



SOUTH DAKOTA DISCLOSURE PACKET

Helpful Hints: The Outline of Coverage, section 13 on page 14, should be completed.

The Conditional Receipt requires the applicant's signature on page 15. It requires your signature as well.

The Long Term Care Insurance Potential Rate Increase Disclosure Form, section 1 on page 17, should be completed.

LEAVE PACKAGE WITH APPLICANT

OUTLINE OF COVERAGE – Section 13 of the Outline of Coverage is the Premium section. Complete this section with the premium information requested. Total premium and a breakdown of premium for included benefits and optional riders are requested. The illustration may be used to complete the details requested as it shows the premium for each optional rider and also gives total premium. An annual mode is assumed.

CONDITIONAL RECEIPT – Please complete the conditional receipt. Be sure to indicate the sum of money enclosed with the application. Please note the applicant's **signature** and the **date** are required on this form. Your signature is required on it as well.

LONG TERM CARE INSURANCE POTENTIAL RATE INCREASE DISCLOSURE FORM – Section 1 of the Long Term Care Insurance Potential Rate Increase Disclosure Form should be completed with the premium information.

**TRANSAMERICA LIFE INSURANCE COMPANY
LONG TERM CARE ADMINISTRATIVE OFFICE
P.O. BOX 869090, PLANO, TEXAS 75086-9090
1-800-227-3740**

**LONG TERM CARE OUTLINE OF COVERAGE FOR
INDIVIDUAL POLICY FORM TLC 2-P SD 0410
RETAIN THIS OUTLINE FOR YOUR RECORDS**

(“We,” “Us,” or “Our” means the Company. “You” or “Your” means the Insured.)

NOTICE TO BUYER: The Policy may not cover all of the costs associated with long term care incurred during the period of coverage. The buyer is advised to review carefully all Policy limitations.

CAUTION

The issuance of this long term care insurance coverage is based upon the answers to the questions on the application. A copy of the application will be included in Your Policy. If any answers are incorrect or untrue, We may have the right to deny benefits or rescind the Policy. The best time to clear up any question is now, before a claim arises! If, for any reason, any of the answers are incorrect or untrue, contact Us at Our Administrative Office: Transamerica Life Insurance Company, P.O. Box 869090, Plano, Texas 75086-9090. Our toll-free number is shown above.

1. POLICY DESIGNATION

The Policy is an individual policy of insurance.

2. PURPOSE OF OUTLINE OF COVERAGE

This Outline of Coverage provides a very brief description of the important features of the Policy. You should compare this Outline of Coverage to Outlines of Coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY.

3. FEDERAL TAX CONSEQUENCES

The Policy 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.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

RENEWABILITY: THE POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of Your Policy, to continue the Policy as long as You pay Your premiums on time. Transamerica Life Insurance Company cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium Benefit: We will automatically change Your Premium Paying Mode to monthly. We will not require the payment of Your monthly premium when You qualify for the Waiver of Premium Benefit.

To qualify for the Waiver of Premium Benefit, You must:

- (1) meet the requirements in the Eligibility for the Payment of Benefits provision;
- (2) satisfy the Elimination Period, if it applies to the benefits You are receiving; and
- (3) be confined as an overnight bed patient and receiving either: (a) the Long Term Care Facility Benefit or
(b) the Accident Benefit, if the Accident Benefit Endorsement is attached to Your Policy; or
- (4) be receiving the Hospice Care Benefit.

We will stop waiving the premium when You no longer qualify for the Waiver of Premium Benefit.

Termination: The Policy will end on the earliest of the following:

- (1) the date the Policy Lapses;
- (2) the date of Your death;
- (3) the date the Policy Maximum Amount has been exhausted; or

(4) Our receipt of Your written request to cancel the Policy. If You do not specify a date to cancel the Policy, it will end on the next Policy monthly anniversary following Our receipt of the request. If You name a date, it will end on Your requested future cancellation date.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS

Right to Change Rates: We can change Your premiums based on Your premium class, subject to approval by the Department of Insurance, if such approval is required under state regulations. Any change in premium may occur only after the Rate Guarantee has expired. Any change in premium can occur only during the Premium Paying Period shown on the Schedule. We must give You at least 60 days written notice before We change Your premiums. Your premiums will not increase due to a change in Your age or health.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

You have 30 days from the day You receive the Policy 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 Policy. Within 30 days of when You receive it, 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 premium paid within 30 days after Our receipt of the returned Policy. The Policy will be void as if it had never been issued.

If the Policy terminates due to Your death, We will refund the portion of the modal premium paid for the period after the monthly anniversary following Your death up to the next Premium Due Date.

If We receive a written request from You to cancel Your Policy, We will refund any premiums paid for the period after Your cancellation.

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

Policies of this category are designed to provide coverage for one or more necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance or personal care services provided in a setting other than an acute care unit of a hospital, such as: (1) in a long term care facility; (2) in the community; or (3) in Your Home.

The Policy provides coverage for Out of Pocket Expenses for Qualified Long Term Care Services. Coverage is subject to policy limitations, an elimination period and other requirements.

9. BENEFITS PROVIDED BY THE POLICY

BENEFIT DESCRIPTIONS

This Outline of Coverage gives a brief description of the benefits available for purchase under the Policy. You and Your agent/insurance producer must decide which options are best suited to Your personal needs and finances. Your application and the actual policy issued to You will determine Your insurance coverage. The benefits You select and their maximums will be shown on Your application and on the Schedule of Your Policy.

In order for benefits to be payable under the Policy:

- (1) You must satisfy the Eligibility for the Payment of Benefits provision;
- (2) all Qualified Long-Term Care Services must begin while Your coverage is in force;
- (3) all charges must be incurred for services rendered or goods provided while the applicable benefit is in force;
- (4) You must satisfy the Elimination Period if it applies to the benefits You are receiving;
- (5) all care and services must be in accordance with accepted medical and nursing standards of practice; and
- (6) all care and services must be consistent with Your current Plan of Care. You must provide Us with both an acceptable Plan of Care and Proof of Loss documentation.

If more than one type of covered care or service is received on the same day, only the daily benefit providing the largest payment will be payable, unless otherwise stated in a benefit section.

Please Note: To be eligible for payment under the Policy, it is not enough for services simply to be Qualified Long Term Care Services. These services must also:

- (1) be services that are otherwise eligible to be paid under the Policy; and
- (2) satisfy all other requirements of the Policy.

ELIGIBILITY FOR THE PAYMENT OF BENEFITS

To be eligible for any benefits provided under the Policy and any rider(s) or endorsement(s) attached, We must receive a Plan of Care that specifies what Qualified Long Term Care Services are needed. The Services must be needed because You have been certified within the last 12 months by a Licensed Health Care Practitioner as:

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

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

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

Severe Cognitive Impairment (including the term “Severely Cognitively Impaired”)

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 Your:

- (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 shall include utilizing cognitive tests with resulting scores consistent with a diagnosis of Severe Cognitive Impairment.

BENEFITS

CASH BENEFIT

We will pay You the Monthly Cash Benefit shown on the Schedule, subject to:

- (1) satisfaction of the Eligibility for the Payment of Benefits provision;
- (2) Our receipt of a Plan of Care; and
- (3) the Policy Maximum Amount.

We will pay You for each Calendar Month You continue to meet those requirements. We will pay this benefit instead of all other benefits under the Policy, except for the Optional Care Coordination Benefit.

We must receive a Plan of Care at least once each 90 days. Bills to show Out of Pocket Expenses are not required for this benefit to be payable. If You meet the Eligibility for the Payment of Benefits requirements and We receive a Plan of Care for only part of a Calendar Month, We will prorate the Monthly Cash Benefit payment.

Payment of this benefit will end when You no longer meet the requirements in the Eligibility for the Payment of Benefits provision. We will stop paying this benefit if We do not receive a Plan of Care as required. We will also stop paying this benefit when You choose to receive other benefits for care and services that are covered under the Policy. Simply call or write to tell Us that You want to switch to other benefits payable under the Policy and We will let You know what You need to do.

If You are confined as an overnight bed patient in a facility and are receiving the Cash Benefit, those days of confinement while receiving the Cash Benefit cannot be applied toward satisfaction of the Elimination Period. The Cash Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period. This benefit does not entitle You to a waiver of premium.

HOME CARE AND ADULT DAY CARE BENEFIT

We will pay You for the Out of Pocket Expenses for each day You receive Home Care Services, Home Health Care Services, or Adult Day Care. Payment is subject to:

- (1) satisfaction of the Eligibility for the Payment of Benefits provision;
- (2) the Home Care and Adult Day Care Maximum Daily Benefit;
- (3) the Policy Maximum Amount; and
- (4) the Elimination Period, if Your Schedule indicates that it applies to this benefit.

Home Care Services or Home Health Care Services must be provided by or through a Home Care Agency in Your Home under a Plan of Care. Adult Day Care must be received for at least 4 hours during any day for which benefits are payable. Adult Day Care must be provided by and at an Adult Day Care Center. Home Care Services, Home Health Care Services and/or Adult Day Care will not be payable on any day that You are confined as an inpatient in a hospital or Long Term Care Facility.

OPTIONAL CARE COORDINATION BENEFIT

We will pay for the Care Coordinator to facilitate an assessment of Your care needs and the development of a Plan of Care. This is in addition to any other benefits paid under the Policy. We will pay for the Care Coordinator to provide Care Coordination services as long as You are certified as meeting the requirements in the Eligibility for the Payment of Benefits provision.

While working with You, Your family, and Your Physician, the Care Coordinator will help to establish an individualized Plan of Care. Upon Your request, the Care Coordinator will provide You with a list of care providers and services in Your area for You to consider. Neither the Care Coordinator nor We will suggest or recommend providers or guarantee the quality of care by any of the providers or services listed. However, it will be a starting point for You to use when seeking care providers. If You desire, the Care Coordinator will assist You in obtaining the services recommended in the Plan of Care. This assistance will be limited to referring You to providers and help in coordinating such referrals.

In order to obtain a Care Coordinator, You will need to contact Us at the Claims Department's toll-free number shown on the Schedule. There is no charge to You for the covered services of a Care Coordinator. No amount will be subtracted from the Policy Maximum Amount.

REMAIN AT HOME BENEFIT

If You are receiving the Optional Care Coordination Benefit, this benefit is available. The Care Coordinator must approve the provider selected by You, as well as the labor, equipment and/or supplies in advance.

While You are living in Your Home, the Remain At Home Benefit can be used to pay for the following Qualified Long Term Care Services: (1) Home Modification; (2) Caregiver Training for a Volunteer Caregiver; (3) Therapeutic Device or Technology; and (4) Medical Alert System.

We will pay You for the Out of Pocket Expenses for care or services You receive under the Remain At Home Benefit. Payment is subject to: (1) satisfaction of the Eligibility for the Payment of Benefits provision; (2) the Remain At Home Maximum Benefit; and (3) the Policy Maximum Amount.

The care or services provided under the Remain At Home Benefit must be consistent with Your care needs. They also must be provided according to a Plan of Care approved by the Care Coordinator. The Remain At Home Benefit is available even if You are receiving the Home Care and Adult Day Care Benefit at the same time. The Remain At Home Benefit is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

RESPITE CARE BENEFIT

If You are being cared for by Your Volunteer Caregiver on a continuous basis, We will pay You for the Out of Pocket Expenses for Respite Care. Payment is subject to:

- (1) satisfaction of the Eligibility for the Payment of Benefits provision;
- (2) the Respite Care Maximum Daily Benefit;
- (3) the Policy Maximum Amount; and
- (4) Respite Care must be provided in a Long Term Care Facility or in Your Home.

Benefits for Respite Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period. Benefits for Respite Care are available for up to the Number of Days Per Calendar Year shown on the Schedule.

LONG TERM CARE FACILITY BENEFIT

We will pay You for the Out of Pocket Expenses for each day You are confined as an overnight bed patient in a Long Term Care Facility. This includes room and board and Qualified Long Term Care Services. We will not pay more than the charge for a one-bedroom unit. Payment is subject to:

- (1) satisfaction of the Eligibility for the Payment of Benefits provision;
- (2) the Elimination Period;
- (3) the Long Term Care Facility Maximum Daily Benefit;
- (4) the Policy Maximum Amount; and
- (5) care and services must be provided while confined as an overnight bed patient in a Long Term Care Facility as defined in the Policy.

EXTENSION OF THE LONG TERM CARE FACILITY BENEFIT

If Your Policy Lapses while You are receiving the Long Term Care Facility Benefit, benefits will be continued until the earliest of the following: (1) You no longer qualify for benefits; (2) You are discharged from the Long Term Care Facility; (3) You exhaust the Policy Maximum Amount of the Policy; or (4) You die. No other Policy benefits or benefits added by rider or endorsement to the Policy will be continued under this benefit.

LONG TERM CARE FACILITY BED RESERVATION BENEFIT

When You are absent for any reason (except discharge) during a Long Term Care Facility confinement, We will pay You for the Out of Pocket Expenses while the room in the Long Term Care Facility is being reserved. We will pay You for each day of Your absence, up to the Long Term Care Facility Maximum Daily Benefit. You must have satisfied the Elimination Period before the Bed Reservation Benefit is available. The Bed Reservation Benefit is available for up to the Number of Days Per Calendar Year shown on the Schedule. It is subject to satisfaction of the Eligibility for the Payment of Benefits provision and the Policy Maximum Amount.

GLOBAL COVERAGE BENEFIT

If You are outside of the fifty (50) United States and the District of Columbia, or Canada, We will pay You for the Out of Pocket Expenses for care or services that otherwise would be covered under the Policy. Payment is subject to:

- (1) the Elimination Period;
- (2) the Global Coverage Maximum Daily Benefit;
- (3) the Global Monthly Cash Benefit, if You are receiving the Cash Benefit under Global Coverage;

- (4) the Global Coverage Maximum Benefit Amount; and
- (5) the Policy Maximum Amount.

If You receive the Cash Benefit under Global Coverage, it is not subject to, nor will it be applied toward the satisfaction of, the Elimination Period.

Benefits that are available under this Global Coverage Benefit are limited to: (1) the Long Term Care Facility Benefit; (2) the Home Care and Adult Day Care Benefit; (3) the Cash Benefit; and (4) the Hospice Care Benefit. All of the terms of the Policy apply to this benefit. The Global Coverage Benefit will pay benefits in lieu of all other benefits under the Policy. Premiums will not be waived while You are receiving the Global Coverage Benefit.

The following requirements must be satisfied:

- (1) You must provide Us with a written certification that is acceptable to Us that You meet the requirements of the Eligibility for the Payment of Benefits provision; and
- (2) You must provide Us with written proof that is acceptable to Us that You meet the requirements of the Conditions section; and
- (3) You must provide Us with written proof that is acceptable to Us that You have satisfied the Elimination Period; and
- (4) You must provide Us with a current written Plan of Care. You must also provide Us with any updates to it; and
- (5) You must provide Us with properly completed claim forms; and
- (6) You must provide Us with proof that is acceptable to Us that You are receiving covered care or services. This means that all care and services must be Qualified Long Term Care Services according to the Policy. No proof of receipt of services is required for the Cash Benefit to be payable under Global Coverage; and
- (7) You must provide Us with a copy of proof acceptable to Us that You are outside of the fifty (50) United States and the District of Columbia, or Canada; and
- (8) all documentation must be provided to Us in English at Your own expense.

If You have a restoration of benefits provision or rider attached to Your Policy, no benefits paid under the Global Coverage Benefit will be restored under that rider.

HOSPICE CARE BENEFIT

We will pay You for the Out of Pocket Expenses for each day You receive Hospice Care. Payment is subject to:

- (1) satisfaction of the Eligibility for the Payment of Benefits provision;
- (2) a certification that You are Terminally Ill;
- (3) the Hospice Care Maximum Daily Benefit;
- (4) the Policy Maximum Amount; and
- (5) Hospice Care must be provided by a Hospice Care Provider.

Benefits for Hospice Care are not subject to, nor will they be applied toward the satisfaction of, the Elimination Period. We will not pay for more than 180 days of Hospice Care. Benefits for Hospice Care will not be payable when other benefits are payable under the Policy except for: the Optional Care Coordination Benefit; and the Global Coverage Benefit.

ALTERNATE PLAN OF CARE BENEFIT

Your Policy provides coverage for a wide range of long term care services. Because there may be new and evolving long term care services that We cannot anticipate at the time Your Policy was issued, the Alternate Plan of Care Benefit gives Us the discretion to consider whether We may want to cover alternate Qualified Long Term Care Services not otherwise expressly covered by the Policy.

We will consider paying benefits to You based on the Out of Pocket Expenses You incur for services requested under an Alternate Plan of Care only if:

- (1) You are currently receiving benefits under the Policy; and
- (2) You request in writing, prior to receipt of such alternative services, that We consider payment for services not identified in the Policy; and
- (3) We determine that You satisfy and continue to satisfy the requirements under the Eligibility for the Payment of Benefits provision of the Policy; and
- (4) the cost of services under the Alternate Plan of Care You request is less expensive than the amount We would otherwise pay for Qualified Long Term Care Services; and
 - the services are clearly specified in Your Plan of Care; and
 - the Alternate Plan of Care Benefit amount is agreed to in a written Alternate Plan of Care agreement that is signed by You and Us.

We have the absolute discretion to determine the amount, if any, We are willing to pay toward the cost of such services. Any benefits paid under this provision will reduce Your Policy Maximum Amount. We will not pay this benefit until Your Elimination Period has been satisfied.

ACCIDENT BENEFIT ENDORSEMENT – Only issued if You are younger than age 67 at the time You purchase the Policy

We will pay You for the Out of Pocket Expenses for Qualified Long Term Care Services needed as a result of an Injury. We will pay up to two times the Maximum Daily Benefit shown on the Schedule. The following conditions must be met:

- (1) Your Injury must occur after the Effective Date of Your Policy;
- (2) Your Injury must occur before Your 67th birthday; and
- (3) prior to this Injury, You were not eligible for the payment of any benefits under the Policy.

All of the requirements of the Policy must be met. You must become eligible for benefits due to this Injury. A Licensed Health Care Practitioner must certify that You are a Chronically Ill Individual as a result of this Injury. This must take place within 90 days of the date of this Injury. You must satisfy the Elimination Period, if it applies to the type of benefits You are receiving.

All of the benefits of the Policy are available to You through the Accident Benefit except for: the Cash Benefit; the Global Coverage Benefit; the Remain At Home Benefit; and the Extension of the Long Term Care Facility Benefit. We will not pay more than Your Out of Pocket Expenses for covered care and services. Even though We will pay up to two times the Maximum Daily Benefit, We will not subtract more than one times the Maximum Daily Benefit from Your Policy Maximum Amount.

If You are age 67 or older at the time of an Injury, this benefit will not be available to You. Any benefits being paid under this Endorsement will end on Your 67th birthday.

CONTINGENT NONFORFEITURE BENEFIT ENDORSEMENT – Only issued if You choose a Lifetime Premium Paying Period

After the expiration of the rate guarantee:

- if We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or greater than the percentage of Your initial annual premium in the chart below; and
- You are unable to afford the increased premium; then

You may choose one of the two Options below. No underwriting is required. We will give You at least 60 days written notice prior to the due date of the premium rate increase.

| Issue Age | % Increase Over Initial Annual Premium | Issue Age | % Increase Over Initial Annual Premium |
|-----------|---|-------------|---|
| | 29 and under | | 36% |
| 30 - 34 | 190% | 73 | 34% |
| 35 - 39 | 170% | 74 | 32% |
| 40 - 44 | 150% | 75 | 30% |
| 45 - 49 | 130% | 76 | 28% |
| 50 - 54 | 110% | 77 | 26% |
| 55 - 59 | 90% | 78 | 24% |
| 60 | 70% | 79 | 22% |
| 61 | 66% | 80 | 20% |
| 62 | 62% | 81 | 19% |
| 63 | 58% | 82 | 18% |
| 64 | 54% | 83 | 17% |
| 65 | 50% | 84 | 16% |
| 66 | 48% | 85 | 15% |
| 67 | 46% | 86 | 14% |
| 68 | 44% | 87 | 13% |
| 69 | 42% | 88 | 12% |
| 70 | 40% | 89 | 11% |
| 71 | 38% | 90 and over | 10% |

Options

We will notify You that You may elect to:

- (1) reduce Your current Policy benefits so that the required premium payments are not increased. You may not reduce Your benefits to less than an amount that is currently available; or
- (2) change Your coverage to a shortened benefit period. You have 120 days after the due date for the rate increase to choose this option. If Your Policy Lapses during this 120-day period, the shortened benefit period will automatically take effect.

The daily benefit amounts available will be the same amounts in effect at the time the coverage would have Lapsed. The maximum benefit amount in force will be equal to all of the premium paid for all coverage combined. This amount will exclude any waived premiums. The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. All optional coverage, including any riders, will end when Your coverage is continued under this Endorsement. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

RETURN OF PREMIUM TO AGE 67 ENDORSEMENT

Subject to any provision to the contrary, if this Endorsement has been continuously in force, a benefit will be paid if You die when You are younger than age 67. No benefit will be paid if You are 67 or older.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid pursuant to the terms of the Policy, from the Effective Date of the Policy up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest. Payment of the benefit will be made in one lump sum to Your beneficiary. Your beneficiary will be the person listed in Your application unless later changed by You.

OPTIONAL RIDERS – Additional Premium Required

NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER

This Rider provides for the Policy to continue on a limited basis if it would have otherwise Lapsed because You stopped paying premiums. Your Policy must have been in effect for at least 3 full years before this Rider will pay benefits. The daily benefit amounts available will be the same amounts in effect at the time the coverage would have Lapsed. The total benefit amount in force will be equal to all of the premium paid for all coverage combined, including this Rider. This amount will exclude any waived premiums. The minimum Policy Maximum Amount will be equal to 30 times the Long Term Care Facility Maximum Daily Benefit at the time the coverage would have Lapsed. All optional coverage, including any other riders, will end when Your coverage is continued under this Rider. If a Benefit Increase Option Rider of any kind was in force at the time Your coverage would have Lapsed, the benefits will NOT continue to increase.

SHARED CARE BENEFIT RIDER

If Your Spouse/Partner exhausts the Policy Maximum Amount under his/her own Transamerica Life Insurance Company policy, We will continue Your Spouse/Partner's coverage under Your Policy. Your Spouse/Partner's coverage is subject to all of the terms and the Policy Maximum Amount of Your Policy as long as You keep Your Policy and this Rider in force.

This will allow Your Spouse/Partner to access benefits under Your Policy if:

- (1) You and Your Spouse/Partner both purchase and maintain identical Long Term Care Insurance Policies issued by Transamerica Life Insurance Company; and
- (2) You and Your Spouse/Partner both have identical Shared Care Benefit Riders attached to Your Policies; and
- (3) the Policy Maximum Amount of Your Spouse/Partner's own Transamerica Life Insurance Company policy has been exhausted; and
- (4) Your Policy has at least some of its Policy Maximum Amount still available; and
- (5) We receive a signed consent form from You allowing Your Spouse/Partner to receive benefits under Your Policy Maximum Amount.

In order for Your Spouse/Partner to access benefits under Your Policy:

- (1) Your Spouse/Partner must have already exhausted the Policy Maximum Amount under his/her own policy; and
- (2) Your Policy must have at least some of its Policy Maximum Amount still available; and
- (3) Your Spouse/Partner must have already satisfied the Elimination Period under his/her own policy, if the benefits used under his/her policy were subject to the Elimination Period; **or**
- (4) Your Spouse/Partner must satisfy the Elimination Period under Your Policy, if the benefits he/she receives are subject to the Elimination Period.

You and Your Spouse/Partner both may receive benefits under Your Policy at the same time. We will not pay benefits that exceed the Policy Maximum Amount of both policies combined.

The Waiver of Premium Benefit contained in Your Policy or in any Rider attached to it will only apply if You are receiving benefits under Your Policy. We will not waive Your Policy's premiums because Your Spouse/Partner is receiving benefits under Your Policy.

The Full Restoration of Benefits Rider, if it is attached to Your Policy, only applies to benefits that You have used under Your Policy. No benefits used by Your Spouse/Partner will be restored under Your Policy.

The Global Coverage Benefit contained in Your Policy is only available to You. Your Spouse/Partner cannot receive the Global Coverage Benefit under Your Policy.

If Your Spouse/Partner dies while this Rider is in effect, We will increase Your Policy Maximum Amount by the amount of the remaining Policy Maximum Amount under Your deceased Spouse/Partner's policy, if any.

MONTHLY BENEFIT RIDER

Long Term Care Facility Maximum Monthly Benefit

Instead of paying the Long Term Care Facility Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Long Term Care Facility confinement based on services received during each Calendar Month. This means that the daily limit for the benefits listed no longer applies. Instead, benefits are paid based on the total services received during the month.

The Maximum Monthly Benefit can also be used for: Bed Reservation; Respite Care; or Hospice Care. You must be confined in a Long Term Care Facility (or in a Hospice Care Facility, in the case of Hospice Care).

The maximum benefit payable during each Calendar Month will be the Long Term Care Facility Maximum Daily Benefit shown on the Schedule times the actual number of days in the month. If You meet the requirements for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

Home Care Maximum Monthly Benefit

Instead of paying the Home Care and Adult Day Care Benefit on a daily basis, We will pay You for the Out of Pocket Expenses for Home Care Services, Home Health Care Services and Adult Day Care based on services received during each Calendar Month. This means that the daily limit for these benefits no longer applies. Instead, benefits are paid based on the total services received during the month. This may allow You to receive multiple services on the same day that would otherwise exceed Your Home Care and Adult Day Care Maximum Daily Benefit. The Maximum Monthly Benefit can also be used for Respite Care or Hospice Care received in Your Home.

The maximum benefit payable during each Calendar Month will be the Home Care and Adult Day Care Maximum Daily Benefit shown on the Schedule times the actual number of days in the month. If You meet the requirements for only part of a Calendar Month, We will prorate the Maximum Monthly Benefit. In no case will the Maximum Monthly Benefit exceed Your Out of Pocket Expenses for the Calendar Month.

FULL RESTORATION OF BENEFITS RIDER

When We have paid claims under the Policy, those Policy benefits can be restored under this Rider. We will restore the Policy Maximum Amount to the amount that it would have been if no benefits had been paid under the Policy. We will restore the Remain At Home Maximum Benefit in the same way. The Global Coverage Benefit will not be restored. The Policy Maximum Amount will be restored only one time during the life of the Policy. We will restore the Remain At Home Maximum Benefit one time during the life of the Policy as well. If You have completely exhausted Your benefits under the Policy, this Rider will not apply.

Requirements For Full Restoration of Benefits

- (1) You must not meet the definition of a Chronically Ill Individual for 180 consecutive days.
- (2) You may not receive any Qualified Long Term Care Services during that time.
- (3) You must notify Us that a Licensed Health Care Practitioner has certified that You are no longer a Chronically Ill Individual.
- (4) You must file that certification with Us.

The 180 consecutive day period begins when Your condition is verified by Us through an Assessment of Your Condition. We will not accept a back-dated certification. The Policy and this Rider must remain in force during this period.

WAIVER OF PREMIUM RIDER – HOME CARE AND ADULT DAY CARE

We will automatically change Your Premium Paying Mode to monthly and We will not require the payment of Your monthly premium when You qualify for this benefit.

To qualify for this Waiver of Premium Benefit, You must:

- (1) meet the requirements in the Eligibility for the Payment of Benefits provision;
- (2) satisfy the Elimination Period, if it applies to the type of benefits You are receiving; and
- (3) be receiving the Home Care and Adult Day Care Benefit; or

(4) be receiving Home Care Services, Home Health Care Services or Adult Day Care Services under the Accident Benefit Endorsement, if it is attached to Your Policy.

We will stop waiving the premium when You no longer qualify for this Waiver of Premium Benefit. We will stop waiving the premium on the date the Policy Maximum Amount has been exhausted. This Waiver of Premium does not apply if You are receiving the Global Coverage Benefit.

WAIVER OF PREMIUM RIDER – CASH BENEFIT

We will automatically change Your Premium Paying Mode to monthly and We will not require the payment of Your monthly premium when You qualify for this benefit.

To qualify for this Waiver of Premium Benefit, You must:

- (1) meet the requirements in the Eligibility for the Payment of Benefits provision; and
- (2) be receiving the Cash Benefit.

We will stop waiving the premium when You no longer qualify for this Waiver of Premium Benefit. We will stop waiving the premium on the date the Policy Maximum Amount has been exhausted. This Waiver of Premium does not apply if You are receiving the Global Coverage Benefit.

JOINT WAIVER OF PREMIUM RIDER

We will waive all premiums for Your Policy for the same months that We are waiving the premiums for Your Spouse/Partner's policy under the Waiver of Premium Benefit. We will stop waiving the premiums for Your Policy under this Rider when We are no longer waiving the premiums for Your Spouse/Partner's policy.

Eligibility for Joint Waiver of Premium: This benefit is only available if:

- (1) both You and Your Spouse/Partner have identical individual long term care policies in force with Us under the same policy form series which includes the Joint Waiver of Premium Rider; and
- (2) Your Spouse/Partner qualifies for and receives the Waiver of Premium Benefit under the same policy form series.

RETURN OF PREMIUM UPON DEATH RIDER

Subject to any provision to the contrary, if this Rider has been continuously in force from its Effective Date, a benefit will be paid after You die. We will also pay this benefit if the Policy has been continuously in force, then it lapses and Your death occurs within 90 days of the date the last premium payment was due.

The amount of this benefit will be the sum of all premiums paid less the amount of any benefits paid under the Policy, from the Effective Date of this Rider up to the date of Your death. The sum of all premiums paid will exclude any waived premiums and will be accumulated without interest.

The benefit payment will be made in one lump sum to Your beneficiary. If You have another return of premium provision in force at the time of Your death, We will only pay the return of premium under this Rider. We will not make return of premium payments under both provisions.

10. GENERAL EXCLUSIONS AND LIMITATIONS

The Policy and any rider(s) or endorsement(s) attached to it will not pay benefits when You are eligible for confinement, care or services:

- (1) for treatment of alcoholism or drug abuse;
- (2) resulting from or arising out of attempted suicide or intentionally self-inflicted injury;
- (3) due to participation in a felony, riot or insurrection;
- (4) for which no charge is normally made in the absence of insurance;
- (5) received outside the fifty (50) United States and the District of Columbia, or Canada; or
- (6) performed by a member of Your Immediate Family. Your Immediate Family member 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 member must receive no compensation other than the normal compensation for employees in his or her job category.

We will not pay for any confinement, care or service that is not included in Your Plan of Care. We will not pay for anything that is prohibited by state or federal law, including any law governing economic and trade sanctions.

The exclusion regarding a member of Your Immediate Family will not apply to the Cash Benefit. This exclusion also will not apply to the Cash Benefit if received under the Global Coverage Benefit.

The exclusion regarding confinement, care or services received outside the fifty (50) United States and District of Columbia, or Canada will not apply to the Global Coverage Benefit.

NONDUPLICATION OF COVERAGE

The Policy and any rider(s) or endorsement(s) attached to it will not pay benefits when confinement, care or services are:

- (1) provided in a government facility (unless otherwise required by law);
- (2) paid 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 under any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law;

except to the extent that Your Out of Pocket Expenses 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.

OTHER INSURANCE WITH US

We may reduce benefits payable under the Policy for long term care confinement, care and services if We also pay benefits for such confinement, care and services under another individual long term care insurance policy issued by Us. This includes policies providing nursing home, assisted living facility and/or home health care coverage, regardless of actual terminology. It also applies whether benefits are payable on an expense reimbursement, indemnity or any other basis.

LIMITATIONS

We will not pay for: Physician's charges; hospital or laboratory charges; prescription or non-prescription medications; medical supplies; durable medical equipment (except as provided under the Remain At Home Benefit); payments in-kind; transportation; and personal expenses, such as items and services furnished at Your request for comfort, convenience, beautification or entertainment.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

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 Policy may be adjusted.

The following Benefit Increase Option Riders are available for an additional premium. Your premiums will be higher than for a policy without a Benefit Increase Option Rider attached to it. Under the Compound Benefit Increase Option Rider, premiums will not increase due to Your age or the amount of the benefit increase. Below is a graph that shows the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graph shows the premiums for those types of policies.

FULL COMPOUND BENEFIT INCREASE OPTION RIDER

On each anniversary of the effective date of this Rider, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage shown on the Schedule. The Policy Maximum Amount will be increased by the same Percentage as the Maximum Daily Benefits. The Remain At Home Maximum Benefit will increase in the same way. These increases will continue as long as this Rider is in force, even if You are receiving benefits on the date of the increase.

FULL TAILORED BENEFIT INCREASE OPTION RIDER

Compound Benefit Increases Prior to Age 61

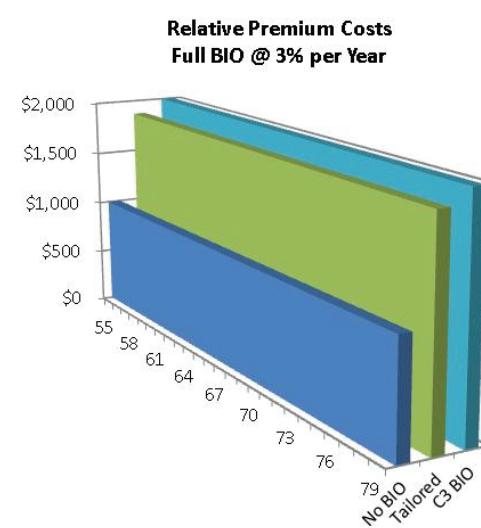
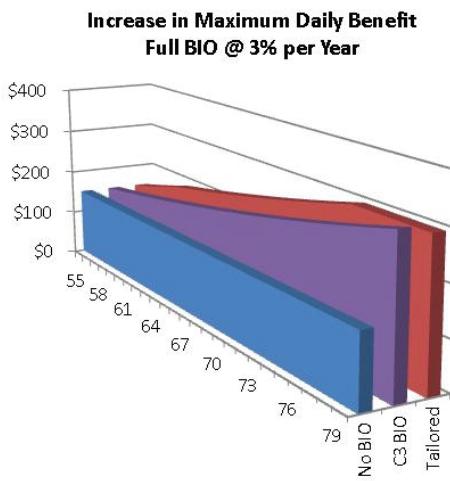
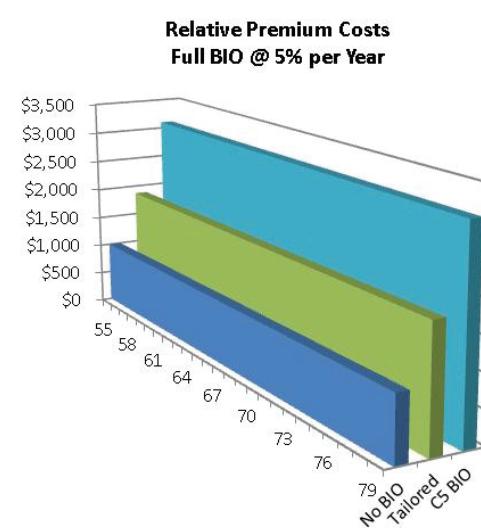
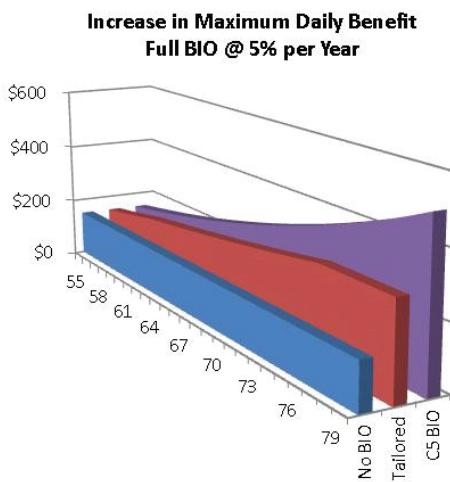
On each anniversary of the effective date of this Rider up to and including the one prior to Your 61st birthday, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage Under Age 61 shown on the Schedule. The Policy Maximum Amount will be increased by the Percentage Under Age 61 shown on the Schedule as well. The Remain At Home Maximum Benefit will increase in the same way.

Compound Benefit Increases Beginning at Age 61 and Prior to Age 76

Starting with the anniversary of the effective date of this Rider on or after Your 61st birthday, We will increase Your current Maximum Daily Benefits. Those benefits will increase by the Percentage Age 61-75 shown on the Schedule. The Policy Maximum Amount will be increased by the Percentage Age 61-75 shown on the Schedule as well. The Remain At Home Maximum Benefit will increase in the same way.

These increases will continue on each anniversary of this Rider up to and including the one prior to Your 76th birthday. Beginning with the anniversary of the effective date of this Rider on or after Your 76th birthday, there will be no more benefit increases under this Rider.

The increases prior to age 76 will continue as long as this Rider and Your Policy are in force, even if You are receiving benefits on the date of the increase. Your premium will not increase as a result of the benefit increases under this Rider. However, Your premium does remain subject to Our right to change premiums.



DEFERRED BENEFIT INCREASE OPTION ENDORSEMENT

This Endorsement is available if You do not add a Benefit Increase Option Rider at the time of Your application for the Policy. You will have the opportunity to add a Compound Benefit Increase Option Rider within the 90-day period prior to the first, the third, or the fifth anniversary dates of the Policy. No additional underwriting will be required. In order to add the Rider, You must not have incurred any claims under the Policy prior to when You add the Rider. The additional premium required to add the Rider will be based on Your age on the anniversary date of the Policy when You exercise this Option.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

The Policy provides coverage for mental and nervous conditions as long as You are certified by a Licensed Health Care Practitioner as being a Chronically Ill Individual as defined in the Policy. This includes coverage for: Alzheimer's disease; Parkinson's disease; senile dementia; and related degenerative and dementing illnesses.

13. PREMIUM

Your total annual premium is \$_____ . This includes \$_____ for the Included Benefits and \$_____ for the Optional Riders You selected.

The Premium Paying Mode You choose will impact Your overall cost of insurance. Please note that the more often You pay, the higher Your total premium amount will be per year. You should compare all of the Premium Paying Modes available. Choose the one that works best for Your personal needs and finances.

14. ADDITIONAL FEATURES

This coverage is medically underwritten.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT TRANSAMERICA LIFE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE POLICY.

CONDITIONAL RECEIPT FOR LONG TERM CARE INSURANCE

ALL PREMIUM CHECKS SHOULD BE MADE PAYABLE TO TRANSAMERICA LIFE INSURANCE COMPANY, P.O. BOX 869090, PLANO, TEXAS 75086-9090. DO NOT MAKE CHECK PAYABLE TO THE AGENT/INSURANCE PRODUCER OR LEAVE PAYEE BLANK.

Received from _____ a) the sum of \$ _____ OR b) payroll deduction/employer paid

For payment received, this receipt is given and accepted with the express understanding that the insurance applied for will go into effect on the date of the accurately completed application (unless a later effective date or a request for the coverage to be effective upon underwriting approval date is indicated in the Effective Date portion of the application, in which case the coverage provided by this receipt, if any, will be effective on that future effective date) if the applicant is found to be insurable in accordance with the Company's underwriting standards as of the date of the application, the policy is issued and the initial premium has been received by the Company. Premiums will be applied from the effective date forward and there will be no coverage for any claims that begin prior to the effective date.

For payroll deduction/employer paid plans, the insurance applied for will go into effect on the date of the accurately completed application if the applicant is found to be insurable in accordance with the Company's underwriting standards as of the date of the application, and the policy is issued. If the initial premium has not been received prior to the date the policy is issued, this Conditional Receipt shall terminate 60 days after the date the policy is issued if the initial premium is not received by the Company prior to the 60th day after the policy is issued.

The Company reserves the right to disapprove the application by offering to issue coverage other than as applied for or by declining to issue coverage. If applicable, monies received with the application will be refunded if coverage, other than applied for, is offered but not accepted, or if the application is declined by the Company. Any delay in completion of the underwriting process or refunding of monies shall not be construed as approval of the application.

X
Signature of Agent/Insurance Producer

Date

X
Signature of Applicant 1

Date

X
Signature of Applicant 2 (If applicable)

Date

Things You Should Know Before You Buy Long - Term Care Insurance

Long-Term Care Insurance:

- A long-term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare:

- Medicare does **not** pay for most long-term care.

Medicaid:

- Medicaid will generally pay for long-term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long-term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long-term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide:

- Make sure the insurance company or agent/insurance producer gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long-Term Care Insurance." Read it carefully. If you have decided to apply for long-term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling:

- Free counseling and additional information about long-term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department of social services for more information about the senior health insurance counseling program in your state.

Facilities:

- Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move to a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.



Home Office: Cedar Rapids, Iowa
Long Term Care Administrative Office
P.O. Box 869090
Plano, Texas 75086-9090
1-800-227-3740

Long Term Care Insurance Potential Rate Increase Disclosure Form

Important Notice: Your long-term care insurance company **may** increase the premium for your policy **every year**. You have certain rights and it's important that you understand them before you buy a long-term care insurance policy. Please read this information and be sure you understand it before you buy a policy.

This policy is guaranteed renewable. Companies can increase the premiums for guaranteed renewable policies in the future. Other than as shown on the Schedule page of Your Policy, the company **cannot** increase your premiums because **you are older or your health declines**. It can increase premiums based on the experience of all individuals with a policy like yours.

1. What Is Your Premium?

The company has quoted you a premium of \$_____ for this policy. This is not a final premium. The premium might change during the underwriting process or if you choose different benefits. The premium you'll be required to pay for your policy will be shown on the schedule page of your policy.

2. How Will I Know If My Premium Is Changing?

The company will send you a notice. The notice will include the new premium and when you will start paying it. It also will give you ways you could avoid paying a higher premium. One likely choice will be to keep your insurance policy, but with fewer or lower benefits than you bought. Another choice may be to stop paying premiums and have a "paid-up" policy with fewer or lower benefits than the policy you bought. You may have other choices.

* Contingent Nonforfeiture

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture option, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter.

Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.

- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy).

Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture

(Percentage increase is cumulative from date of original issue. It does NOT represent a one-time increase.)

| Issue Age | Percent Increase Over Initial Premium |
|--------------|---------------------------------------|
| 29 and under | 200% |
| 30-34 | 190% |
| 35-39 | 170% |
| 40-44 | 150% |
| 45-49 | 130% |
| 50-54 | 110% |
| 55-59 | 90% |
| 60 | 70% |
| 61 | 66% |
| 62 | 62% |
| 63 | 58% |
| 64 | 54% |
| 65 | 50% |
| 66 | 48% |
| 67 | 46% |
| 68 | 44% |
| 69 | 42% |
| 70 | 40% |
| 71 | 38% |
| 72 | 36% |
| 73 | 34% |
| 74 | 32% |
| 75 | 30% |
| 76 | 28% |
| 77 | 26% |
| 78 | 24% |
| 79 | 22% |
| 80 | 20% |
| 81 | 19% |
| 82 | 18% |
| 83 | 17% |
| 84 | 16% |
| 85 | 15% |
| 86 | 14% |
| 87 | 13% |
| 88 | 12% |
| 89 | 11% |
| 90 and over | 10% |

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

This HIPAA authorization must be fully completed and signed as a condition of applying for insurance with Transamerica Life Insurance Company (“Transamerica”). Your application will not be accepted without a signed authorization. It is an act of fraud to intentionally withhold, or cause to be withheld, medical records or other health information material to the underwriting of an application for coverage.

I HEREBY AUTHORIZE THE USE OR DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

- (1) **Person(s) or group(s) of persons authorized to use or disclose the information:** Any physicians, medical practitioners, hospitals, clinics, laboratories, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies (including Transamerica), and insurance support organizations such as the MIB.
- (2) **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** Transamerica and its authorized representatives, including affiliates, agents, business associates and insurance support organizations and/or any entity or individual, including my employer if applicable, who is designated as the owner of the policy for which I have applied.
- (3) **Description of the information that may be used or disclosed:** This authorization specifically includes the release of *all information related to my health* (except psychotherapy notes) and *my insurance policies and claims*, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as AIDS.
- (4) **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my application for long term care insurance with Transamerica, including providing a brief report of my personal health information to MIB, and, if a policy is issued, for evaluating contestability and eligibility for benefits and for the continuation or replacement of the policy. As applicable, in connection with the rights of any policyowner as it relates to the ownership of the policy for which I have applied.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to Transamerica is protected by federal privacy regulations and that Transamerica will only use and disclose such information as described in its Notice of Health Information Privacy Practices. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations, the disclosed information may no longer be protected by those regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides Transamerica with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Transamerica Life Insurance Company, Underwriting Supervisor, P.O. Box 869090, Plano, TX 75086-9090. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- I understand that I am entitled to receive a copy of this signed authorization.
- This authorization will expire 24 months from the date signed.

Applicant's Name: _____

Applicant's Signature: _____ Date Signed: _____

(Applicant Copy) A copy of this authorization will be considered as valid as the original.

DISCLOSURE NOTICES
MIB AND FAIR CREDIT REPORTING

Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company or its reinsurers may, however, make a brief report to MIB, Inc. ("MIB"), a non-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member Company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Life Insurance Company or its reinsurers may also release information in this file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

An investigative consumer report may be obtained as part of the normal procedure for processing your application. These reports are made available by independent sources known as consumer reporting agencies. Their reports typically contain information from third parties and you related to: your health; character; general reputation; mode of living; and personal characteristics. Upon request, you have the right to be informed of the name and address of the agency if a report is requested in connection with your application. Also, you may request to be interviewed in connection with this report. And you have the right to make a written request to receive additional information concerning the nature and scope of the investigation. To make this request, write to: Transamerica Life Insurance Company, LTC Administrative Office, Underwriting Department, P. O. Box 869090, Plano, TX 75086-9090.

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, Transamerica Life Insurance Company, and Transamerica Premier Life Insurance. 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

- 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.
- 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.
- 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.
- 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.

Your Privacy Rights

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: 4333 Edgewood Road NE, 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.

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Home Office: Cedar Rapids, Iowa
Long Term Care Administrative Office
P.O. Box 869090
Plano, TX 75086-9090
1-800-227-3740

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

SOUTH DAKOTA SENIOR HEALTH INFORMATION & INSURANCE EDUCATION (SHIINE)

The South Dakota Senior Health Information & Insurance Education (SHIINE) program provides long-term care insurance counseling to South Dakota citizens. You can contact someone at the program by writing to SHIINE at 2300 West 46th Street, Sioux Falls, South Dakota 57105, calling toll-free at 1-800-536-8197 or via the web at www.shiine.net.

SHIINE Regional Coordinators:

Eastern South Dakota
Phone: 1-800-536-8197 or 605-333-3314
E-Mail: SHIINE@cfag.org

Central South Dakota:
Phone: 1-877-331-4834 or 605-224-3212
E-mail: SHIINE@centralsd.org

Western South Dakota:
Local: 1-877-286-9072 or 605-342-8635
E-mail: SHIINE@westriversd.org