TRANSAMERICA
LIFE INSURANCE COMPANY

Transamerica Life Insurance Company
Home Office: Cedar Rapids, Iowa 52499
Administrative Office: 6400 C Street SW
Cedar Rapids, IA 52499

# Supplemental Application for Long Term Care Rider (LTCR)

This is a supplement to the Application for Life Insurance for the proposed Insured. Please complete if LTC Rider is being elected.
The mode of payment for the LTC Rider must be the same mode of payment elected for the underlying policy, to which the rider is attached.
Premium Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly ☐ Other _____ ☐ PAC Direct Bill

☐ **New Application** ☐ **Reinstatement** (Check the applicable box.)

## Section 1 Proposed Insured and Owner Information

| | First Name | M.I. | Last Name | Date of Birth (MM/DD/YYYY) |
|---|---|---|---|---|
| Proposed Insured: | | | | |
| Owner: (if other than the proposed Insured) | | | | |

## Section 2 Protection Against Unintended Lapse

I, the Owner, understand that I have the right to designate at least one person, other than myself, to receive notice of lapse or termination of this long term care insurance rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. (Check the applicable box.)

☐ I designate the following person to receive notice prior to cancellation of my rider for nonpayment of premium (complete information below):

☐ I elect **NOT** to designate a person to receive this notice. I may change my election at a future date.

Signature Date

First Name M.I. Last Name

| Address (Cannot be a P.O.Box) | City | State | Zip Code |
|---|---|---|---|
| | | | |

## Section 3 Health Questions - In this section, "You" means the proposed Insured.

| | | |
|---|---|---|
| 1. During the last 12 months, have you ever: | | |
| a) required assistance or supervision of any kind to perform any every day activity, such as mobility (including the use of pronged canes), taking medications, dressing, eating, walking, bathing, transferring or toileting? | ☐ Yes | ☐ No |
| b) used a catheter, chair lift, crutches, dialysis, motorized scooter, oxygen equipment, quad or three-pronged cane, respirator, walker or wheelchair? | ☐ Yes | ☐ No |
| c) been advised to enter or resided in a nursing home, assisted living facility, long term care facility, CCRC (Continuing Care Retirement Community), or rehabilitation facility, or attended an adult day care facility, or required home health care? | ☐ Yes | ☐ No |
| 2. During the last 3 years, have you ever used insulin to treat Diabetes, or have you ever been diagnosed or treated for Diabetes WITH COMPLICATIONS (such as Neuropathy, Retinopathy, Nephropathy, Heart Disease, Stroke or Peripheral Vascular Disease)? | ☐ Yes | ☐ No |
| 3. Have you EVER been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following condition(s): | | |
| Alzheimer's disease or Dementia | ☐ Yes | ☐ No |
| Amputation due to disease | ☐ Yes | ☐ No |
| ALS (Lou Gehrig's disease) | ☐ Yes | ☐ No |
| Arthritis with narcotic pain medication | ☐ Yes | ☐ No |
| Multiple Strokes/CVA's/TIA's | ☐ Yes | ☐ No |
| Organ Transplant (other than Corneal) | ☐ Yes | ☐ No |
| Multiple Sclerosis | ☐ Yes | ☐ No |
| Huntington's Chorea | ☐ Yes | ☐ No |
| Muscular Dystrophy | ☐ Yes | ☐ No |
| Myasthenia Gravis | ☐ Yes | ☐ No |
| Organic Brain Syndrome | ☐ Yes | ☐ No |
| Osteoporosis with fractures | ☐ Yes | ☐ No |
| Parkinson's disease | ☐ Yes | ☐ No |
| Polymyositis | ☐ Yes | ☐ No |
| Scleroderma | ☐ Yes | ☐ No |
| Memory loss | ☐ Yes | ☐ No |
| Unplanned weight loss greater than 15 pounds within the last 2 years | ☐ Yes | ☐ No |
| 4. Do you have a direct family history (parents or siblings) of Huntington's Chorea or Polycystic Kidney Disease? | ☐ Yes | ☐ No |

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

5. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a member of the medical profession for any of the following conditions:

| | | |
|---|---|---|
| Disorientation | ☐ Yes | ☐ No |
| Used a Straight Cane | ☐ Yes | ☐ No |
| Chest pain | ☐ Yes | ☐ No |
| Transient Ischemic Attack (TIA) | ☐ Yes | ☐ No |
| Loss of Balance | ☐ Yes | ☐ No |
| Loss of Strength | ☐ Yes | ☐ No |
| Tremors | ☐ Yes | ☐ No |
| Dizziness | ☐ Yes | ☐ No |

6. Do you have a handicap sticker, handicap placard, or handicap license plate? (Give reason below.) ☐ Yes ☐ No

7. In the last 24 months, have you had to limit or been advised by a member of the medical profession to limit, reduce, discontinue or restrict any activities or hobbies? (Give reason below.) ☐ Yes ☐ No

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

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

8. Have you ever received any long term care benefits, disability income benefits or Social Security Disability benefits? If the answer is yes, provide details in Section 5, Remarks. ☐ Yes ☐ No

9. Within the past 5 years, have you ever been declined for long term care insurance including long term care insurance provided by rider to a life insurance or other policy? List company name, date and reason in Section 5, Remarks. ☐ Yes ☐ No

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

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

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

| Name and Address of Insurance Company | Policy/Certificate Number | Type and Amount of Benefits | Lapse Date | Currently In Force? Yes | Currently In Force? No | Being Replaced? Yes | Being Replaced? No |
|---|---|---|---|---|---|---|---|
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |
| | | | | ☐ | ☐ | ☐ | ☐ |

**Section 5 Remarks**

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

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

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

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

**Fraud Warning: Any life insurance producer, examining physician or other person who knowingly makes a false or fradulent statement or representation in or relative to an application for life or disability insurance, or who makes any such statement to obtain a fee, commission, money or benefit is guilty of a class 2 misdeanor.**

X _____ _____

Signature of proposed Insured | Date ( MM/DD/YYYY)

X _____ _____

Signature of Owner (if other than proposed Insured) | Date ( MM/DD/YYYY)

X _____ _____

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

**AGENT/INSURANCE PRODUCER'S REPORT**

## Insurance Producer's Report

1. Did you personally interview the proposed Insured, ask all the questions and witness the signatures? ☐ Yes ☐ No
2. Did you see or hear or were you advised of any physical impairment of the proposed Insured with regard to walking, speaking, any form of tremor or any signs of confusion or disorientation? ☐ Yes ☐ No
3. Did you review the current long term care, medical or health or disability insurance coverage of the proposed Insured and find that the coverage applied for is appropriate for the applicant's needs? ☐ Yes ☐ No
4. To the best of your knowledge, is the insurance applied for intended to replace any other long term care, medical or health or disability insurance coverage in force with this or any other company? ☐ Yes ☐ No
5. To the best of your knowledge, is the information provided in this application true and complete? ☐ Yes ☐ No
6. Does the proposed Insured live alone? ☐ Yes ☐ No

**LIST ANY OTHER HEALTH INSURANCE COVERAGE YOU HAVE SOLD ON THE PROPOSED INSURED**

(1) List policies or other coverage sold that are still in force; and

(2) List policies or other coverage sold within the last five (5) years that are no longer in force.

| Insurance Company | Policy/Certificate Number | Type and Amount of Benefits | In Force | Lapse Date |
|---|---|---|---|---|
| | | | ☐ Yes ☐ No | |
| | | | ☐ Yes ☐ No | |
| | | | ☐ Yes ☐ No | |

Licensed Agent/Insurance Producer: _____
Last First

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

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

TRANSAMERICA® LIFE INSURANCE COMPANY

**HOME OFFICE: CEDAR RAPIDS, IOWA**
**Long Term Care Division**
**PO Box 159**
**Cedar Rapids, IA 52406-0159**
**1-800-227-3740**
**LTCQuestions@Transamerica.com**

# NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND SICKNESS OR LONG-TERM CARE INSURANCE

## SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long-term care insurance and replace it with a long-term care insurance policy to be issued by Transamerica Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new policy carefully, comparing it with all accident and sickness or long-term care insurance coverage you now have, and terminate your present coverage only if, after due consideration, you find that purchase of this long-term care insurance policy is a wise decision.

## STATEMENT TO THE APPLICANT BY AGENT/INSURANCE PRODUCER, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement policy may not contain new preexisting conditions or probationary periods. The insurer will waive any time periods applicable to preexisting conditions or probationary periods in the new policy for similar benefits to the extent such time was spent under the original coverage.

3. If you are replacing existing long-term care insurance coverage, you may wish to secure the advice of your present insurer or its agent/insurance producer regarding the proposed replacement of your present coverage. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

4. If, after due consideration, you still wish to terminate your present coverage and replace it with this new policy, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

_____ _____

*Signature of Agent/Insurance Producer, Broker or Other Representative*

_____

*Type or print Name & Address of Agent/Insurance Producer, Broker or Other Representative*

_____ _____

Applicant's Signature

The "Notice to Applicant" was delivered to me on the above date

Transamerica Life Insurance Company
Home Office: Cedar Rapids, IA
Administrative Office:
6400 C Streeet SW
Cedar Rapids, IA 52499
1-800-TLC-HOST

**LONG TERM CARE INSURANCE**
**OUTLINE OF COVERAGE**
**Rider Form LTCR03 AZ**

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

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

1. The Long Term Care rider is attached to an individual life insurance policy.

2. **PURPOSE OF OUTLINE OF COVERAGE.** This outline of coverage provides a very brief description of the important features of the rider. You should compare this outline of coverage to outlines of coverage for other long term care riders or policies available to you. This is not an insurance contract, but only a summary of coverage. Only the underlying life insurance policy and rider contain governing contractual provisions. This means that the life insurance policy and rider set forth in detail the rights and obligations of you, the Insured (if other than yourself) and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR POLICY AND RIDER CAREFULLY!

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

4. **TERMS UNDER WHICH THE RIDER MAY BE CONTINUED IN FORCE OR DISCONTINUED.** (a) **Renewability** – THE RIDER IS GUARANTEED RENEWABLE. This means we may not, on our own, cancel or reduce the coverage it provides. Subject to the rider's termination provision, this rider will remain in force for as long as the policy remains in force and the required charges for this rider are paid. rider charges are subject to change, but we will not increase the rates above the maximum rates shown in the Policy Data. (b) **Waiver of Rider Charges** – While benefits under the rider are being paid, the Long Term Care rider charges will be waived. However, charges for the underlying policy and/or any other riders providing additional benefits will continue to be assessed.

5. **TERMS UNDER WHICH THE COMPANY MAY CHANGE RIDER CHARGES.** Rider charges are subject to change. They are based on the policy's amount at risk (as determined for purposes of the Monthly Cost of Insurance) and our table of Long Term Care rider rates then in effect. The table in effect at any time will generally contain rates that increase with the age of the Insured. We may change the table from time to time, but we cannot increase the rates beyond the maximum rates shown in the policy. We can only change the rider rate table if we

change it for everyone under this rider form who is in the same risk class. A risk class includes persons with the same benefits, issue age, and underwriting risk class at issue and whose Long Term Care riders have been in effect for the same length of time. We will give you at least 60 days advance written notice at your last address shown in our records before we change your rider rate table.

6. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED.** You have 30 days from the day you receive the rider to review it and return it to us if you decide not to keep it. You do not have to tell us why you are returning the rider. Within 30 days of when it is received, simply return it to us at our Administrative Office or to the Agent/Insurance Producer through whom it was purchased. We will refund the full amount of any rider charge deducted from the Policy Value, within 30 days after our receipt of the returned rider. The rider will be void as if it had never been issued. If you wish to cancel the rider without canceling the policy, you must return the policy and the rider to us so that we can send you back the policy without the rider.

7. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.** If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide available from the company. That booklet is called the "Guide to Health Insurance for People with Medicare." Neither Transamerica Life Insurance Company nor its Agents/Insurance Producers represent Medicare, the federal government or any state government.

8. **LONG TERM CARE COVERAGE.** Contracts of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital such as: (a) a Long Term Care Facility; (2) an Adult Day Care Center; (3) a Hospice Care Facility; or (4) the home.

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

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

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

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

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

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

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

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

   **Elimination Period.** The rider has an Elimination Period of 90 days. This means that we will not pay benefits under the rider for any period before the Insured has incurred expenses, on each of 90 separate days during which the rider is in effect, for Qualified Long Term Care Services that would

otherwise be covered under the rider. These days of care or services need not be continuous. The Elimination Period has to be satisfied only once while the rider is in effect. You must provide us with Proof of Loss in order to satisfy the Elimination Period.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11. **RELATIONSHIP OF COST OF CARE AND BENEFITS.** Because the costs of Long Term Care services will likely increase over time, you should consider whether and how the benefits of the rider should be used. The rider does not include inflation protection coverage. Increases and decreases to the policy's death benefit resulting from the exercise of your rights under that policy, including your right to make policy loans and withdrawals, will cause a change in the maximum Monthly Long Term Care Rider Benefit Amount as well as the policy's death benefit.

12. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS.** The rider provides coverage for these conditions as long as the Insured is certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in the rider. Covered illnesses include, but are not limited to, Alzheimer's Disease, Parkinson's Disease, senile dementia and related degenerative and dementia-based illnesses.

13. **LONG TERM CARE RIDER CHARGE.** The Guaranteed Maximum Monthly Charge Rates per $1000 of amount at risk are shown in the Policy Data.

14. **ADDITIONAL FEATURES.** Interaction of policy provisions and the rider:

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

    **Policy Face Amount Changes.** While this rider is In Force you may not request an increase in the policy's Face Amount. Transactions that increase or reduce the Face Amount of the policy will also result in a dollar-for-dollar change in the Long Term Care Specified Amount.

    **Loans and Withdrawals.** Loans and withdrawals will not be permitted while benefits are being paid under the rider.

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

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

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

**End of Eligibility.** If rider benefit payments cease because the Insured no longer qualifies for benefits under this rider, the following will apply:

1. If the policy's No Lapse Ending Date has not passed, the test to determine whether the No Lapse Guarantee is in effect will not require a Minimum No Lapse Premium for those months while we were paying benefits under this rider.
2. Any negative Policy Value will be reset to zero.
3. Policy transactions that were restricted while we were paying benefits under this rider will become unrestricted.

**Monthly Reporting.** We will provide a monthly report detailing payment of Long Term Care benefits; their effect on death benefits or cash value remaining for the underlying policy; and the amount of Long Term Care benefits remaining, following payment of Long Term Care benefits.

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

# HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices ("Notice") covers an Affiliated Covered Entity ("ACE"). When this Notice refers to the Transamerica ACE or "we", "our" or "us", it is referring to the health care components of the following affiliated entities; Transamerica Financial Life Insurance Company, and Transamerica Life Insurance Company. Each of the companies listed above is a hybrid covered entity under the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder (collectively, "HIPAA"). The combined companies listed are designated as a single covered entity for purposes of compliance with HIPAA and certain covered health care components of such companies. The single covered entity shall be known as the Transamerica Affiliated Covered Entity or the "Transamerica ACE." This designation may be amended from time-to-time to add new covered entities that are under common control and ownership to the Transamerica ACE.

The Transamerica ACE is required under HIPAA to protect the privacy of your protected health information ("PHI"), provide you with notice of our legal duties and privacy practices with respect to PHI and abide by the terms of the Notice currently in effect for the Transamerica ACE. This Notice describes how the Transamerica ACE may use and disclose your PHI and your rights to access and amend your PHI.

**This notice is effective September 23, 2013 as revised per the date set forth in the footer below, and provided to you in connection with your health plan from the Transamerica ACE. In some cases, this may include product riders purchased with a product that is not considered a health plan subject to HIPAA. Health plans include, but are not limited to: Dental, Long Term Care, Medicare Supplement, Prescription Drug Coverage, Supplemental Medical Expense, Medical Expense, and TRICARE.**

## Our Commitment to Your Privacy

We are committed to maintaining the privacy of your PHI. This notice will tell you about the ways in which we may use and disclose your PHI for payment, health care operations, and other circumstances as either required or permitted by law. Permitted uses and disclosures may include use and disclosure between the affiliates within the Transamerica ACE. **Except as outlined below, we will not use or disclose your PHI without your written authorization, which you may revoke as described in the "Your Privacy Rights" section below.** For example, use or disclosure of your PHI for marketing, certain uses or disclosures of psychotherapy notes, or any disclosure that would constitute a sale of your PHI, would require your authorization.

We are required by law to: safeguard your PHI; give you this Notice of our duties and privacy practices; notify you in the event of a breach of your unsecured PHI; and abide by the terms of the Notice of Privacy Practices currently in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this Notice, and to make the new notice effective for all PHI maintained by us. In the event of a material change, a revised notice will be sent to all of our policyholders who are enrolled in a health plan subject to HIPAA.

## USES AND DISCLOSURES OF YOUR PHI

1. **Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors, hospitals, long term care facilities, and other health care providers involved in your care.

2. **Payment**. We may use and disclose your PHI as necessary for benefit verification and claims processing purposes. For instance, we may use information regarding health care services you receive from service providers such as physicians, hospitals, pharmacies, nursing homes, assisted living facilities, and home health care agencies to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf. Examples of our payment related purposes also include our collection of premiums, coordinating reinsurance, and care coordination activities.

3. **Health Care Operations.** We will use and disclose your PHI as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance, auditing, rating, customer service, fraud prevention and reporting, payment of agent commissions, and other functions related to your health plan. With the exception of certain long-term care insurance, we are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. If our long-term care insurance underwriting uses genetic information, it will only be used in a manner allowed by law.

4. **Family and Friends Involved in Your Care.** We may disclose your PHI to certain family, friends, and others who are involved in your care or in the payment for your care based on your authorization or if we inform you and you do not object. We may also share your PHI to individuals or others based on your authorization. If you are unavailable, incapacitated, or facing an emergency medical situation, or if we have determined, based on our professional judgment and review of the circumstances, that you would not object and that a limited disclosure may be in your best interest, we may share limited PHI without your approval. If you have designated a person to help prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited PHI to a public or private entity that is authorized

to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.

5. **Business Associates**. Certain services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, claims investigation and adjudication, underwriting support services, care coordination services, etc. We may disclose your PHI to one or more of these outside persons or organizations that assist us with our operations. We obligate business associates to appropriately safeguard the privacy of your PHI.

6. **Collection of Information.** To properly underwrite, rate, and administer your health plan, we may collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization, we may also collect or verify information by contacting information sources such as: insurance support organizations (like Medical Information Bureau, Inc.); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.

7. **Agents.** Your agent is our business associate. For customer service purposes, your agent may be notified of certain coverage-related matters and information necessary to assist in servicing your coverage. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when there is a change in premium paying status, when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent may be notified on their commission statement that your policy remains in force for as long as you continue to pay your premium.

8. **Plan Sponsors.** We may also use or disclose PHI to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

9. **Health-Related Products, Benefits and Services.** We or our business associates may contact you regarding health-related benefits, products and services that may be of interest to you.

10. **Mergers and Acquisitions.** Your PHI may also be disclosed as a part of a potential sale, merger or acquisition involving our business.

**USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES**

1. Your PHI may be used or disclosed as applicable without your authorization in the following circumstances:
   - for any purpose when required by law;
   - for public health and/or law enforcement activities consistent with law, including if we suspect child abuse, elder abuse, or neglect or believe you to be a victim of abuse, neglect, domestic violence, or other crimes;
   - as required by law for a governmental oversight agency conducting audits, investigations (such as investigations in to consumer complaints), or civil or criminal proceedings;
   - in a judicial or administrative proceeding, as required by a court or an administrative ordered subpoena, or in response to a subpoena or discovery request;
   - as required by law for certain law enforcement purposes; about deceased persons to coroners, medical examiners, and funeral directors consistent with law;
   - if necessary for organ and tissue donation or transplant;
   - for research purposes as permitted by law;
   - upon reasonable belief to avert a serious threat to health or safety;
   - for specialized government functions (such as military personnel and inmates in correctional facilities);
   - for national security or intelligence activities;
   - to workers' compensation agencies as permitted or required by law;
   - to Non-affiliated organizations or persons as permitted by HIPAA, such as other insurance institutions, agents, insurance support organizations (such as Medical Information Bureau, Inc.), or law enforcement and governmental authority as necessary to prevent or investigate criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage;
   - to our parent company and affiliates in conjunction with health care operation purposes;
   - to the Department of Health and Human Services for HIPAA compliance purposes.

**<u>Your Privacy Rights</u>**

Your rights are explained below. ***Any written requests to exercise those rights should be directed to the address provided at the end of this notice.***

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your PHI for treatment, payment, or health care operations, or with certain persons involved in your care, by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, consistent with HIPAA we are not required to agree to the restriction, unless it is a restriction to a health plan for a specific treatment or service that you, or someone on your behalf, has paid for in full, out of pocket, the disclosure is for payment or health operations purposes, and the disclosure is not otherwise required by law.

   We retain the right to terminate an agreed upon restriction, other than a specific restriction as to payment or health care operations mentioned above, if we believe such termination is appropriate.

In the event of a termination by us, it will only apply to health information created or received after you have been notified of the termination. You also have the right to terminate a restriction, in writing. You may obtain a Request for Restriction form (or terminate a restriction) by contacting us at the phone number or address listed at the end of this notice.

2. **Confidential Communications.** You may request that we send communications of health information to you by alternative means or to alternative locations. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests. We must accommodate a reasonable request if you inform us that disclosure of some or all of your health information could endanger you. You may obtain a Request for Confidential Communication form by contacting us at the phone number or address listed at the end of this notice.

3. **Access.** You have a right to access certain PHI that we retain on your behalf. This means you may submit a written request, signed by you or your representative, to inspect or obtain a copy of your complete health record, or to direct us to disclose your PHI to a third party. If your health record is maintained electronically, you also have the right to request a copy in electronic format. We may charge a reasonable fee for copies, postage, labor and supplies. In certain cases, we may deny your request and you may have the right to appeal that decision. If we approve your request, we are required to provide you with access to your records within 30 days of your written request unless an extension is necessary. In such cases, we will notify you of the reason for the delay and the expected date when the request will be fulfilled. You may obtain a Request for Access form by contacting us at the phone number or address listed at the end of this notice.

4. **Amendment.** You have the right to request that PHI we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we will notify you and we will also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary or as identified by you. You may obtain a Request for Amendment form by contacting us at the phone number or address listed at the end of this notice.

5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your PHI within the six (6) calendar years immediately preceding such a request. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting us at the phone number or address listed at the end of this notice.

6. **Revocation of Authorization**. If you have signed an authorization for uses and disclosures of health information, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance on such authorization or the authorization was obtained as a condition of obtaining insurance coverage, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.

7. **Paper Copy of this Notice.** You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time by contacting us at the phone number or address listed below. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

**NOTE:** The rights granted to you do not extend to information about you relating to or in anticipation of a claim or civil or criminal proceeding.

**Complaints**

If you believe your privacy rights have been violated, you can file a complaint with us by sending your written complaint to our Consumer Affairs Department at the address given below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

**Contacting Us**

To file a complaint or to make a request as described in the section entitled "Your Privacy Rights," please send your written request to the company at: 6400 C St SW, Cedar Rapids, IA 52499. Requests should be directed to our Customer Service Department and Complaints should be sent to the attention of our Consumer Affairs Department. Please be sure to include the following information:

- Your full name
- Address
- Date of Birth
- Last four digits of your Social Security Number
- Policy number
- The nature of your request or complaint

**FOR FURTHER INFORMATION** regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy practices, please write to us at the address shown above or call 1-866-512-7495.

**THIS NOTICE IS REQUIRED BY FEDERAL LAW. WE MAKE IT AVAILABLE TO THE GENERAL PUBLIC, APPLICANTS AND POLICYHOLDERS. YOUR RECEIPT OF THIS NOTICE IS NOT EVIDENCE OF COVERAGE.**