]
BONE MARROW FAILURE	[\$1,000 - \$250,000]	[\$500 - \$250,000]
CARCINOMA IN SITU	[\$62.50 - \$62,500]	[\$31.25 - \$62,500]
PROSTATE CANCER WITH		
TNM CLASSIFICATION OF T1	[\$62.50 - \$62,500]	[\$31.25 - \$62,500]
SKIN CANCER	[\$12.50 - \$12,500]	[\$6.25 - \$12,500]
[OCCUPATIONAL HIV (INSURED ONLY)	[\$1,000 - \$250,000]	

SPECIMEN

DEFINITIONS

Terms important to understanding this Certificate are defined below and are capitalized in this Certificate.

Active Service – Performing in the usual manner all of the regular duties of your occupation on a scheduled work day at the normal place of business or other location as directed by your employer.

You are considered to be in Active Service on a day which is not a scheduled work day only if you would meet the requirements above if it were a scheduled work day and you were in Active Service on the last preceding regular work day.

Active Service does not apply if employment is not an eligibility requirement.

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

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

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

Child – A Child of yours who is under the age of 26 and is:

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

If applicable, Child will also include children of your Other Adult Dependent in the same manner as a stepchild.

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

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

Covered Person – You and your Dependents who have been accepted for coverage.

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

Alzheimer's Disease - A clinically established diagnosis of the disease by a psychiatrist or neurologist, resulting in the inability to perform, independently, 2 or more of the activities of daily living (bathing, dressing, eating, toileting, transferring, or continence).

Coronary Artery Disease Requiring Bypass Grafts – Coronary artery disease requiring a surgical operation to correct narrowing or blockage of one or more coronary arteries with bypass grafts, as confirmed in writing by a board-certified cardiologist. Angiographic evidence to support the necessity for this surgery will be required. For purposes of this benefit, a surgical operation to correct narrowing or blockage does not include the following procedures: balloon angioplasty; laser embolectomy; atherectomy; stent placement; or other non-surgical procedures.

Coronary Artery Disease Requiring Angioplasty/Stent – Coronary artery disease requiring a balloon angioplasty or other forms of catheter-based percutaneous transluminal coronary artery therapy to correct the narrowing or blockage of one or more coronary arteries, as confirmed in writing by a board-certified cardiologist. This benefit is confined to the heart; therefore, a narrowing or blockage of renal arteries or other peripheral arteries is not coronary artery disease and does not qualify for this benefit.

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

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

1. The presence of three or more of the following indicators:
 - a. pain, pressure, fullness, discomfort or squeezing in the center of the chest;
 - b. radiating pain to shoulder(s), neck, back, arm(s) or jaw;
 - c. new EKG changes indicative of myocardial infarction;
 - d. diagnostic increase of specific cardiac markers typical for Heart Attack; and
 - e. confirmatory imaging studies.
2. In the event of death, an autopsy confirmation identifying Heart Attack as the cause of death will be accepted.

Major Organ Failure – The irreversible failure of a Covered Person’s heart, lung, pancreas, entire kidney or any combination, for which a Physician has determined that there is medical evidence to support the complete replacement of such organ with an entire organ from a human donor. It can also be the irreversible failure of a Covered Person’s liver for which a Physician has determined that there is medical evidence to support the complete or partial replacement of the liver or liver tissue from a human donor. The need for a transplant must be due to severe organ disease. Such Covered Person has been placed on the Transplant List or the transplant procedure has been performed.

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

Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)
Encephalitis/meningitis
Rocky Mountain Spotted Fever
Typhoid Fever
Anthrax
Cholera
Primary Sclerosing Cholangitis (Walter Payton’s Disease)
Tuberculosis

Other Specified Organ Failure – One of the following occurring independently of any other covered Critical Illness:

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

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

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

Stroke does not include cerebral symptoms due to:

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

Dependent – Your Spouse or Other Adult Dependent or Child covered under this Certificate.

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

First Occurrence – The first time each covered Critical Illness is diagnosed on or after the Covered Person’s Effective Date. (Diagnosis can occur after death if death is due to a Critical Illness.)

Immediate Family Member – Anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these. The term “spouse” includes a common law marriage partner, domestic partner, or civil union partner, if legally recognized in the governing jurisdiction.

Insured, you, or your – The employee or member covered for this insurance.

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

Physician – A person who is providing services within the scope of his or her license, and is either:

1. Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. Legally qualified and licensed as a medical practitioner and is required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

Such person must not be an Immediate Family Member of any Covered Person. Practitioners of homeopathic, naturopathic and related medicines are not considered eligible Physicians under this Policy.

Policy – The complete contract of insurance, which includes the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any Amendments, Endorsements, and Riders.

Policyholder – The entity named on the Schedule of Benefits to whom the Policy is issued.

Spouse – Your legally married Spouse.

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

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

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

ELIGIBILITY AND EFFECTIVE DATE

Coverage will start at 12:01 a.m. at the main place of business of the Policyholder.

Employee or Member Eligibility – To be eligible for coverage under the Policy, you must:

1. Meet the eligibility requirements listed on the Policyholder Application;
2. Be in Active Service; and
3. Provide satisfactory Evidence of Insurability to us, if required.

Employee or Member Effective Date – Your insurance will take effect on the later of: (1) the Policy Effective Date; or (2) the first day of the calendar month which coincides with or next follows the date you are accepted for coverage; provided you are: (a) an eligible employee or member on such date; and (b) we have received your first premium payment.

If you do not meet the eligibility requirements on the date your coverage is to take effect, your coverage will take effect on the first day of the calendar month which coincides with or next follows the date you satisfy the requirements.

Dependent Eligibility, if available under the Policy – To be eligible under the Policy, a Dependent must:

1. Meet the definition of an eligible Dependent;
2. Not be eligible as an employee or member under the Policy; and
3. Provide satisfactory Evidence of Insurability to us, if required.

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

Dependent Effective Date – Insurance on each Dependent will take effect on the later of: (1) the date your coverage becomes effective; or (2) the first day of the calendar month which coincides with or next follows the date the Dependent is accepted for coverage, provided that: (a) the Dependent is an eligible Dependent on such date; and (b) we have received any additional premium.

If a Dependent does not meet the eligibility requirements on the date his or her coverage is to take effect, coverage on that Dependent will take effect on the first day of the calendar month which coincides with or next follows the date the Dependent satisfies the requirements.

Child Enrollment; Noncustodial Parents - If you are required by a court or administrative order to provide health benefit plan coverage for a Child, we will:

1. Allow the parent to enroll a Child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
2. Enroll the Child upon application of the Child's other parent or the Department of Health and Human Services in connection with its administration of the Medical Assistance or Child Support Enforcement Program if the parent is enrolled but fails to make application to obtain coverage for the Child.
3. Not disenroll or eliminate coverage of the Child unless we are provided satisfactory written evidence that: (a) The court or administrative order is no longer in effect; or (b) The Child is or will be enrolled in comparable health benefit plan coverage through another health insurer, which coverage will take effect not later than the effective date of disenrollment.

If a Child has coverage through a noncustodial parent, we will:

1. Provide such information to the custodial parent as may be necessary for the Child to obtain benefits.
2. Permit the custodial parent (or the health care provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent.
3. Make payments on claims directly to the custodial parent, the provider, or the Department of Health and Human Services.

Coverage for Newborn Child, Newly Adopted Child, or Foster Child - A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, as long as your coverage is in force on that date. An adopted or foster Child will become insured for coverage automatically on the day he or she is placed for adoption or placed in the foster home so long as such placement occurs while your coverage is in force on that day. The Child will be automatically covered for 31 days. If additional premium is required in order to continue the Child's coverage, you must notify us by the end of the 31-day period and pay the additional premium, if applicable.

The following definitions apply to this provision:

Child means, in connection with any adoption or placement for adoption, an individual who has not attained 18 years of age as of the date of the adoption or placement for adoption.

Foster Child means a minor:

1. Over whom a guardian has been appointed by the clerk of superior court of any county in North Carolina; or
2. The primary or sole custody of whom has been assigned by order of a court of competent jurisdiction.

Placement for adoption means the assumption and retention by you of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child. The Child's placement with you terminates upon the termination of such legal obligations.

Placement in the foster home means physically residing with a person appointed as guardian or custodian of a foster Child as long as that guardian or custodian has assumed the legal obligation for total or partial support of the foster Child with the intent that the foster Child reside with the guardian or custodian on more than a temporary or short-term basis.

BENEFITS

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

If a Covered Person is later diagnosed with the First Occurrence of one of the remaining Critical Illnesses and that illness is medically unrelated (as determined by a Physician) to any other Critical Illness for which we have paid a benefit, we will pay the applicable benefit for the newly diagnosed Critical Illness as long as the diagnosis is made 90 days or more after the last Critical Illness for which we paid a benefit.

If the last Critical Illness benefit payment under this Certificate was less than 100% of the applicable Benefit Amount, we will waive the requirements of being medically unrelated and separated by 90 days for the newly diagnosed Critical Illness.

Benefit Payments – Benefit payments will be made directly to you. Proof of any Critical Illness diagnosis must be submitted to us.

EXCLUSIONS AND LIMITATIONS

We do not cover losses caused by, or as a result of, the Covered Person's:

1. Participation or attempting to participate in an illegal activity.
2. Intentionally causing self-inflicted injury.
3. Committing or attempting to commit suicide, whether sane or insane.
4. Involvement in any period of armed conflict.

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

PREMIUMS

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

Premium Changes – We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 60-day advance written notice to the Policyholder, or to you if the Portability Option is in effect.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

Premium Refunds – If your Spouse or Other Adult Dependent is covered and you divorce or legally terminate the Other Adult Dependent relationship or such Dependent dies and we are notified in writing at our Administrative Office, we will refund premiums for the period of time following the date of divorce/dissolution or death of such Dependent. Premiums will not be refunded for any period prior to 30 days before such notification is received in our Administrative Office.

If your Children are covered and coverage for all Children ends, we will refund premiums for the period of time following the last day of coverage. We must be notified in writing at our Administrative Office. Premiums will not be refunded for any time period prior to 30 days before such notification is received in our Administrative Office.

Unpaid Premiums – Any premium due and unpaid may be deducted from a claim payment.

TERMINATION OF INSURANCE

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

1. The date the Policy terminates, subject to the Portability Option;
2. The date you cease to be eligible for coverage;
3. The date of your death;
4. The premium due date on which we fail to receive your premium, subject to the Grace Period provision; or
5. The date you send us a written notice that you want to cancel coverage.

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

1. The date your coverage terminates;
2. The premium due date on which we fail to receive your premium, subject to the Grace Period provision;
3. The date the Dependent Child no longer meets the definition of Child;
4. The date a Covered Spouse or Other Adult Dependent no longer meets the definition of same;
5. The date the Policy is modified so as to exclude Dependent coverage; or
6. The date you send us a written notice that you want to cancel coverage on your Dependent.

We may end the coverage of any Covered Person who submits a fraudulent claim under the Policy.

Termination of your insurance will not affect any claim which begins before the date of termination.

PORTABILITY OPTION

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

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

CLAIM PROVISIONS

Notice of Claim – Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the contract or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Covered Person or the beneficiary to us at the Administrative Office shown on page 1 of this Certificate, or to any authorized agent of the Company, with information sufficient to identify the Covered Person will be deemed notice to us.

Claim Forms – Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

Proof of Loss – Due written Proof of Loss must be given to us at our Administrative Office. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 180 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 180 days after the date of such loss.

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

Payment of Claim Benefits – All benefits payable under your Certificate will be paid to you. Any benefits that are not paid at your death will be paid to your Spouse or Other Adult Dependent or if there is no Spouse or Other Adult Dependent, then to your estate.

If any benefit is payable to your estate or to a Covered Person or beneficiary who is a minor or otherwise not competent to give a valid release, we may pay such benefit, up to \$1,000, to one of your relatives by blood or connection by marriage who we deem to be equitable entitled to such benefit. Such payment, made in good faith, fully discharges us to the extent of the payment.

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

Time of Payment of Claims – Benefits for a covered loss will be paid immediately after we receive due written Proof of Loss. We will acknowledge a claim within 30 days after receiving written Notice of Claim. Acknowledgement will include one of the following: (1) a statement advising that the claim is being investigated or that Proof of Loss is required; (2) payment of the claim; (3) a written offer of settlement; or (4) a written denial of the claim.

GENERAL PROVISIONS

Change of Beneficiary - The right to change beneficiary is reserved to the Insured and the consent of the beneficiary or beneficiaries will not be required to surrender or assign this Certificate or to change beneficiaries, or to make any other coverage changes.

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

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

Entire Contract; Changes – The Entire Contract consists of the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any attached Amendments, Endorsements, and Riders. Only our President, Vice President, Secretary, or an Assistant Secretary may make any changes to the Policy or this Certificate and then only in writing. No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Grace Period – A Grace Period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy and/or Certificate will terminate at the end of the Grace Period if the premium has not been paid.

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

Legal Action – No legal action may be brought to recover under the Policy or Certificate within 60 days after written Proof of Loss has been provided to us as required nor more than three years from the time written Proof of Loss is required to be furnished.

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

Reinstatement – If any renewal premium is not paid within the time granted for payment, a subsequent acceptance of premium by us or by any of our authorized agents, without requiring an application for reinstatement, will reinstate the Certificate. However, if we or our agent require an application for reinstatement and issue a conditional receipt, the Certificate will be reinstated upon our approval of such application, or, lacking such approval, upon the 45th day following the date of such conditional receipt, unless we have previously notified the Insured in writing of our disapproval of such application. The reinstated Certificate will only cover loss resulting from an Accident sustained after the date of reinstatement. The reinstated Certificate will only cover loss due to a covered Sickness that begins more than 10 days after the reinstatement date. In all other respects you and the Company will have the same rights as each had under the Certificate immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

Time Limit on Certain Defenses

Misstatements in the Application – We will not use any misstatement to void or reduce benefits after your coverage has been in effect for two years. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts is subject to a new two year contestable period for the increased amount only.

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

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

TRANSAMERICA LIFE INSURANCE COMPANY

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

CANCER BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

The definition of **Critical Illness** in the contract to which this Rider is attached is amended to add the cancer conditions set forth below. A diagnosis of cancer must be made by a Pathological Diagnosis or a Clinical Diagnosis. A postmortem diagnosis of cancer will be accepted if the requisite Pathological or Clinical Diagnosis can only be determined by postmortem examination. If the cancer diagnosis is made postmortem, the date of diagnosis will be assumed to be retroactive to the date of the Covered Person's terminal admission to the hospital but not less than 45 days prior to the date of death.

Invasive Cancer - A cancer which is evidenced by the presence of a malignant tumor characterized by uncontrolled and abnormal growth and spread of malignant cells, and the invasion of tissue. Leukemia, Hodgkin's Disease (except Stage 1 Hodgkin's Disease), and malignant melanoma will be considered Invasive Cancer.

Invasive Cancer does not include:

1. Pre-malignant conditions or conditions with malignant potential;
2. Prostatic cancers which are histologically described as TNM Classification T1 (including T1(a) or T1(b), or of other equivalent or lesser classification); and
3. Any malignancy associated with the diagnosis of HIV.

Skin Cancer - Basal cell epithelioma or squamous cell carcinoma. Skin Cancer does not include malignant melanoma or mycosis fungoides, which are not considered Skin Cancer under this Rider for the purpose of paying benefits.

Carcinoma In Situ - Cancer that is confined to the site of origin without having invaded neighboring tissue.

Prostate Cancer with TNM Classification of T1- Microscopic tumors of the prostate that are neither palpable nor visible on transrectal ultrasonography.

Bone Marrow Failure - The irreversible failure of a Covered Person's bone marrow for which a Physician has determined that medical evidence supports the replacement of bone marrow with bone marrow from the Covered Person or another human donor.

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

Clinical Diagnosis - A diagnosis based on the study of symptoms. We will accept a Clinical Diagnosis in lieu of a Pathological Diagnosis only when:

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

Pathological Diagnosis - A Pathological Diagnosis is based on a microscopic study of fixed tissue or preparations from the hemic (blood) system and on medical criteria accepted by the American Board of Pathology or the Osteopathic Board of Pathology for the type of cancer being investigated. This type of diagnosis must be done by a certified pathologist.

RIDER EFFECTIVE DATE

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

EXCLUSIONS

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

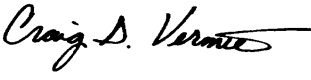
TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination; or
3. The date the contract terminates.

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

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

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[General Counsel and Secretary]

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[President]

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TRANSAMERICA LIFE INSURANCE COMPANY

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RECURRENT CRITICAL ILLNESS BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

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

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

BENEFITS

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

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

1. The diagnosis for the prior occurrence was at least 12 months before the new diagnosis; and
2. If it is a Cancer condition and the Cancer Benefit Rider is part of this contract, the Covered Person has been Treatment Free for at least 12 months.

If a Covered Person is diagnosed with a Recurrent Critical Illness, we will pay a lump sum benefit equal to the Recurrent Critical Illness Benefit Amount applicable to the Critical Illness as shown in the Schedule of Benefits. The positive diagnosis must be made after the Rider Effective Date and while this Rider is in force.

For each Critical Illness, only one Recurrent Critical Illness Benefit may be paid per Covered Person.

RIDER EFFECTIVE DATE

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

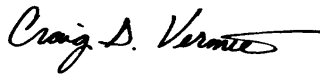
TERMINATION

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2. The date the Insured requests termination; or
3. The date the contract terminates.

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

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

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[General Counsel and Secretary]

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[President]

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WELLNESS INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

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

Health Screening Test means one of the following tests performed under the supervision of or recommendation by a Physician while this Rider is in force:

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

BENEFIT

We will pay the amount shown on the Schedule of Benefits once per Covered Person per Calendar Year in which such Covered Person undergoes a Health Screening Test, regardless of the number of tests the Covered Person undergoes.

RIDER EFFECTIVE DATE

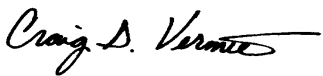
This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

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

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[General Counsel and Secretary]

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[President]