

## NOTICE OF PRIVACY PRACTICES TRANSAMERICA COMPANIES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. We value our customers and your trust in us, especially when you share your personal information with us. We understand that the privacy and security of that personal information is important to you. We call this information “customer data” or just “data”. This Notice describes the customer data we collect and how we use, share and protect that data. The types of personal information we collect and share depend on the product or service you have with us. If your relationship with us ends, we will continue to handle your data in accordance with this Notice.

**Customer Data That We Collect:** We collect the following types of customer data:

Data	Typical Sources
Name, email and physical address, age, social security and driver's license numbers, employment, financial and health data and history.	From you directly, when you submit applications and forms and engage in communications with us. We may also receive this data from employers, healthcare providers and other insurance companies.
Data about your transactions with us and unaffiliated third parties (“Third Parties”), such as account balances, accrued benefits, coverages, premiums, payment and claims history and medical or health data. This may also include information you share with us through your online experiences with Transamerica websites and applications.	From our affiliates (companies under common ownership) and Third Parties. From Transamerica websites, digital platforms, and applications.
Credit history, employment information and other information about your creditworthiness, medical care and health.	Consumer reporting agencies and other service providers we use. We may also receive this data from your employers, healthcare providers and other insurance companies.
Information about products and services you obtain or in which you might be interested.	You or possibly Third Parties with whom we have joint marketing arrangements or other Third Parties.
Information you provide to unaffiliated third parties (“Third Parties”) where you agree to allow the Third Party to share information with other parties. This includes information collected through those Third Party applications, websites, or other digital interfaces.	Third Party applications, websites, or other digital interfaces where you have agreed to sharing of your data.

**How We Use Your Data:** We use data for purposes allowed by law. For example, we may use your data to:

- Process claims and transactions,
- Research, develop, provide and market products and services,
- Prevent and prosecute fraud or criminal activities,
- Support online customer experiences, digital platforms, and/or applications you elect to participate in.
- Maintain your accounts,
- Comply with applicable laws
- Maintain, operate, and market our business, or

**Sharing Data:** We may share your data with Third Parties and affiliates as permitted or required by law, or when you authorize us to do so. In certain situations, our ability to share information is limited by other restrictions, such as certain contractual agreements with plan sponsors or similar arrangements. We will honor those restrictions to the extent they conflict with the terms of this Notice. We may also share your data with Third Parties in certain circumstances, such as:

- Those who provide services to support our business, including processing claims, account maintenance, and marketing and sales,
- Credit bureaus,
- Insurance regulators, law enforcement, governmental authorities and other Third Parties in response to legal process or as required by law,
- Health care professionals, including to verify coverage or to provide information relating to a medical condition,
- Governmental agencies so they can decide if you are eligible for public benefits,
- Other financial companies in connection with joint marketing efforts,
- Other insurance companies (including successor insurers), agents and insurance support organizations to coordinate your benefits or in connection with insurance transactions involving you,
- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,

- Your employer or plan sponsor as needed to support the administration of employee accounts (but only as permitted by law and only if you have established an account in connection with your employer),
- Your representatives and lawyers,
- Those who have a legal or beneficial interest in your assets (such as creditors with a lien on your account),
- To prevent and prosecute fraud or criminal activities,
- To conduct actuarial or research studies, and
- In connection with the sale or merger of all or part of our business.

Our affiliates include a broad range of companies who provide financial services. These include insurance companies and agencies, and investment advisors. They also include agencies and broker/dealers who may not be included in the scope of this Notice. If we serve you through one of these professionals, you may contact them directly for information regarding their privacy practices. Specific contact information for these professionals can be found on your statements and other correspondence from them. We do not share information about your creditworthiness among our affiliates. The Transamerica affiliated companies with whom we may share your other information may include our companies with a Transamerica or Stonebridge name.

For example, we may share your data with our affiliates:

- For their everyday business purposes;
- So they can tell you about products and services they offer;
- So they can determine which of their products and services may be of interest to you;
- So they can provide various services to us to support our business, such as claims processing, maintaining your account, and marketing products and services to you; or
- So they can audit themselves or their agents.

**Your Choice to Limit Marketing by Transamerica Affiliates:** You may limit our affiliates' use of certain types of data to market their own products and services to you. To do this, choose one of the Opt Out methods set forth below. This data relates to your transactions and experiences with us. For example, this may include the products you own and your account history. Your choice to limit marketing offers from our affiliates will apply for at least 5 years from when you Opt Out. Once that period expires, we will send you a renewal Notice. That renewal Notice will allow you to continue to limit marketing offers from our affiliates for at least another 5 years. If you have already Opted Out of marketing offers from our affiliates, you do not need to Opt Out again until you receive a renewal Notice. If you hold a policy or account jointly with someone else, your Opt Out choices will apply to everyone on the account. When you are no longer our customer, we continue to share your data as described in this Notice (including your Opt Out, if applicable). However, you may contact us at any time to limit our sharing.

**To Opt Out:** To limit our sharing of data with affiliates for marketing by affiliates as described above, you may:

- Call us at **877-257-4690** and our menu will prompt you through your choice(s), or
- Visit us online at **[www.transamerica.com/optout](http://www.transamerica.com/optout)**.

**Your Right of Access and Correction:** You have a right of access and correction with respect to data we collect except data that relates to and is collected in connection with a claim or criminal or civil lawsuit involving you. You must make your request to us in writing listing the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it. If we agree, we will correct our records. If we don't agree, you may dispute our findings in writing and send your statement to us. We will include your statement whenever we provide your disputed information to anyone outside Transamerica. This is a summary of your rights. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 4333 Edgewood Rd NE, Cedar Rapids, IA 52499.

**Protecting Your Data:** We restrict access to customer data to persons who need access to it in order to do their jobs or to provide products and services to you. We train our workforce in the proper handling of customer data. In addition, we maintain other physical, electronic, and procedural safeguards to protect your data.

**Other Privacy Protections for Vermont Residents only.** We will not share data we collect about you with Third Parties, except as permitted by Vermont law or authorized by you. We may still share data about our transactions or experiences with you with our affiliates. **For California Residents only.** If you are a California resident, you will receive a separate notice. That separate notice will give you additional choices.

We may revise this Notice. If we make material changes, we will notify you as required by law. This Notice is provided by the following Transamerica companies and any separate accounts established for products they offer:

**Transamerica Advisors Life Insurance Company**  
**Transamerica Casualty Insurance Company**  
**Transamerica Investors Securities Corporation**  
**Transamerica Premier Life Insurance Company**  
**Transamerica Retirement Solutions, LLC**

**Transamerica Capital, Inc**  
**Transamerica Financial Life Insurance Company**  
**Transamerica Life Insurance Company**  
**Transamerica Retirement Advisors, LLC**  
**Stonebridge Benefit Services, Inc**

# INSURANCE POLICY







# ***Transamerica***

## **Life Insurance Company**

A Stock Company (Hereinafter called: We, Our or Us)  
Home Office: Cedar Rapids, Iowa  
Administrative Office: PO Box 869094, Plano, Texas 75086-9817  
Toll Free Telephone No: 1-888-763-7474

### **NOTICE TO INSURANCE FIDUCIARY**

UNDER NORTH CAROLINA GENERAL STATUTE SECTION 58-50-40, NO PERSON, EMPLOYER, PRINCIPAL, AGENT, TRUSTEE, OR THIRD PARTY ADMINISTRATOR, WHO IS RESPONSIBLE FOR THE PAYMENT OF GROUP HEALTH OR LIFE INSURANCE OR GROUP HEALTH PLAN PREMIUMS, SHALL: (1) CAUSE THE CANCELLATION OR NONRENEWAL OF GROUP HEALTH OR LIFE INSURANCE, HOSPITAL, MEDICAL, OR DENTAL SERVICE CORPORATION PLAN, MULTIPLE EMPLOYER WELFARE ARRANGEMENT, OR GROUP HEALTH PLAN COVERAGES AND THE CONSEQUENTIAL LOSS OF THE COVERAGES OF THE PERSONS INSURED, BY WILLFULLY FAILING TO PAY THOSE PREMIUMS IN ACCORDANCE WITH THE TERMS OF THE INSURANCE OR PLAN CONTRACT, AND (2) WILLFULLY FAIL TO DELIVER, AT LEAST 45 DAYS BEFORE THE TERMINATION OF THOSE COVERAGES, TO ALL PERSONS COVERED BY THE GROUP POLICY A WRITTEN NOTICE OF THE PERSON'S INTENTION TO STOP PAYMENT OF PREMIUMS. THIS WRITTEN NOTICE MUST ALSO CONTAIN A NOTICE TO ALL PERSONS COVERED BY THE GROUP POLICY OF THEIR RIGHTS TO HEALTH INSURANCE CONVERSION POLICIES UNDER ARTICLE 53 OF CHAPTER 58 OF THE GENERAL STATUTES AND THEIR RIGHTS TO PURCHASE INDIVIDUAL POLICIES UNDER THE FEDERAL HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT AND UNDER ARTICLE 68 OF CHAPTER 58 OF THE GENERAL STATUTES. VIOLATION OF THIS LAW IS A FELONY. ANY PERSON VIOLATING THIS LAW IS ALSO SUBJECT TO A COURT ORDER REQUIRING THE PERSON TO COMPENSATE PERSONS INSURED FOR EXPENSES OR LOSSES INCURRED AS A RESULT OF THE TERMINATION OF THE INSURANCE.

# ***Transamerica***

## ***Life Insurance Company***

A Stock Company (Hereinafter called: We, our or us)

Home Office: Cedar rapids, Iowa

Administrative Office:[PO Box 869094, Plano, Texas 75086-9817]

Toll Free Telephone No: [1-888-763-7474]

### **ADVERSE UNDERWRITING NOTICE**

In the event of an adverse underwriting decision, upon written request within 90 business days from the date of the mailing of notice or other communication of an adverse underwriting decision, the Covered Person may receive the specific reason or reasons in writing. The specific reasons for the adverse underwriting decision shall be provided by Us within 21 business days from the date of receipt of such written request and shall include the following:

- (1) The specific reason or reasons for the adverse underwriting decision;
- (2) The specific items of personal and privileged information that support those reasons, provided, however that We shall not be required to furnish specific items of privileged information if We have a reasonable suspicion, based upon specific information available for review by the Commissioner, that the Covered Person has engaged in criminal activity, fraud, material misrepresentation, or material nondisclosure,
- (3) Specific items of medical-record information supplied by a medical-care institution or medical professional shall be disclosed to the Covered Person about whom the information relates; and
- (4) The names and addresses of the institutional sources that supplied the specific items of information given.

When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights shall be given orally.

#### **Access to Recorded Personal Information**

The Covered Person may submit a written request to Us for access to recorded personal information about the Covered Person that is reasonably described by the Covered Person and reasonably locatable and retrievable by Us, We shall within 30 business days from the date such request is received:

- (1) Inform the Covered Person of the nature and substance of such recorded personal information in writing;
- (2) Permit the Covered Person to see and copy, in person, such recorded personal information pertaining to him or to obtain a copy of such recorded personal information by mail, whichever the Covered Person prefers, unless such recorded personal information is in coded form, in which case an accurate translation in plain language shall be provided in writing;
- (3) Disclose to the Covered Person the identity, if recorded, of those persons to whom We have disclosed such personal information within 2 years prior to such request, and if the identity is not recorded, the names of those insurance institutions, agents, insurance-support organizations or other persons to whom such information is normally disclosed; and

- (4) Provide the Covered Person with a summary of the procedures by which he may request correction, amendment, or deletion of recorded personal information.

#### **Correction of Recorded Personal Information**

Within 30 business days from the date of receipt of a written request from the Covered Person to correct, amend, or delete any recorded personal information about the Covered Person within Our possession, We shall either:

- (1) Correct, amend, or delete the portion of the recorded personal information in dispute; or
- (2) Notify the Covered Person of: (a) Our refusal to make such correction, amendment, or deletion; (b) The reasons for the refusal; and (c) The Covered Person's right to file a statement as set forth below.

If We correct, amend, or delete recorded personal information in accordance with the Covered Person's request, We shall so notify the Covered Person in writing and furnish the correction, amendment, or fact of deletion to: (a) Any person specifically designated by the Covered Person who, within the preceding 2 years, may have received such recorded personal information; (b) Any insurance-support organization whose primary source of personal information is insurance institutions if We have systematically received such recorded personal information from the Insurance institution within the preceding 7 years. The correction, amendment, or fact of deletion need not be furnished if the insurance-support organization no longer maintains recorded personal information about the Covered Person; and

- (3) Any insurance-support organization that furnished the personal information that has been corrected, amended, or deleted.

If the Covered Person disagrees with Our refusal to correct, amend, or delete recorded personal information, the Covered Person shall be permitted to file with Us:

- (1) A concise statement setting forth what the Covered Person thinks is the correct, relevant, or fair information; and
- (2) A concise statement of the reasons why the Covered Person disagrees with Our refusal to correct, amend, or delete recorded personal information.

In the event a Covered Person files either statement as described above, We shall:

- (1) File the statement with the disputed personal information and provide a means by which anyone reviewing the disputed personal information will be made aware of the Covered Person's statement and have access to it; and
- (2) In any subsequent disclosure by Us of the recorded personal information that is the subject of disagreement, clearly identify the matter or matters in dispute and provide the Covered Person's statement along with the recorded personal information being disclosed; and
- (3) Furnish the statement to such persons.



## **NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholder will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the guaranty association will assess its other member insurance companies for the money to pay the claims of the insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the guaranty association is not unlimited, however. And, as noted *in the box* below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association  
Post Office Box 10218  
Raleigh, North Carolina 27605

North Carolina Department of Insurance, Consumer Services Division  
1201 Mail Service Center  
Raleigh, NC 27699-1201

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. *On the back of this page* is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

### **COVERAGE**

Generally, individuals will be protected by the life and health insurance guaranty association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

## **EXCLUSIONS FROM COVERAGE**

However, persons holding such policies are not protected by this association if:

- 1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- 2) the insurer was not authorized to do business in this state;
- 3) their policy was issued by an H M O , a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The association also does not provide coverage for:

- 1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- 2) any policy of reinsurance (unless an assumption certificate was issued);
- 3) interest rate yields that exceed the average rate specified in the law;
- 4) dividends;
- 5) experience or other credits given in connection with the administration of a policy for a group contractholder;
- 6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- 7) unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

## **LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the association is obligated to pay out as follows:

- 1) The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- 2) Except as provided in (3) and (4) below, the guaranty association will pay a maximum of \$300,000 per individual, per insolvency, no matter the number of policies or types of policies issued by the insolvent company.
- 3) The guaranty association will pay a maximum of \$1,000,000 with respect to the payee of a structured settlement annuity.
- 4) The guaranty association will pay a maximum of \$5,000,000 to any one unallocated annuity contract holder.

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499  
A Stock Company

Policyholder: CITY OF GOLDSBORO

Address: 200 NORTH CENTER STREET  
GOLDSBORO NC 27530

Policy Number: AV00060773

Effective Date: JANUARY 1 2018

Anniversary Date: FEBRUARY 1

Governing Jurisdiction: North Carolina

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

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

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

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

This Policy is a legal contract between the Policyholder and the Company. **READ YOUR POLICY CAREFULLY.**

**IMPORTANT CANCELLATION INFORMATION – PLEASE REFER TO THE "POLICY CHANGES AND TERMINATION" SECTION OF THIS POLICY.**

**[WHEN THE SICKNESS ONLY DISABILITY INCOME RIDER IS PART OF YOUR ISSUED COVERAGE, IT CONTAINS A 30-DAY WAITING PERIOD AND A PREEXISTING CONDITION LIMITATION.]**

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



General Counsel and Secretary



President

## GROUP MASTER POLICY FOR ACCIDENT ONLY INSURANCE

**PREMIUM RATE SUBJECT TO CHANGE  
BENEFITS LIMITED TO LOSS DUE TO ACCIDENTS ONLY NO  
BENEFITS PROVIDED FOR LOSS FROM ANY OTHER CAUSE  
THIS IS A LIMITED BENEFIT POLICY – READ YOUR POLICY CAREFULLY  
NONPARTICIPATING – NO ANNUAL DIVIDENDS**

Administrative Office:  
2700 W Plano Pkwy, PO Box 869094  
Plano, Texas 75086-9817  
Customer Service: 1-888-763-7474

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## DEFINITIONS

**Active Service** – To be considered in Active Service, the employee or member 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 employee or member 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 employee or member 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.

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

**Certificate** – The document that is given to each Insured that describes the terms of the insurance made available to insured employees or members and their insured Spouses and any insured Dependent Children.

**Covered Person** – Any or all of the following: the Insured, Insured's Spouse, or Insured's and/or Spouse's Child(ren) who have been accepted by us for coverage.

**Dependent** – The Insured's Child or Spouse covered under the Certificate.

**Effective Date** – The date when this Policy takes effect. It is shown on the Policy's Cover Page. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

**Employee** – A nonseasonal person who works on a full-time basis, with a normal work week of 30 or more hours and who is otherwise eligible for coverage. This does not include a person who works on a part-time, temporary, or substitute basis.

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

**Grace Period** – A 31-day period after the premium due date.

**Group Master Policy or Policy** – This document that describes the coverage provided to Insureds, as well as the administrative duties between you and us.

**Insured** – The employee or member covered under a Certificate.

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

## ELIGIBILITY

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

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

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

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

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

The Insured may elect Dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
2. Completing any required form for payroll deduction.

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

No application will be required for a newly born child, an adopted child or a foster child who is added subsequent to the initial enrollment date. However, if the employee or member is adding a Spouse or other Dependent subsequent to the initial enrollment, then an application will be required for that individual.

If an employee or member and his or her Spouse are both eligible as an employee or member, the Child(ren) may be insured as Dependents of either the employee or member or his or her Spouse, but not both.

**Child Enrollment: Noncustodial Parent** - If you and your Spouse are both eligible as an employee or member, your Child may be insured as a Dependent of either you or your Spouse, but not both.

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, under the Policy, a Child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
2. Enroll the Child under the Policy 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.

## PREMIUMS

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

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

**Change in Premium Rates** - We have the right to change the premium rates on any premium due date. Premium rates will be guaranteed for the first contract year and adjusted no more often than once every six months thereafter, based on twelve (12) months of experience. If the rates are changed, we will give you at least a 45-day advance written notice. If an increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased.

## POLICY CHANGES AND TERMINATION

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

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

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

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

Termination of an Insured's coverage prior to any termination of this Policy will be governed by the Termination of Insurance section of the Certificate. You are required to notify us of any such termination.

## POLICYHOLDER PROVISIONS

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

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

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

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

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

**Inspection of Policy** – You must make this Policy available for inspection by your employees or members at all reasonable times during normal business hours.

**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.

## GENERAL PROVISIONS

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

**Conformity with State Laws** – Should any provision of the Policy conflict with a law of the governing jurisdiction, it is hereby amended to conform to the minimum requirements of that law.

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

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

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

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

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

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

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

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

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

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

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

**Time Effective** – For any dates used in this Policy, the effective time will be 12:01 AM at your main place of business.

## CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY

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



# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499  
A Stock Company

This Certificate explains the benefits provided under the Group Master Policy for Accident Only Insurance that is underwritten by Transamerica Life Insurance Company.

The Policy is a legal contract between the Group Policyholder and the Company. **READ YOUR CERTIFICATE CAREFULLY.**

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 for Accidental Bodily Injuries that occur as the result of an Accident and where expenses are incurred. The Accident must occur while the Covered Person is insured under the Policy, subject to the provisions of this Certificate.

## **IMPORTANT CANCELLATION INFORMATION – PLEASE REFER TO THE “TERMINATION OF INSURANCE” SECTION OF THIS CERTIFICATE.**

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

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

This Certificate is issued in consideration of statements made in your Application and the payment of the first full premium shown on the Schedule of Benefits.

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



General Counsel and Secretary



President

## **CERTIFICATE FOR GROUP ACCIDENT ONLY INSURANCE**

**PREMIUM RATE SUBJECT TO CHANGE  
BENEFITS LIMITED TO LOSS DUE TO ACCIDENTS ONLY  
NO BENEFITS PROVIDED FOR LOSS FROM ANY OTHER CAUSE  
READ YOUR CERTIFICATE CAREFULLY  
NONPARTICIPATING – NO ANNUAL DIVIDENDS**

**WHEN THE SICKNESS ONLY DISABILITY INCOME RIDER IS PART OF YOUR ISSUED COVERAGE, IT CONTAINS A 30-DAY WAITING PERIOD AND A PREEXISTING CONDITION LIMITATION.**

Administrative Office:  
2700 W Plano Pkwy, PO Box 869094  
Plano, Texas 75086-9817  
Customer Service: 1-888-763-7474

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## SCHEDULE OF BENEFITS

INSURED: XXXXXXXXXX

AGE AT ISSUE: XX

CONTRACT NUMBER: XXXXXXXXXXXX

EFFECTIVE DATE: XXXXXXXX

TYPE OF COVERAGE: [INDIVIDUAL, SINGLE PARENT FAMILY,  
TWO ADULT FAMILY, or FAMILY]

TOTAL PREMIUM: \$XX.XX

PREMIUM MODE: [MONTHLY]

Policyholder: CITY OF GOLDSBORO

### BENEFITS

### NUMBER OF UNITS

MODULE 1 – ACCIDENT EMERGENCY TREATMENT

8

MODULE 2 – FOLLOW-UP VISITS AND PHYSICAL THERAPY

2.5

MODULE 3 – INITIAL ACCIDENT HOSPITALIZATION

3

### **FORM NUMBER - OPTIONAL BENEFIT RIDERS**

CRHICU00 – ACCIDENT HOSPITAL AND ICU INCOME RIDER

5

CREXPB00 – EXPANDED BENEFITS RIDER

1

CRWELB00 - WELLNESS BENEFIT RIDER

10

## DEFINITIONS

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

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

**Active Service** – To be considered in Active Service, you must be doing the following:

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

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

**Ambulatory Surgical Center** - A licensed, free-standing surgical facility consisting of an operating room, facilities for the administration of general anesthesia, and a post-surgery recovery room. It must also require that the patient be admitted, treated, and released during a 24-hour period.

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

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

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

**Certificate** - This document that describes your insurance coverage.

**Child** - A Child of yours who is unmarried, under the age of 25, dependent upon you for more than 50% of his or her support and maintenance, and is:

1. A natural Child; or
2. A legally adopted Child or a Child who has been placed for adoption with you; or
3. A stepchild, grandchild, or foster Child; or
4. A Child for whom you have been appointed legal guardian; or
5. A Child not living with you, but for whom you are legally required to provide support.

If a Dependent Child has reached age 25, but is incapable of self-support because of mental retardation or physical impairment, we will continue the Child's coverage under the following conditions:

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after the 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 25; and
4. Your coverage must remain in force.

**Chip Fracture** – A Fracture in which a piece of the bone is broken off near a joint at a place where a ligament is usually attached. It must be diagnosed by a Physician through the use of an X-ray.

**Covered Person** – You and any Dependents that have been accepted by us for coverage under this Certificate.

**Dependent** – Your Spouse or Child covered under this Certificate.

**Dislocation** – A completely separated joint. It must be diagnosed as a Dislocation by a Physician within 96 hours after the date of the Accident. The Dislocation must require correction by a Physician. It can be corrected by open or closed reduction.

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

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

**Extended Care Facility** – An institution or that part of an institution that:

1. Is licensed or accredited to provide nursing or rehabilitative care under the supervision of a Physician or a registered nurse;
2. Provides 24-hour skilled nursing service; and
3. Maintains daily medical records on each patient.

It does not include institutions or parts of institutions which are primarily for the care and treatment of drug addiction, alcoholism, or the aged.

**Fracture** – A break in a bone that can be seen by X-ray. It must be diagnosed as a Fracture by a Physician within 14 days after the date of the Accident. The Fracture must require correction by a Physician. It can be corrected by open or closed Reduction.

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

**Group Master Policy or Policy** – The document that is issued to the Policyholder.

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

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

We will consider a Government or Charity Hospital as any other Hospital. **Hospital** will also include a duly licensed North Carolina tax-supported institution even though it may not have an operating room and related equipment for the performance of surgery.

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

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

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

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

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

**Outpatient** – A Covered Person who receives medical tests, treatment, or services from a Hospital, Ambulatory Surgical Center, medical clinic, or Physician's office and is not charged for room and board.

**Physical Therapist** – Anyone, other than you or your Immediate Family Member, who is licensed as a Physical Therapist and certified to treat physically disabled or handicapped persons with physical agents and methods such as massage, manipulation, therapeutic exercises, cold, heat, hydrotherapy, electrical stimulation, and light to assist in rehabilitation.

**Physician** – A licensed medical practitioner of the healing arts who:

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

Physician will also include other licensed medical practitioners, such as nurse practitioners, Physician's assistants, and chiropractors that operate within the scope of their license.

**Policyholder** – The entity named on the Policy's Cover Page and is shown on the Certificate's Schedule of Benefits.

**Reduction** – Open-surgical repair or closed-manipulative repair.

**Spouse** – As named in the Application, includes your legally married Spouse, your common law Spouse, domestic partner, or civil union partner if legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and the Company.

**Type of Coverage** – Insurance coverage selected for this Certificate is shown on the Schedule of Benefits. The types of coverage available are:

1. Individual – Coverage on the Insured only.
2. Single Parent Family – Coverage on the Insured and any Dependent Child.
3. Two-Adult Family – Coverage on the Insured and Spouse only.
4. Family – Coverage on the Insured, the Insured's Spouse, and any Dependent Child.

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

## ELIGIBILITY AND EFFECTIVE DATE

Coverage will start on the Effective Date shown on the Schedule of Benefits. Coverage will start on that date at 12:01 AM at the main place of business of the Policyholder. Effective Dates for Riders and all persons added to coverage after this Certificate is issued will be reflected by an endorsement to the Certificate.

**Employee or Member Eligibility** – You must meet the following requirements to be eligible for insurance:

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

**Employee or Member Effective Date** – Your insurance will take effect on the Effective Date if the following events have taken place:

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

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

If you are not in Active Service on what otherwise would be the Effective Date, your coverage will be deferred until the first day of the month following the date you are in Active Service.

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

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

You may elect Dependent coverage by:

1. Applying for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
2. Completing any required form for payroll deduction or premium payment.

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

If an eligible Dependent does not become a Covered Person on your Effective Date, you may add the Dependent to this Certificate by taking the following steps:

1. Submitting an Application;
2. Satisfying any Evidence of Insurability requirements; and
3. Paying any additional premium, if required.

No application will be required for a newly born child, an adopted child or a foster child who is added subsequent to the initial enrollment date. However, if you are adding a Spouse or other Dependent subsequent to the initial enrollment, then an application will be required for that individual.

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

**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, under the Policy, a Child who is otherwise eligible for the coverage without regard to any enrollment season restrictions.
2. Enroll the Child under the Policy 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.

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

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

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

If a Dependent is Disabled on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage for that Dependent will be deferred until the first of the month following cessation of Disability for that Dependent.

**Newborn Child, Adopted or Foster Child Effective Date** - 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 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.

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

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

If this Certificate is issued as either Single Parent Family or Family coverage, the Child will remain covered beyond the initial 31-day period and no additional premium will be required.

## BENEFITS

If a Covered Person receives an Accidental Bodily Injury and expenses are incurred for Necessary Treatment, we will pay the following benefits according to the Benefits section of this Certificate. Such injury must be independent of disease or bodily infirmity other than an Accident. Such Accident must occur while coverage is in force.

Benefit payments will be made directly to you, unless you assign benefits. Proof of Loss must be submitted to us for each incurred expense. Under no conditions will we pay any benefits for losses or medical expenses incurred prior to the Effective Date.

The following benefits are payable per unit, per Covered Person, as shown below. The number of units selected by the Policyholder for each benefit is shown on the Schedule of Benefits.

### Module 1 – Accident Emergency Treatment

**Accident Emergency Treatment Benefit** – If a Covered Person receives treatment for an Accidental Bodily Injury, we will pay \$25 per unit for treatment received. This benefit is payable for treatment by a Physician, X-rays, treatment received in a Hospital emergency room, or Physician's office. Treatment must be received within 96 hours of such Accident for benefits to be payable. This benefit is payable once per Accident, per Covered Person. Benefits will not be paid for services rendered by an Immediate Family Member.

**Major Diagnostic Examinations Benefit** – We will pay \$40 per unit, per Covered Person, for one Major Diagnostic Examination per Accident. This benefit is limited to one Major Diagnostic Examination per Accident. Such examination must be performed within 90 days of the Accidental Bodily Injury. Major Diagnostic Examinations are limited to the following:

1. CT (computerized tomography) scan;
2. MRI (magnetic resonance imaging); and
3. EEG (electroencephalogram).

**Dislocation Benefit** - Dislocations which are reduced under general anesthesia are payable as follows:

1. If a Covered Person receives more than one Dislocation in an Accident and requires open or closed Reduction, we will pay 1½ times the amount for the Dislocation involved that has the highest benefit amount. No other amount will be paid under this benefit;
2. If a Covered Person receives a Dislocation and a Fracture in the same Accident, we will pay 1½ times the amount for the Dislocation or Fracture involved that has the highest benefit amount. No other amount under this benefit or the Fracture Benefit will be paid; and
3. If a Dislocation is reduced without general anesthesia by a Physician, we will pay 25% of the amount shown for the Dislocation involved.
4. Benefits are payable only for the first Dislocation of a joint. If a Covered Person dislocates a joint and then dislocates the same joint again, the second same joint Dislocation would not be covered.



<b>Dislocation Benefit</b>	<b>Benefit per Unit</b>
Hip	
Open Reduction .....	\$800
Closed Reduction .....	\$270
Knee or Shoulder	
Open Reduction .....	\$270
Closed Reduction .....	\$110
Collar Bone	
Open Reduction .....	\$430
Closed Reduction .....	\$ 80
Ankle or Foot (excluding toes)	
Open Reduction .....	\$270
Closed Reduction .....	\$ 80
Lower Jaw	
Open Reduction .....	\$270
Closed Reduction .....	\$140
Wrist or Elbow	
Open Reduction .....	\$220
Closed Reduction .....	\$110
Toe or Finger	
Open Reduction .....	\$ 60
Closed Reduction .....	\$ 30

**Fracture Benefit** – If a Covered Person receives more than one Fracture in an Accident and requires open or closed Reduction, we will pay 1½ times the amount for the Fracture involved that has the highest benefit amount. No other amount will be paid under this benefit.

If a Covered Person receives a Fracture and a Dislocation in the same Accident, we will pay 1½ times the amount for the Fracture or Dislocation involved that has the highest benefit amount. No other amount under this benefit or the Dislocation benefit will be paid.

Chip Fractures pay 10% of the benefit amount for the Fracture involved.

<b>Fracture Benefit</b>	<b>Benefit per Unit</b>
Hip	
Open Reduction .....	\$1,000
Closed Reduction .....	\$340
Leg	
Open Reduction .....	\$420
Closed Reduction .....	\$340
Skull	
Depressed .....	\$540
Simple.....	\$200
Hand (excluding fingers) Foot (excluding toes/heel), Wrist, Shoulder Blade, Forearm, Ankle, Elbow, Kneecap, Sternum or Lower Jaw	
Open Reduction .....	\$340
Closed Reduction .....	\$170
Vertebrae (body of), Pelvis (excluding coccyx) .....	\$170
Upper Jaw, Upper Arm or Face (excluding Nose), Collar Bone	
Open Reduction .....	\$400
Closed Reduction .....	\$170
Rib(s)	
Open Reduction .....	\$670
Closed Reduction .....	\$70

**Fracture Benefit (continued)****Benefit per Unit**

Nose, Heel or Finger(s)	
Open Reduction .....	\$340
Closed Reduction .....	\$70
Coccyx	
Open Reduction .....	\$140
Closed Reduction .....	\$70
Toe(s)	
Open Reduction .....	\$140
Closed Reduction .....	\$70
Vertebral Processes	
Open Reduction .....	\$670
Closed Reduction .....	\$100

Benefits are not payable for services rendered by an Immediate Family Member.

## Module 2 – Follow-Up Visits and Physical Therapy

**Accident Follow-Up Treatment Benefit** – While this coverage is in force, if a Covered Person first receives treatment for an Accidental Bodily Injury within 96 hours of an Accident and later requires additional treatment for the same injury, we will pay \$10 per unit for such follow-up treatment as follows:

1. This benefit is payable up to a maximum of three follow-up treatments per Accident per Covered Person.
2. Such treatment must begin within 30 days of, and be completed within, the six-month period following the later of the following dates:
  - a. The Accident;
  - b. Discharge from the Hospital from a covered Confinement; or c. Discharge from the Extended Care Facility; and
3. Treatments must be furnished by a Physician in a Physician's office or in a Hospital on an Outpatient basis.

**Physical Therapy Benefit** – While this coverage is in force, if a Physician advises a Covered Person to seek treatment from a Physical Therapist, we will pay a benefit amount of \$10 per unit, per treatment, up to a maximum of 10 treatments per Accident. Physical Therapy must begin within 120 days of the Accident. All treatments must be completed within one year of the Accident.

## Module 3 – Initial Accident Hospitalization

**Initial Accident Hospitalization Benefit** – When a Covered Person is Hospital Confined for 24 hours or more for an Accidental Bodily Injury, we will pay the following benefit amounts:

1. Hospital admission – \$300 per unit for the first Hospital admission due to an Accident; and
2. Intensive Care Unit (ICU) – \$300 per unit for the first ICU admission due to an Accident.

An ICU admission benefit is paid even if admitted to the Hospital initially, and then transferred to ICU later during the same hospitalization.

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

**Ambulance Benefit** – We will pay for ambulance transportation by a licensed ambulance service if the Covered Person is transferred by ambulance to the nearest Hospital for treatment within 96 hours of an Accident in the amounts as follows:

1. \$60 per unit for ground ambulance; or
2. \$300 per unit for air ambulance.

## EXCLUSIONS AND LIMITATIONS

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

1. Driving any taxi for wage, compensation, or profit;
2. Mountaineering, parachuting, or hang gliding;
3. Voluntarily taking, administering, absorbing, or inhaling poison, gas, or fumes;
4. Alcoholism or drug addiction;
5. Participating in any sport or sporting activity for wage, compensation, profit, or racing any type vehicle in an organized event;
6. Traveling in or descending from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip;
7. War, or any act of war, whether declared or undeclared;
8. Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the Accident occurred;
9. Participating in a riot, civil commotion, civil disobedience, or unlawful assembly.
10. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
11. Intentionally self-inflicting a bodily injury or attempting suicide, while sane or insane;
12. Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception;

## PREMIUMS

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

We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 45-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.

## TERMINATION OF INSURANCE

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

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

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

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

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

**Extension of Benefits** - Whenever termination of coverage under this section occurs due to termination of your employment or membership, such termination will be without prejudice to:

1. Any Hospital Confinement which began while coverage was in force; or
2. Any covered treatment or service for which benefits would be provided and which began while coverage was in force; provided, however, that the Covered Person is and continues to be Hospital Confined or receiving treatment.

Such Extension of Benefits will continue for up to the earlier of:

1. 30 days; or
2. The date on which the Covered Person is no longer hospitalized or receiving treatment.

## PORTABILITY OPTION

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

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

## CLAIMS PROVISIONS

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

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

**Notice of Claim** - Written notice of claim must be given to us within 20 days after the occurrence or commencement of any loss covered by the Policy, 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.

**Payment of Claim Benefits** - Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to you. Accrued benefits that are not paid at your death will be paid to your Spouse, or if there is no Spouse, 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.

**Proof of Loss** - Satisfactory written Proof of Loss must be given to us at our Administrative Office. 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 that it was furnished as soon as it was reasonably possible. In any event, the proof required must be given no later than one year from the time of loss, unless the claimant was legally incapacitated.

**Time of Payment of Claims** – After receiving satisfactory written Proof of Loss, we will immediately pay all benefits then due under this Certificate.

## GENERAL PROVISIONS

**Assignment** - The Insured may assign benefits under this Certificate. We assume no responsibility for the validity or effect of any assignment of this Certificate or any interest in it.

**Change of Beneficiary** - Unless the Insured makes an irrevocable designation 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.

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

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

**Conformity with State Laws** – Should any provision of this Certificate conflict with a law of the governing jurisdiction, it is hereby amended to conform to the minimum requirements of that law.

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

**Grace Period** – A period of 31 days from the premium due date will be allowed for each premium payment after the first premium payment has been made. Coverage will stay in force during this time. The coverage under this Certificate will terminate at the end of the Grace Period if the premium has not been paid.

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

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

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

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

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

**Time Limit on Certain Defenses**

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

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

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



**Company which issued the Policy or Certificate (referred to as "Contract" herein)  
to which this form is attached:**

Transamerica Life Insurance Company - Home Office: Cedar Rapids, Iowa

Administrative Office: 2700 W Plano Pkwy, PO Box 869094, Plano, Texas 75086-9817

## ENDORSEMENT

This Endorsement is made part of the Contract to which it is attached, and is subject to all its provisions which are not in conflict with the provisions of this Endorsement. The Effective Date of this endorsement is the same as the Effective Date of the Contract to which it is attached or January 1, 2011, whichever is later.

Beginning on January 1, 2011, the definition of Child is hereby amended as follows:

- The limiting age for a Child is now increased to cover Children through age 25.
- Any restriction that requires a Child be unmarried is now removed.
- Any restriction that requires a Child be a full-time student is now removed.
- Any restriction that requires a Child be living with you is now removed, with the exception of grandchildren (where available).
- Any restriction that requires a Child be financially dependent on you is now removed, with the exception of grandchildren (where available).

In all other respects the provisions and conditions of the Contract remain the same.

Signed for the Company at our Home Office on its Effective Date by:

A handwritten signature in black ink, appearing to be a stylized "J" or "G" followed by a horizontal line.

General Counsel and Secretary

Accepted by: \_\_\_\_\_

Title: \_\_\_\_\_  
(e.g. Insured, Owner, Guardian, or Officer Position if signing for a Group Policyholder)

Date: \_\_\_\_\_





# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499

Administrative Office: 2700 W Plano Pkwy, PO Box 869094, Plano, Texas 75086-9817  
(Hereinafter called "the Company," "we," "us," or "our")

## ACCIDENT HOSPITAL AND ICU INCOME RIDER

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

### DEFINITIONS

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

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

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

ICU includes:

1. Intensive cardiac and coronary care units;
2. Neonatal intensive care units; and
3. Burn intensive care units, if such units meet the conditions of this definition.

The following care units do not qualify as an ICU:

1. Progressive Care Units;
2. Sub-acute Intensive Care Units;
3. Intermediate Care Units;
4. Step-Down Units;
5. Private rooms with monitoring; or
6. Any lesser care units.

### BENEFITS

The following benefits are payable per unit as shown below. The number of units selected by the Policyholder for this Rider is shown on the Schedule of Benefits.

**Accident Hospital Income Benefit** - While this Rider is in force, if a Covered Person requires Hospital Confinement for treatment of an Accident, we will pay \$10, per unit, per day, of Confinement. Confinement must start within 30 days of the Accident. We will pay this benefit up to 365 days per Accident.

**Accident ICU Benefit** - While a Covered Person is receiving the Accident Hospital Income Benefit, we will pay an additional \$30, per unit, for each day the Covered Person is Confined in an ICU. This ICU benefit is payable for up to 15 days per Accident.

### EFFECTIVE DATE

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

## TERMINATION

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

1. The date the contract terminates;
2. The date the Insured requests termination on any premium due date;
3. The date of the Insured's death; or
4. The expiration of the Grace Period for any premium in default.

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

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

A handwritten signature in black ink, consisting of a stylized 'G' followed by a horizontal line and a small flourish.

General Counsel and Secretary

A handwritten signature in black ink, featuring a large, stylized 'B' followed by a horizontal line and a small flourish.

President

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499

Administrative Office: 2700 W Plano Pkwy, PO Box 869094, Plano, Texas 75086-9817

(Hereinafter called "the Company," "we," "us," or "our")

## EXPANDED BENEFITS RIDER

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

### DEFINITIONS

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

**Coma** - A state of unconsciousness for 14 consecutive days due to an Accident with:

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

**Prosthetic Device** - An artificial device which is prescribed by a Physician, designed to replace a missing body part when the Covered Person loses a hand, foot, or an eye due to an Accident.

### BENEFITS

This Rider provides the following benefits once per Accident, per Covered Person, for Accidental Bodily Injury. The benefit amounts shown below are the amounts per unit. The number of units selected by the Policyholder for this Rider is shown on the contract's Schedule of Benefits.

#### A. Burns

#### Benefit Amount

Benefits are payable for Burns treated by a Physician within 96 hours after the Accident.

- |   |           |
|---|-----------|
| 1. Second-degree burns of at least 25% but not more than 35% of body surface        | \$ 60.00  |
| 2. Second-degree burns of more than 35% of body surface                             | \$ 150.00 |
| 3. Third-degree burns covering 6 through 10 square centimeters of the body surface  | \$ 150.00 |
| 4. Third-degree burns covering 10 through 25 square centimeters of the body surface | \$ 400.00 |
| 5. Third-degree burns covering 25 through 35 square centimeters of the body surface | \$ 900.00 |
| 6. Third-degree burns covering more than 35 square centimeters of the body surface  | \$1200.00 |

One or more skin grafts for a covered burn will be paid at 50% of the Burn benefit amount we paid for the Burn involved.

#### B. Lacerations

Benefits are payable for lacerations treated or repaired within 96 hours after the Accident.

- |  |          |
|--|----------|
| 1. Lacerations not requiring sutures           | \$ 4.00  |
| 2. Single laceration less than 7.5 centimeters | \$ 8.00  |
| 3. Lacerations 7.6 to 20 centimeters           | \$ 30.00 |
| 4. Lacerations over 20 centimeters             | \$ 60.00 |

#### C. Eye Injury

Benefits are payable for eye injury.

- |  |          |
|--|----------|
| 1. With surgical repair                                | \$ 40.00 |
| 2. Non-surgical removal of foreign body by a Physician | \$ 7.00  |

#### D. Emergency Dental Work

Benefits are payable for dental benefits for broken teeth.

- |   |          |
|---|----------|
| 1. One or more broken teeth repaired with crowns; and | \$ 30.00 |
| 2. One or more broken teeth resulting in extractions. | \$ 8.00  |

- E. Brain Concussion** \$ 20.00  
Benefits are payable for a concussion that is diagnosed by a Physician within 96 hours after the Accident.
- F. Coma** \$1,500.00  
Benefits are payable for a Coma.
- G. Paralysis**  
Benefits are payable for paralysis lasting a minimum of 30 days.
1. Quadriplegia (paralysis of four limbs) \$1,500.00
  2. Paraplegia (paralysis of lower limbs) \$ 750.00
- H. Tendons, Ligaments, and/or Rotator Cuffs**  
Benefits are payable for tendons, ligaments, and/or rotator cuffs that are detached, torn, ruptured, or severed. Surgical repair must be performed by a Physician within one year of the Accident. Only one of the following benefits is payable:
1. Arthroscopic surgery with no repair; \$ 20.00
  2. Repair of one; or \$ 50.00
  3. Repair of two or more. \$100.00
- I. Ruptured Discs and/or Torn Knee Cartilage**  
Benefits are payable for a disc in the spine that is ruptured and/or knee cartilage that is torn. Surgical repair must be performed by a Physician within one year of the Accident. Only one of the following benefits is payable:
1. Shaved cartilage (debridement) or arthroscopic surgery with no repair; \$ 20.00
  2. Repair of one; or \$ 50.00
  3. Repair of two or more. \$100.00
- J. Major Surgery** \$150.00  
Benefits are payable for an open abdominal, cranial, or thoracic surgery performed by a Physician within one year of the Accident. Laparoscopic procedures are excluded.
- K. Appliance** \$ 20.00  
Benefits are payable for a medical appliance recommended by a Physician as an aid in personal locomotion. Benefits include and are payable for such items as crutches, leg braces, wheelchairs, and walkers. This benefit is not payable for Prosthetic Devices.
- L. Prosthetic Devices**  
Benefits are payable for one or more Prosthetic Devices. The Prosthetic Device(s) must be received within one year of the Accident. This benefit is not payable for hearing aids, dental aids (including false teeth), eye glasses, or for cosmetic Prosthetic Devices such as hair wigs. We will not pay for joint replacement, such as an artificial hip or knee.
1. Benefit for one Prosthetic Device; or \$75.00
  2. Benefit for two or more Prosthetic Devices. \$150.00
- M. Blood, Plasma, and Platelets** \$40.00  
Benefits are payable for blood, plasma, and/or platelets required for the treatment of Accidental Bodily Injury. Immunoglobulins are not covered.
- N. Transportation** \$60.00  
Benefits are payable per round trip, up to 2 round trips to the Hospital per Accident, per Covered Person if special treatment and Hospital Confinement occurs within 30 days of an Accidental Bodily Injury. The local attending Physician must prescribe the treatment, and the treatment must not be available locally. This benefit is not payable for transportation to any Hospital located within a 100-mile radius of the site of the Accident or residence of the Covered Person.
- O. Family Lodging** \$15.00  
Benefits are payable per day, up to a maximum of 30 days per Accident, for one motel/hotel room for a member(s) of the Immediate Family to accompany the Covered Person if Hospital Confinement is within 30 days of an Accident for the treatment of Accidental Bodily Injury. Benefits are payable only for the same time period that the injured Covered Person is Hospital Confined in a facility 100 or more miles from the Covered Person's residence. The local attending Physician must prescribe the treatment. Benefits will not be paid for services rendered by an Immediate Family Member.

## EFFECTIVE DATE

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

## TERMINATION

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

1. The date the contract terminates;
2. The date the Insured requests termination on any premium due date;
3. The date of the Insured's death; or
4. The expiration of the Grace Period for any premium in default.

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

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



General Counsel and Secretary



President

# TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499

Administrative Office: 2700 W Plano Pkwy, PO Box 869094, Plano, Texas 75086-9817

(Hereinafter called "the Company," "we," "us," or "our")

## WELLNESS BENEFIT RIDER

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

### DEFINITION

**Waiting Period** - The number of days shown on the Schedule of Benefits from this Rider's Effective Date that no benefits are payable.

### BENEFITS

#### Wellness Benefit

After any Waiting Period shown on the contract's Schedule of Benefits, we will pay \$10 per unit, per Calendar Year, for one annual health screening benefit for the Insured, and one annual health screening benefit for the covered Spouse for routine examinations or other preventive testing. The number of units selected by the Policyholder for this Rider is shown on the Schedule of Benefits.

The annual health screening tests payable under this benefit are listed as follows:

#### Health Screening Tests:

Blood test for triglycerides

Bone marrow testing

Breast ultrasound

CA 125 (blood test for ovarian cancer)

CA 15-3 (blood test for breast cancer)

CEA (blood test for colon cancer)

Chest X-ray

Colonoscopy

Fasting blood glucose test

Flexible sigmoidoscopy

Hemocult stool analysis

Mammography

Pap test

PSA (blood test for prostate cancer)

Serum cholesterol test to determine HDL/LDL level

Serum Protein Electrophoresis (blood test for myeloma)

Stress test on a bicycle or treadmill

Thermography

Health screening tests must be performed under the supervision of or recommended by a Physician, and a charge must be incurred. Satisfactory proof of the charges incurred for the health screening tests must be submitted with each new claim.

### EFFECTIVE DATE

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

### TERMINATION

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

1. The date the contract terminates;
2. The date the Insured requests termination on any premium due date;
3. The date of the Insured's death; or
4. The expiration of the Grace Period for any premium in default.

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

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



General Counsel and Secretary



President

## **COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS**

Agents who sell and service our products are paid a commission. It varies by the type of insurance policy sold and the state where the policy was sold, and is based on a percentage of the premium received in the first year, and at policy renewal. Agents may receive advances or loans against anticipated commissions for cases sold or to be sold. These advances may or may not require the payment of interest, depending upon the agent's total business and historical experience with TEB.

Agents may receive other compensation from TEB in the form of cash or non-cash awards or prizes, based upon a variety of factors that may include the level of premium written or earned, persistency and growth of premium, or other performance measures. Agents who manage, supervise or recruit other agents or wholesale our products and services to other agents, may receive commission overrides on business that results from their efforts.

Some of our agents may receive additional payments for providing services in connection with the administration of our products. Fees for such services may be calculated on a per policy or per certificate basis or upon the premium volume associated with a specific case. TEB may additionally reimburse these agents/administrators for certain expenses, such as the cost of mailings.

Agents may occasionally obtain exclusive rights to market TEB products or services to agents, employers, employees or members of associations or unions. Certain groups or associations may also agree to endorse TEB's products to their members. TEB may pay a fee for these exclusive marketing rights or endorsements. See your proposed plan documents or policy certificate package for more information on any such arrangements.

For up to date information regarding our compensation practices, please consult our website at: [www.transamericaemployeebenefits.com](http://www.transamericaemployeebenefits.com).