TRANSAMERICA®

Revised April 30, 2021

NOTICE OF PRIVACY PRACTICES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. It is important to us that you understand how we use and share your personal information. This Notice describes the data we collect and how we use, share and protect it. The types of data we collect and share depend on the type of product or service you have with us. We also provide notices and terms on our websites and applications. Those notices and terms provide further detail regarding data use on our websites or applications. If your relationship with us ends, we will continue to use your data as set forth in this Notice.

Data That We Collect: We collect the following types of data from the following sources:

Data	Typical Data Sources
Name, email and physical address, age, social security and driver's license numbers, employment, financial and health data and history	• You directly, when you submit applications and forms and engage in communications with us • Our affiliates (companies under common ownership) • Employers, healthcare providers, other insurance companies and other authorized entities
Data about your transactions with us and/or Third Parties. ("Third Parties" are unaffiliated third parties. This includes agents, other financial organizations, and service providers.) Such transactional data can include, but is not limited to, account balances, accrued benefits, coverages, premiums, payment and claims history, financial transactions, and medical or health data	• Our affiliates • Third Parties • Transamerica's websites, digital platforms, and applications • Assistive technologies, mobile or wearable devices, or other similar technology
Credit history, employment information and other information about your creditworthiness, and medical or health data	• Consumer reporting agencies and other service providers we use such as third party data suppliers • Your employers, healthcare providers, insurance support organization (including reports prepared from such organizations which may retain and disclose such information), credit bureaus, other insurance companies and other authorized entities
Data about products and services you obtain or in which you might be interested	• You • Third Parties with whom we have joint marketing arrangements • Other Third Parties as allowed
Third party data, including data you provide to Third Parties when you have authorized the Third Party to share such data with other parties, such as data collected through Third Party applications, websites, or other digital interfaces, data you have authorized us to receive, or data you have authorized Third Parties to share with us	• Third Party applications, websites, or other digital interfaces where you have agreed to share your data • Assistive technologies, mobile or wearable devices, or other similar technology

How We Use Your Data: We use data to provide our services and as allowed by law. This includes use authorized by you. For example, we may use your data to:

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

Sharing Data: We may share your data with Third Parties and affiliates as permitted or required by law, or when you authorize us to do so. We may share your data with:

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

coordinate your benefits or in connection with insurance transactions involving you,

- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,
- Those who have an interest in your assets (such as creditors with a lien on your account),
- Your employer or plan sponsor as needed to support the administration of employee accounts (but only as permitted by law and only if you have established an account in connection with your employer),
- Your representatives and lawyers,
- Those to prevent and prosecute fraud or criminal activities,
- Those to conduct actuarial or research studies, and
- Those in connection with the sale or merger of all or part of our business.

You do not have the right to opt out of our sharing data with Third Parties for these legally permitted purposes.

Our affiliates include a broad range of companies who provide financial services. These include insurance companies and agencies, investment advisors, and broker/dealers, some of whom may not be included in the scope of this Notice. You may have additional privacy notices from these professionals. We do not share information about your creditworthiness among our affiliates. However, we may share information about our transactions and experiences with you among affiliates for their everyday business purposes. For example, we may share your data with our affiliates:

- So they can tell you about products and services they offer,
- So they can determine which of their products and services may be of interest to you,
- So they can provide various services to us to support our business, such as claims processing, applying for insurance, opening and maintaining your account, or marketing products and services to you,
- So they can audit themselves or their agents, or
- So you can communicate with us or Transamerica affiliated companies about your accounts.

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

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

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

Your Right of Access and Correction: You may have a right of access and correction with respect to data we collect. To exercise these rights, please list the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it. If we agree, we will correct our records. If we don't agree, you may dispute our findings in writing and send your statement to us. We will include your statement whenever we provide your disputed information to anyone outside Transamerica. This is a summary of your rights. For a copy of our more detailed Notice of Insurance Information Practices as applicable to your product or service, please send a written request to 6400 C St. SW, Cedar Rapids, IA 52499-0001.

Protecting Your Data: We maintain appropriate controls to limit access to data to persons who need access to it. These persons access your data so that they can do their jobs or provide products and services to you. We train our workforce to properly handle data. In addition, we maintain other physical, technical, and administrative or procedural safeguards to protect your data.

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

We may revise this Notice. If we make material changes, we will notify you as required by law. This Notice is provided by the Transamerica companies below. Transamerica companies that are not covered by this notice may make available other applicable notices.

Transamerica Capital, Inc
Transamerica Financial Life Insurance Company
Transamerica Casualty Insurance Company
Transamerica Life Insurance Company

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

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

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

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

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

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.
- They acquired rights to receive payments through a structured settlement factoring transaction.

The association also does not provide coverage for:

- Any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed the average rate specified in the law;
- Dividends;
- Experience or other credits given in connection with the administration of a policy by a group contractholder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that unallocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.
- A policy or contract commonly known as Medicare Part C, Medicare Part D, Medicaid or any regulations issued pursuant thereto.

LIMITS ON AMOUNT OF COVERAGE

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

- The guaranty association cannot pay out more than the insurance company would owe under the policy or contract.
- Except as provided in (3) (4) and (5) below, the guaranty association will pay a maximum of $300,000 per individual, per insolvency, no matter how many policies or types of policies issued by the insolvent company.
- The guaranty association will pay a maximum of $500,000 with respect to health benefit plan.
- The guaranty association will pay a maximum of $1,000,000 with respect to the payee of a structured settlement annuity.
- The guaranty association will pay a maximum of $5,000,000 to any one unallocated annuity contract holder.

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.

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: 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.

TRANSAMERICA LIFE INSURANCE COMPANY

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

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

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

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

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

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

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

[Craig D. Vermie]
[General Counsel and Secretary]

[Linda Clancy]
[President]

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

IMPORTANT CANCELLATION INFORMATION – PLEASE REFER TO THE "TERMINATION OF INSURANCE" SECTION OF THIS CERTIFICATE.

NO RECOVERY FOR PREEXISTING CONDITION – READ CAREFULLY. No benefits will be provided during the first 12 months of coverage for loss caused by a Preexisting Condition unless the Waiver of Preexisting Condition Limitation Amendatory Rider is attached to the Policy.

[This Certificate of Insurance provides all of the benefits mandated by the North Carolina Insurance Code, but is issued under a group master policy located in another state and may be governed by that state's laws.]

Group Certificate for Hospital Indemnity Insurance

LIMITED BENEFIT – READ YOUR CERTIFICATE CAREFULLY

THIS CERTIFICATE IS NOT MAJOR MEDICAL INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL INSURANCE. IT DOES NOT QUALIFY AS MINIMUM ESSENTIAL HEALTH COVERAGE UNDER THE FEDERAL AFFORDABLE CARE ACT. IF YOU PURCHASE THIS CERTIFICATE ONLY, YOU WILL NOT SATISFY THE FEDERAL REQUIREMENT THAT YOU HAVE HEALTH COVERAGE, WHICH IS IN EFFECT BEGINNING JANUARY 1, 2014.

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

TABLE OF CONTENTS

SCHEDULE OF BENEFITS

POLICYHOLDER:	[ABC Eligible Group]
GROUP POLICY NUMBER:	[1234567]
POLICY EFFECTIVE DATE:	[January 1, 2013]
GOVERNING JURISDICTION:	[STATE OF ISSUE]
MONTHLY PREMIUM:	[$XX.XX]

BENEFIT COVERAGE	**BENEFIT PER COVERED PERSON**
DAILY IN-HOSPITAL INDEMNITY BENEFIT	
DAILY IN-HOSPITAL INDEMNITY BENEFIT AMOUNT	[$20 - $2,500]
[MAXIMUM NUMBER OF DAYS PER CONFINEMENT:	[31 - 60]]
[LIFETIME MAXIMUM NUMBER OF DAYS:	[31 - 365]]
[CALENDAR YEAR MAXIMUM:	[$5,000 - $150,000]**]**

OPTIONAL RIDERS – The following Optional Riders are part of your coverage.

[CRAMB400 – AMBULANCE INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY FOR GROUND/WATER AMBULANCE	[$50 - $1,500]
BENEFIT AMOUNT PER DAY FOR AIR AMBULANCE	[$50 - $3,000]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1 – 3]
[LIFETIME MAXIMUM NUMBER OF DAYS	[3 – 6]]**]**

[CRCI0400 – CRITICAL ILLNESS INDEMNITY BENEFIT RIDER	
CRITICAL ILLNESS BENEFIT-	
INSURED	[$2,500 - $50,000]
[DEPENDENT	[25% - 100%] OF INSURED BENEFIT]
SKIN CANCER BENEFIT	[1-10%] OF CRITICAL ILLNESS BENEFIT
CARCINOMA IN SITU BENEFIT	[1-10%] OF CRITICAL ILLNESS BENEFIT
SUBSEQUENT CRITICAL ILLNESS BENEFIT	100% OF CRITICAL ILLNESS BENEFIT**]**

[CRERS400 – EMERGENCY ROOM SICKNESS INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	[$50 - $500]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[2 -4]**]**

[CRHA0400 - HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	[$250 - $15,000]
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	[1 – 5]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1 - 5]**]**

[CRDA0400 - INPATIENT DRUG AND ALCOHOL ADDICTION INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	[$50 - $2,500]
[MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[20 – 31]]
[LIFETIME MAXIMUM NUMBER OF DAYS	[60 - 90]]**]**

[CRMN0400 - INPATIENT MENTAL AND NERVOUS DISORDER INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	[$50 - $2,500]
[MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[20 – 31]]
[LIFETIME MAXIMUM NUMBER OF DAYS	[60 - 90]]**]**

[CRIPM400 – INPATIENT MISCELLANEOUS INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	[$10 - $500]
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	[10 – 31]**]**

[CRISRG00 – INPATIENT SURGICAL INDEMNITY BENEFIT RIDER	
SURGICAL BENEFIT AMOUNT PER DAY	[$50 - $5000]
ANESTHESIA BENEFIT AMOUNT PER DAY	[$10 - $1500]
[MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1 - 2]]**]**

[CRCICU00 - INTENSIVE CARE INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$100 - $2,500]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[10 – 30]**]**

[CRACIN00 - OFF-THE-JOB ACCIDENTAL INJURY INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$50 - $1,500]
MAXIMUM NUMBER OF DAYS PER ACCIDENT	[1 - 2]
MAXIMUM NUMBER OF ACCIDENTS PER CALENDAR YEAR	[1 – 5]**]**

[CRASD400 - OUTPATIENT ADVANCED STUDIES DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$100 - $2,000]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1 - 3]**]**

[CRLAB400 - OUTPATIENT DIAGNOSTIC LABORATORY TEST INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$10 - $200]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[2 - 12]**]**

[CROPV400 - OUTPATIENT PHYSICIAN OFFICE VISIT INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$20 - $200]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1 – 10]**]**

[CRSDT400 - OUTPATIENT SELECT DIAGNOSTIC TEST INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$50 - $1000]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1 - 5]**]**

[CROPS400 - OUTPATIENT SURGICAL INDEMNITY BENEFIT RIDER

SURGICAL BENEFIT AMOUNT PER DAY	[$25 - $2,000]
ANESTHESIA BENEFIT AMOUNT PER DAY	[$5 - $600]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[1-3]**]**

[CRRX0400 –PRESCRIPTION DRUG INDEMNITY BENEFIT RIDER

[BENEFIT AMOUNT PER DAY	[$5 - $100]]
[GENERIC PRESCRIPTION BENEFIT AMOUNT PER DAY	[$5 - $100]
BRAND NAME PRESCRIPTION BENEFIT AMOUNT PER DAY	[$10 - $150]]
[MAXIMUM NUMBER OF DAYS PER MONTH	[1 – 5]]
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	[5 – 36]**]**

[CRSN0400 - SKILLED NURSING INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$50 – 2,500]
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	[30 – 60]
LIFETIME MAXIMUM NUMBER OF DAYS	[60 – 120]**]**

[CRSRGP00 – SURGICAL AND ANESTHESIA INDEMNITY BENEFIT RIDER

INPATIENT SURGICAL BENEFIT PER DAY	[$500 - $5,000]
INPATIENT ANESTHESIA BENEFIT PER DAY	[$100 - $1,500]
MAXIMUM INPATIENT NUMBER OF DAYS PER CALENDAR YEAR	[1 – 2]
OUTPATIENT SURGICAL BENEFIT PER DAY	[$250 - $2500]
OUTPATIENT ANESTHESIA BENEFIT PER DAY	[$50 - $750]
MAXIMUM OUTPATIENT NUMBER OF DAYS PER CALENDAR YEAR	[1 – 2]
OUTPATIENT MINOR SURGICAL BENEFIT PER DAY	[$50 - $500]
OUTPATIENT MINOR SURGICAL ANESTHESIA BENEFIT PER DAY	[$10 - $150]
MAXIMUM OUTPATIENT MINOR SURGICAL NUMBER OF DAYS PER CALENDAR YEAR	[1 – 3]
[CALENDAR YEAR MAXIMUM FOR ALL OUTPATIENT BENEFITS	[$250 - $3000]]

[CRHWEL00 – WELLNESS INDEMNITY BENEFIT RIDER

BENEFIT AMOUNT PER DAY	[$50 - $500]
[MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR PER COVERED PERSON OVER AGE 2	[1 - 3]]
[MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR FOR ALL COVERED PERSONS OVER AGE 2	[1 - 9]]
MAXIMUM NUMBER OF WELL BABY DAYS PER CALENDAR YEAR	
PER COVERED PERSON AGE NEWBORN TO 12 MONTHS	[1 – 4]
PER COVERED PERSON AGE 13 MONTHS TO 2ND BIRTHDAY	[1 – 2]**]**

[CRPREX00 – WAIVER OF PREEXISTING CONDITION AMENDATORY RIDER]

DEFINITIONS

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

Accident or Accidental Injury – A sudden, unexpected, and unintended injury that:
1. Is independent of any Sickness;
2. Is caused by or is the result of external means; and
3. Takes place while the Covered Person's coverage is in force.

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

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

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

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

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

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

Child – A Child of yours who is under the age of 26 and is:
1. A natural Child; or
2. A legally adopted Child or a Child who has been placed for adoption with you; or
3. A stepchild or foster Child from the moment of placement; or
4. A Child for whom you have been appointed legal guardian; or
5. A Child for whom you are legally required to provide support.

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

Child also includes a Child who is incapable of self-support due to a mental or physical impairment. If a Child has reached age 26, but is incapable of self-support because of mental or physical impairment, we will continue the Child's coverage under the following conditions:
1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate;
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains age 26; and
4. Your coverage must remain in force.

Confinement or Confined - That period of time the Covered Person is admitted into a Hospital as a resident bed patient. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a freestanding surgical facility or an outpatient facility.

Complications of Pregnancy –
1. Conditions requiring Hospital stays when the pregnancy or childbirth is not terminated, whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and
2. Non-elective caesarean section, ectopic pregnancy that is terminated and spontaneous termination of pregnancy that occurs during a period of gestation in which a live birth is not possible. A non-elective caesarean section is a caesarean delivery that:
    a. Is done on an urgent or emergency basis when maternal or fetal problems or complications develop before or during labor; or
    b. Is planned prior to the normal delivery date when a known medical problem would make labor dangerous for the mother or the baby.

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a medically distinct Complication of Pregnancy.

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

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

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

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

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

A State tax-supported institution will be considered a Hospital even if it does not have an operating room and related equipment for surgery on its premises or in facilities available on a contractually prearranged basis.

Notwithstanding the above, Hospital does not include an institution or that part of an institution operated as:

1. A nursing home;
2. An extended care facility;
3. A skilled nursing facility;
4. A mental institution or a facility for the treatment of mental disorders;
5. A rest home or home for the aged;
6. A rehabilitation center; or
7. A place for alcoholics or drug addicts.

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

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

Observation Unit – A specialized area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician. Such a unit must:

1. Be under the direct supervision of a Physician or registered nurse;
2. Be staffed by nurses assigned specifically to that unit; and
3. Provide care seven days per week, 24 hours per day.

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

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

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

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

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

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

[Preexisting Condition – A Covered Person’s Sickness or physical condition for which medical advice, diagnosis, care or treatment was recommended by or received from a Physician within 12 months before the date the Covered Person’s coverage became effective.]

Sickness – Illness or disease which first manifests itself while the Covered Person's coverage is in force and is the direct cause of the loss.

Spouse – Your legally married Spouse.

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

ELIGIBILITY AND EFFECTIVE DATE

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

Employee or Member Eligibility – To be eligible for coverage under the Policy, you must:
1. Meet the eligibility requirements listed on the Policyholder Application;
2. Be in Active Service; and
3. Provide satisfactory Evidence of Insurability to us, if required.

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

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

Dependent Eligibility, if available under the Policy – To be eligible under the Policy, a Dependent must:
1. Meet the definition of an eligible Dependent;
2. Be able to perform a majority of the normal activities of a person of like age in good health;
3. Not be eligible as an employee or member under the Policy; and
4. Provide satisfactory Evidence of Insurability to us, if required.

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

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

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

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

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

Coverage for Newborn Child, Newly Adopted Child, or Foster Child - A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, as long as your coverage is in force on that date. An adopted or foster Child will become insured for coverage automatically on the day he or she is placed for

adoption or placed in the foster home so long as such placement occurs while your coverage is in force on that day. The Child will be automatically covered for 31 days. If additional premium is required in order to continue the Child's coverage,, you must notify us by the end of the 31-day period and pay the additional premium.

Coverage for a newly born or newly adopted Child will consist of coverage for Accident and Sickness including confinements for medically diagnosed congenital defects and birth abnormalities within the scope of the Policy.

The following definitions apply to this provision:

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

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

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

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

DAILY IN-HOSPITAL INDEMNITY BENEFIT

We will pay the Daily In-Hospital Indemnity Benefit amount shown in the Schedule of Benefits for each day the Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. This benefit is limited to any maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

EXCLUSIONS AND LIMITATIONS

With respect to benefits provided under this Certificate, no benefits will be payable as the result of:
1. A Covered Person's suicide or attempted suicide, while sane or insane.
2. A Covered Person's intentionally self-inflicted injury.
3. Rest care or rehabilitative care and treatment.
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
5. Any pregnancy of a Dependent Child, except for Complications of Pregnancy, including Confinement rendered to her Child after birth.
6. Routine newborn care. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
7. A Covered Person's abortion, except for medically necessary abortions performed to save the mother's life.
8. The treatment of:
   a. A Covered Person's mental or emotional disorder. This exclusion does not apply to coverage under the optional Inpatient Mental and Nervous Disorder Indemnity Benefit Rider, if attached as part of the contract.
   b. A Covered Person's alcoholism or drug addiction. This exclusion does not apply to coverage under the optional Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider, if attached as part of the contract.
9. A Covered Person's active participation in a riot, or insurrection.
10. Dental care or treatment, except for such care or treatment due to Accidental Injury to sound natural teeth within 12 months of the Accident and except for dental care or treatment necessary due to congenital disease or anomaly.

11. Any Accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred).
12. A Covered Person's sex change, reversal of tubal ligation or reversal of vasectomy.
13. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's services, unless required by law.
14. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
15. Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
16. Any loss incurred while a Covered Person is on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)
17. An Accident or Sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made. This exclusion does not apply to claims covered by the North Carolina Workers' Compensation Act, Article 1 of Chapter 97 of the General Statutes, unless the Insured, employer of the Insured, or the workers' compensation insurance carrier is liable or responsible according to a final adjudication of the claim under that Article or an order of the North Carolina Industrial Commission approving a settlement agreement entered into under that Article.
18. A Covered Person's involvement in any war or act of war, whether declared or undeclared.

[Preexisting Condition Limitation - No benefits are provided during the first 12 months this coverage is in force for a Preexisting Condition. After this 12-month period, loss due to such Preexisting condition will be payable unless specifically excluded from coverage. This 12-month period is measured from the date coverage becomes effective for each Covered Person.

No claim for a loss that starts 12 months after coverage becomes effective may be reduced or denied because of a physical condition, not excluded by name or specific description before the date of loss, that existed before the Covered Person's coverage become effective.**]**

PREMIUMS

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

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

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

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

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

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

TERMINATION OF INSURANCE

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

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

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

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

PORTABILITY OPTION

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

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

CLAIM PROVISIONS

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

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

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

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

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

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

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

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

Other Insurance With Us - If you have more than one hospital indemnity policy, certificate, or similar coverage with us, only the one chosen by you will remain in effect. We will refund all premiums paid for any other such coverage.

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

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

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

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

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
Administrative Office: PO Box 869094, Plano, TX 75086-9817
(Hereinafter called "the Company," "we," "us," or "our")

HOSPITAL INDEMNITY ENDORSEMENT

This Endorsement is part of the contract to which it is attached and is subject to all provisions of the contract which are not in conflict with the provisions of this Endorsement.

I. The definition of **Confinement or Confined** is deleted and replaced with the following:

That period of time the Covered Person is admitted into a Hospital as a resident bed patient as established by the records of the Hospital. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an Observation Unit or recovery room, a freestanding surgical facility or an outpatient facility.

II. The **Coverage for Newborn Child, Newly Adopted Child, or Foster Child** provision is deleted and replaced with the following:

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

Coverage for a newly born or newly adopted Child or newly placed Foster Child will consist of coverage for Accidental Injury or Sickness of the Child including confinements for medically diagnosed congenital defects and birth abnormalities within the scope of the Policy.

The following definitions apply to this provision:

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

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

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

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

III. The benefit description for the **Daily Hospital Indemnity Benefit** in the contract is deleted and replaced with the following:

We will pay the Daily In-Hospital Indemnity Benefit amount shown in the Schedule of Benefits for each day the Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. This benefit is limited to any maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit or recovery room. We also will not pay a Daily In-Hospital Indemnity Benefit for a newborn Child's stay in the Hospital unless the newborn Child is Confined to the Hospital and is being treated for Accidental Injury or Sickness.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

IV. The following exclusion is added to the contract's **EXCLUSIONS AND LIMITATIONS** section:

Hospital Confinement of a newborn Child following the Child's birth, unless the newborn Child is being treated for Accidental Injury or Sickness.

V. If a **Hospital Confinement Indemnity Benefit Rider** is part of the contract then the rider's **Benefit** section is deleted and replaced with the following:

BENEFIT

We pay a Hospital Confinement Indemnity Benefit for each day a Covered Person is Confined to a Hospital as the result of the Covered Person's Accidental Injury or Sickness. Confinement must begin while this Rider is in force and must last a minimum of 24 continuous hours from time of admission as a resident bed patient. Each stay in a Hospital must meet the contract's definition of Confinement. The Hospital Confinement Indemnity Benefit amounts and the maximum number of days the benefit is payable in a Calendar Year are shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit or recovery room. We also will not pay a Hospital Confinement Indemnity Benefit for a newborn Child's stay in the Hospital unless the newborn Child is Confined to the Hospital and is being treated for Accidental Injury or Sickness.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

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

Jay Orlandi, Secretary

Blake Bostwick,President

TRANSAMERICA LIFE INSURANCE COMPANY

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AMBULANCE INDEMNITY BENEFIT RIDER

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

BENEFIT

We will pay the Ambulance Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person receives ambulance transportation to a Hospital or emergency center as the result of a covered Accident or Sickness. Ambulance service must be provided by a licensed ambulance company within 96 hours of the Accident or onset of Sickness. Benefits are subject to the maximums shown in the Schedule of Benefits.

RIDER EFFECTIVE DATE

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

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

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

General Counsel and Secretary

President

TRANSAMERICA LIFE INSURANCE COMPANY

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HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER

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

BENEFIT

We will pay the Hospital Confinement Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. Confinement must begin while this Rider is in force and must last a minimum of 24 continuous hours from time of admission as a resident bed patient. Each stay in a Hospital must meet the definition of Confinement. Benefits are limited to the maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

RIDER EFFECTIVE DATE

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

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

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

General Counsel and Secretary

President

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OUTPATIENT SURGICAL INDEMNITY BENEFIT RIDER

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

BENEFIT

We will pay the Outpatient Surgical Indemnity Benefit amount shown in the Schedule of Benefits for each day a Covered Person undergoes outpatient surgery in a Hospital outpatient facility or a free-standing outpatient surgery center as the result of a covered Accident or Sickness, provided the Covered Person is not subsequently Confined to the Hospital on an inpatient basis. Surgery must be performed while this Rider is in effect. Benefits are limited to the maximums shown in the Schedule of Benefits.

This benefit excludes any surgery that takes place in a Physician's office.

RIDER EFFECTIVE DATE

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

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

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

General Counsel and Secretary

President