

NOTICE OF PRIVACY PRACTICES TRANSAMERICA COMPANIES

This Notice is provided to you by the Transamerica companies listed at the end of this Notice. We value our customers and your trust in us, especially when you share your personal information with us. We understand that the privacy and security of that personal information is important to you. We call this information “data”. This Notice describes the data we collect and how we use, share and protect such data. The types of data we collect and share depend on the type of product or service you have with us. Also, Transamerica websites’ and applications’ Terms of Use and Privacy Statements provide additional detail on the treatment and handling of data when interacting with these sites or applications. If your relationship with us ends, we will continue to handle your data in accordance with this Notice.

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

Data	Typical Data Sources
Name, email and physical address, age, social security and driver’s license numbers, employment, financial and health data and history.	<ul style="list-style-type: none"> • You directly, when you submit applications and forms and engage in communications with us • Employers, healthcare providers, other insurance companies and other authorized entities
Data about your transactions with us. Data about your transactions with unaffiliated third parties (“Third Parties”) that is shared with Transamerica. Transactional data collected as part of your interaction with Transamerica or provided by Third Parties can include , but is not limited to, account balances, accrued benefits, coverages, premiums, payment and claims history, financial transactions, and medical or health data.	<ul style="list-style-type: none"> • Our affiliates (companies under common ownership) • 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, medical care and health.	<ul style="list-style-type: none"> • Consumer reporting agencies and other service providers we use such as third party data suppliers • Your employers, healthcare providers, other insurance companies and other authorized entities
Data about products and services you obtain or in which you might be interested.	<ul style="list-style-type: none"> • You • Third Parties with whom we have joint marketing arrangements • Other Third Parties as allowed
Data you provide to Third Parties when you have authorized the Third Party to share such data with other parties. This includes data collected through Third Party applications, websites, or other digital interfaces, data you share with us, data you have authorized us to receive, or data you have authorized Third Parties to share with us.	<ul style="list-style-type: none"> • 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 for purposes 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,
- Support online customer experiences, digital platforms, and/or applications you elect to participate in
- Maintain your accounts,
- Comply with applicable laws and for security purposes,
- Maintain, operate, and market our business, or

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

We may also share your data with Third Parties in certain circumstances, such as:

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

- Other insurance companies (including successor insurers), agents and insurance support organizations to coordinate your benefits or in connection with insurance transactions involving you,
- Group policyholders, for example, regarding claims experience or to support service audits,
- Certificate or policyholders regarding the status of an insurance transaction,
- Those who have a legal or beneficial 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,
- To prevent and prosecute fraud or criminal activities,
- To conduct actuarial or research studies, and
- In connection with the sale or merger of all or part of our business

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

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

Your Choice to Limit Marketing by Transamerica Affiliates: You may limit our affiliates' use of certain types of data to market their own products and services to you ("Opt Out"). To do this, choose one of the Opt Out methods set forth below. This data relates to your transactions and experiences with us. For example, this may include the products you own and your account history. Your choice to limit marketing offers from our affiliates will apply for at least 5 years from when you Opt Out. Once that period expires, we will send you a renewal Notice. That renewal Notice will allow you to continue to limit marketing offers from our affiliates for at least another 5 years. If you have already Opted Out of marketing offers from our affiliates, you do not need to Opt Out again until you receive a renewal Notice. If you hold a policy or account jointly with someone else, your Opt Out 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 (including 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 have a right of access and correction with respect to data we collect except data that relates to and is collected in connection with a claim or criminal or civil lawsuit involving you. You must make your request to us in writing listing the account or policy numbers with the data you are requesting to access. If you tell us of an error in the data, we will review it and 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 in order to do their jobs or to provide products and services to you. We train our workforce in the proper handling of data. In addition, we maintain other physical, technical, and administrative or procedural safeguards to protect your data.

Other Privacy Protections for Vermont Residents only. We will not share data we collect about you with Third Parties, except as permitted by Vermont law or authorized by you. We may still share data about our transactions or experiences with you with our affiliates. **For California Residents only.** If you are a California resident, you will receive a separate notice 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 following Transamerica companies and any separate accounts established for products they offer:

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

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

How you're protected if your life or health insurance company fails

The Texas Life and Health Insurance Guaranty Association protects you by paying your covered claims if your life or health insurance company is insolvent (can't pay its debts). **This notice summarizes your protections.**

The Association will pay your claims, with some exceptions required by law, if your company is licensed in Texas and a court has declared it insolvent. You must live in Texas when your company fails. If you don't live in Texas, you may still have some protections.

For each insolvent company, the Association will pay a person's claims only up to these dollar limits set by law:

- **Accident, accident and health, or health insurance (including HMOs):**
 - Up to \$500,000 for health benefit plans, with some exceptions.
 - Up to \$300,000 for disability income benefits.
 - Up to \$300,000 for long-term care insurance benefits.
 - Up to \$200,000 for all other types of health insurance.
- **Life insurance:**
 - Up to \$100,000 in net cash surrender or withdrawal value.
 - Up to \$300,000 in death benefits.
- **Individual annuities:** Up to \$250,000 in the present value of benefits, including cash surrender and net cash withdrawal values.
- **Other policy types:** Limits for group policies, retirement plans and structured settlement annuities are in Chapter 463 of the Texas Insurance Code.
- **Individual aggregate limit:** Up to \$300,000 per person, regardless of the number of policies or contracts. A limit of \$500,000 may apply for people with health benefit plans.
- **Parts of some policies might not be protected:** For example, there is no protection for parts of a policy or contract that the insurance company doesn't guarantee, such as some additions to the value of variable life or annuity policies.

To learn more about the Association and your protections, contact:

Texas Life and Health Insurance Guaranty Association
515 Congress Avenue, Suite 1875
Austin, TX 78701
1-800-982-6362 or www.txlifega.org

For questions about insurance, contact:

Texas Department of Insurance
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439 or www.tdi.texas.gov

Note: You're receiving this notice because Texas law requires your insurance company to send you a summary of your protections under the Texas Life and Health Insurance Guaranty Association Act (Insurance Code, Chapter 463). These protections apply to insolvencies that occur on or after September 1, 2019. **There may be other exceptions that aren't included in this notice.** When choosing an insurance company, you should not rely on the Association's coverage. Texas law prohibits companies and agents from using the Association as an inducement to buy insurance or HMO coverage.

Chapter 463 controls if there are differences between the law and this summary.

Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company or HMO first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company or HMO. If you don't, you may lose your right to appeal.

Transamerica Life Insurance Company

To get information or file a complaint with your insurance company or HMO:

Toll-free: 1-888-763-7474

Online: www.transamericaemployeebenefits.com

Email: TEBcustresp@Transamerica.com

Mail: 2700 W Plano Pkwy, PO Box 869094, Plano, TX 75086-9817

The Texas Department of Insurance

To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439

File a complaint: www.tdi.texas.gov

Email: ConsumerProtection@tdi.texas.gov

Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros o HMO. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros o HMO. Si no lo hace, podría perder su derecho para apelar.

Transamerica Life Insurance Company

Para obtener información o para presentar una queja ante su compañía de seguros o HMO:

Toll-free: 1-888-763-7474

Online: www.transamericaemployeebenefits.com

Email: TEBcustresp@Transamerica.com

Mail: 2700 W Plano Pkwy, PO Box 869094, Plano, TX 75086-9817

El Departamento de Seguros de Texas

Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439

Presente una queja en: www.tdi.texas.gov

Correo electrónico: ConsumerProtection@tdi.texas.gov

Dirección postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
A Stock Company

Policyholder: THREE RIVERS ISD
Address: 351 SOUTH SCHOOL RD
THREE RIVERS TX 78071
Policy Number: CN00077104
Policy Effective Date: SEPTEMBER 1 2021
Policy Anniversary Date: OCTOBER 1
Premium Rate Guarantee Date: SEPTEMBER 1 2022
Governing Jurisdiction: TX

Transamerica Life Insurance Company ("the Company," "We," "Us," and "Our") agrees to pay the benefits described in this Group Master Policy ("Policy"), subject to all terms, conditions, and limitations, in consideration of:

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

By Our acceptance of the first premium paid by the Policyholder ("You," "Your," and "Yours") and by Your receipt of this Policy, You agree:

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

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



General Counsel and Secretary



President

Group Master Policy for Cancer Only Insurance

BENEFITS LIMITED TO LOSS DUE TO CANCER ONLY
NO BENEFITS PROVIDED FOR ANY OTHER SICKNESS OR CONDITION
PRE-EXISTING CONDITIONS ARE NOT COVERED DURING THE FIRST 12 MONTHS
READ YOUR POLICY CAREFULLY
NONPARTICIPATING - NO ANNUAL DIVIDENDS

Administrative Office:
PO Box 869094
Plano, TX 75086-9817
Customer Service: 1-888-763-7474

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DEFINITIONS

The defined terms below are subject to the provisions of this Policy:

Active Service - The Insured is:

1. Performing in the usual manner all of the regular duties of his or her occupation on a scheduled work day; and
2. These duties are performed at one of the places of business where the Insured normally does such duties or at some location to which his or her employment sends the Insured.

The Insured is said to be in Active Service on a day which is not a scheduled work day only if he or she would be able to perform in the usual manner all of the regular duties of his or her occupation if it were a scheduled work day, and he or she were in Active Service on the last preceding regular work day.

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

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

Certificate – The document given to each Insured that describes the terms of the insurance made available to insured employees or members and their insured Spouses and/or insured Dependent Children, as defined in the Certificate, if applicable.

Effective Date or Policy Effective Date - The date coverage is in effect is shown on the cover page of this Policy. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

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

Group Master Policy or Policy – The complete contract of insurance, which includes the Policy as issued to You, as well as any Certificates issued to each Insured, including any Amendments, Endorsements, Riders, and Applications.

Insured – The eligible employee or member as defined by the Policyholder, and who has been approved by Us for coverage, and whose name appears on the Certificate's Schedule of Benefits.

Policyholder – The entity named on the cover page of this Policy.

ELIGIBILITY

EMPLOYEE OR MEMBER AND DEPENDENT ELIGIBILITY REQUIREMENTS

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

1. Meet eligibility requirements as selected on the Policyholder's Application;
2. Provide satisfactory Evidence of Insurability to Us, if required; and
3. Be in Active Service on the Effective Date of coverage.

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

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

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

The Insured may elect Dependent coverage by:

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

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

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

PREMIUMS

Premium Calculation And Due Dates - The premium due will be the sum of the premiums applicable for all Insureds. You must pay the premiums to Us at Our Administrative Office.

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

Premium Rate Guarantee - These premium rates are guaranteed until the date shown on the Policy's cover page and is subject to the Change in Premium Rates provision.

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

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

Change in Premium Rates - We have the right to change the premium rates on any premium due date after the end of the Premium Rate Guarantee. If the rates are changed, We will give You at least a 31-day advance written notice. If an increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases Our liability, premium rates may be changed on the date that Our liability is increased without regard to any Premium Rate Guarantee.

POLICY CHANGES

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

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

POLICYHOLDER PROVISIONS

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

1. If You submit a 60-day advance written request to Us to terminate this Policy, this Policy will terminate on the date specified in that request;
2. If We give a 60-day advance written notice to You that We intend to terminate this Policy, this Policy will terminate on the date specified in that notice;
3. If any premium payable by You is not paid within its Grace Period, this Policy will terminate on the day after the end of the Grace Period;
4. If You fail to comply with any terms of this Policy or the Application, or otherwise fail to fulfill any obligations or duties under or pertaining to this insurance, or fail to comply with or cooperate with Us in satisfying the requirements of any applicable law or regulation pertaining to this insurance, this Policy will terminate on the 32nd day after We have given You written notice of Our intent to terminate; or
5. If the number of Insureds during any 12-month period does not meet the Minimum Participation Requirement shown in Your Application, this Policy may terminate at Our discretion on the 32nd day after We have given You written notice of Our intent to terminate.

Termination of an Insured's coverage that was effective prior to the date Your coverage terminated will be governed by the Termination of Insurance provision of the Certificate. You are required to notify Us of any such termination.

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

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

Minimum Participation Requirement – You must maintain the participation levels described in the Policyholder Application. If participation falls below the minimum participation limit, We have the right to cancel this Policy.

GENERAL PROVISIONS

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

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

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

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

Entire Contract - The entire contract consists of: this Policy; Policyholder Application; the Certificates; any attached Amendments, Endorsements, Riders; and Insureds' Applications.

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

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

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

Time Limit On Certain Defenses - Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after this Policy has been in force for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts would be 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.

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

CERTIFICATE PROVISIONS MADE A PART OF THIS POLICY
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The remainder of this Policy consists of the provisions that appear in the Certificate, including any Amendments, Endorsements, or Riders, that describe the insurance made available to the employees or members (and their Spouses and/or Dependent Children, if applicable) under this Policy.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
A Stock Company

This Certificate explains the Group Master Policy for Cancer Only Insurance ("Policy") that is underwritten by Transamerica Life Insurance Company. 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 in this Certificate.

Important Notice - Benefits are payable for loss due to Cancer while the Covered Person is insured under the Policy, subject to the provisions of this coverage. It does not provide benefits for any other sickness or condition.

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

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

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



General Counsel and Secretary



President

Certificate for Group Cancer Only Insurance

**BENEFITS LIMITED TO LOSS DUE TO CANCER ONLY
NO BENEFITS PROVIDED FOR ANY OTHER SICKNESS OR CONDITION
PRE-EXISTING CONDITIONS ARE NOT COVERED DURING THE FIRST 12 MONTHS
READ YOUR CERTIFICATE CAREFULLY
NONPARTICIPATING - NO ANNUAL DIVIDENDS**

Administrative Office:
PO Box 869094
Plano, TX 75086-9817
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SCHEDULE OF BENEFITS

INSURED: XXXXXXXXXXXX

AGE AT ISSUE: XX

CERTIFICATE NUMBER: XXXXXXXXXXXX

EFFECTIVE DATE: XX/XX/XXXX

COVERAGE TYPE: [INDIVIDUAL, INSURED and DEPENDENT CHILDREN, or FAMILY]

TOTAL PREMIUM: \$XX.XX

PREMIUM MODE: [MONTHLY]

TYPE OF COVERAGE

NUMBER OF UNITS

	PLAN 1	PLAN 2
MODULE 1 - HOSPITAL BENEFITS	1 UNITS	2 UNITS
MODULE 2 - SURGERY BENEFITS	1 UNITS	2 UNITS
MODULE 3 - RADIATION AND CHEMOTHERAPY BENEFITS	2 UNITS	3 UNITS
MODULE 4 - WELLNESS AND MISCELLANEOUS BENEFITS	1 UNITS	1 UNITS
MODULE 5 - CANCER MAINTENANCE THERAPY BENEFITS	1 UNITS	2 UNITS
First Occurrence Rider	1 UNIT	2 UNITS
Intensive Care Rider	1 UNITS	2 UNITS

DEFINITIONS

The defined terms below are subject to the provisions of the Policy and this Certificate:

Active Service - You are:

1. Performing in the usual manner all of the regular duties of Your occupation on a scheduled work day; and
2. These duties are performed at one of the places of business where You normally do such duties or at some location to which Your employer sends You.

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

Activities of Daily Living ("ADL") - Activities used in measuring levels of personal functioning capacity. Normally, these activities are performed without Direct Personal Assistance, allowing personal independence in everyday living.

The ADLs are:

1. Contenance: Maintaining control of urination and bowel movements, including the ability to use ostomy supplies or other devices such as catheters;
2. Transferring: Moving between the bed and the chair, or the bed and a wheelchair;
3. Dressing: Putting on and taking off all necessary items of clothing and/or medically necessary braces and artificial limbs usually worn;
4. Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene;
5. Eating: Performing all major tasks of getting food into the body; and
6. Bathing: Ability to bathe by a sponge bath or in a tub or shower, including the task of getting into and out of the tub or shower.

Actual Charge(s) - The amount actually paid by or on behalf of the Covered Person and accepted by the provider as payment for the particular goods or services provided.

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

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

Anesthesiologist or Anesthetist - A licensed practitioner, other than a member of Your Immediate Family, who specializes in anesthesiology.

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

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

Cancer - A disease evidenced by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes carcinoma, sarcoma, malignant melanoma, lymphoma, leukemia, Hodgkin's Disease or any malignant tumor. Cancer does not include other conditions which may be considered precancerous including, but not limited to, leukoplakia, hyperplasia, polycythemia vera, moles, lesions, or similar diseases.

Certificate - This document that describes Your Cancer Only insurance coverage.

Chemotherapist - A licensed healthcare practitioner that authorizes or administers chemotherapy treatment.

Child - A Child of Yours who is unmarried; under the age of 25; dependent upon You for more than 50% of his or her support and maintenance; who lives with You; and is:

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

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

1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after coverage would otherwise terminate;
3. We may require additional proof of such incapacity from time to time, but not more often than once a year after the Child attains age 25; and
4. Your coverage must remain in force.

Common Carrier - Commercial airline, inter-city bus line, or passenger train.

Continuous Loss - Those losses which result from the same or related causes for which benefits are payable under the Policy.

Covered Person - Any or all of the following: You, Your Spouse or Your Child(ren), who have been accepted by Us for coverage.

Date of Positive Diagnosis - It is the day on which:

1. Tissue specimen is taken, or the definitive diagnostic test is performed which confirms Positive Diagnosis when performed by a Pathologist; or
2. Positive Diagnosis is pronounced when a clinical diagnosis is made.

Dependent - Your Child or Spouse as defined in this Certificate. "Family" includes coverage for Child and Spouse.

Direct Personal Assistance - The Covered Person needs physical assistance from another party each and every time they need to perform ADLs. The Covered Person is not able to perform the entire ADL alone even with supports and/or mechanical aids that are normally available.

Effective Date or Certificate Effective Date - The date coverage is in effect is shown on the Schedule of Benefits. The Effective Date will start at 12:01 AM at the main place of business of the Policyholder.

Evidence of Insurability - The correct and complete answers to the questions in Our Application and medical history, if necessary, which may be used by Us to base Our acceptance of any proposed Covered Person.

Extended Care Facility - An institution or that part of an institution licensed or accredited to provide nursing or rehabilitative care under the supervision of a Physician or a Registered Nurse which provides 24-hour skilled nursing service and maintains daily medical records on each patient. It does not include institutions or parts of institutions which are primarily for the care and treatment of the aged, drug addicts, or alcoholics.

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

Group Master Policy or Policy - The complete contract of insurance, which includes the Policy as issued to the Policyholder, as well as any Certificates issued to Insureds, including any Amendments, Endorsements, Riders, and Applications.

Hospice Center - A facility which provides short periods of confinement for terminally ill patients. A Hospice Center must operate a program of hospice care which meets the standards set by the National Hospice Organization. It must also be directed by a Physician, supervised by a Nurse, and licensed or certified by the state in which it is located.

Hospice Team - A team of licensed professionals including a Physician and a Nurse. It may also include a social worker, clergyman, clinical psychologist, physical therapist, or counselor. It must exist primarily to administer a hospice care program meeting the standards of the National Hospice Organization in the patient's home with hospice care available 24 hours a day, 7 days a week.

Hospital - A licensed institution that has on its premises or in facilities available to the Hospital on a contractual 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.

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

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

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

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

Insured - The employee or member covered for this insurance and named in the Schedule of Benefits.

Oncologist - A licensed Physician (MD) with a specialty in the treatment of Cancer.

Outpatient - A Covered Person who receives medical tests, treatment, or services from a Hospital, Ambulatory Surgical Center, or a medical clinic and is not charged for room and board.

Pathologist - A licensed Physician who has been certified by the American Board of Pathology or the Osteopathic Board of Pathology to practice pathological anatomy.

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

Physician - A licensed practitioner of the healing arts who:

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

Policyholder - The entity named on the cover page of the Policy.

Positive Diagnosis/Positively Diagnosed - A diagnosis made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system either during life or post mortem (i.e., a pathological diagnosis). The Pathologist's judgment for establishing the diagnosis will be based solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor or tissue specimen. We will accept a clinical diagnosis in lieu of a pathological diagnosis only when:

1. The pathological diagnosis cannot be made;
2. Medical evidence substantially documents the diagnosis; and
3. Definitive treatment is received for the Cancer; or
4. We pay benefits under Skin Cancer.

Pre-Existing Condition - A sickness or physical condition for which the Covered Person:

1. Had treatment; or
2. Incurred expense; or
3. Took medication; or
4. Received a diagnosis or advice from a Physician,

during the 12-month period immediately before the Effective Date of the Covered Person's coverage.

The term "Pre-Existing Condition" will also include a condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment.

Private Duty Nurse - Anyone, other than You or Your Immediate Family Member, who is a Licensed Practical Nurse (L.P.N.), a Licensed Vocational Nurse (L.V.N.), or a graduate Registered Nurse (R. N.).

Radiologist or Radiation Therapist - A Physician certified by the American Board of Radiology to administer therapeutic radiation.

Schedule of Benefits or Schedule - The benefit schedule set forth in this Certificate.

Skin Cancer - Basal cell epithelioma or squamous cell carcinoma. It does not include malignant melanoma or mycosis fungoides. These are not considered Skin Cancers under this Certificate for the purpose of paying benefits under the Skin Cancer provision.

Speech Pathologist/Therapist - Anyone, other than You or Your Immediate Family Member, who is licensed to practice speech pathology.

Spouse - Your legally married Spouse named in the Application. If You are not legally married, "Spouse" may include Your common law spouse if named in the Application and if legally recognized in the state in which You reside.

Total Disability or Totally Disabled - Through age 64, Total Disability will mean the inability to perform all of the material and substantial duties of Your regular occupation. Total Disability will be considered to exist when You are under the regular care and attendance of a Physician for the necessary treatment of Cancer. After the first two years of Total Disability, You will continue to be considered Totally Disabled if You are unable to engage in any employment or occupation for which You are or You become qualified by reason of education, training, or experience.

On Your 65th birthday and thereafter, Total Disability will mean that Your Physician has certified that You are unable to perform two or more Activities of Daily Living without Direct Personal Assistance as a result of Your Cancer.

Twelve-Month (12-Month) Benefit Period - The initial 12-Month Benefit Period is the 12-month period beginning on the Date of Positive Diagnosis. Subsequent 12-Month Benefit Periods begin on the same month and day as the immediately preceding 12-Month Benefit Period; however, if the Covered Person incurs no covered loss during the 3 months after the end of any 12-Month Benefit Period, the next 12-Month Benefit Period will begin on the next date a covered loss is incurred. Twelve-Month Benefit Periods are determined separately for each Covered Person.

We, Us, or Our - The Insurer that underwrites this coverage: Transamerica Life Insurance Company.

You, Your, or Yours - The Insured.

ELIGIBILITY AND EFFECTIVE DATE

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

Employee or Member Eligibility - To be eligible for insurance You must:

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

Employee or Member Effective Date - Your insurance will take effect on the Effective Date of the Policy if:

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

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

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

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

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

You may elect Dependent coverage by:

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

You must complete an Application for enrollment of a Spouse or Child, and pay any required premium within 31 days of the date Your Spouse or Child meets these eligibility criteria. If such Application is not made within that 31-day period, Your Spouse or Child will be considered a late enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Any eligible Dependent who does not become a Covered Person on Your Effective Date may be added to this Certificate subject to:

1. The completion of an Application;
2. Satisfaction of any Evidence of Insurability requirements; and
3. Payment of any additional premium, if required.

If You and Your Spouse are both eligible as an employee or member, the Children may be insured as Dependents of either You or Your Spouse, but not both.

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

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

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

Newborn Child Effective Date - A newborn Dependent Child will become insured for coverage automatically on the day he or she is born, as long as You have Family coverage in force on that date.

If You do not have Dependent coverage in force, the newborn Child's coverage will not continue past the 31-day period following birth, unless:

You have notified Us by the end of the 31-day period of the addition of such newborn Child; and
You have paid any applicable additional premium.

BENEFIT PROVISIONS

If a Covered Person has been Positively Diagnosed with Cancer, We will pay benefits according to the Benefit Provisions section of this Certificate, provided that the loss is incurred (e.g. treatment is received or the service is performed) while this Certificate is in force.

Benefits will begin on the Date of Positive Diagnosis, or as follows:

1. On the date the Covered Person is admitted to the Hospital, if Positive Diagnosis is made during the same Period of Hospital Confinement; but not more than 15 days prior to the Date of Positive Diagnosis; or
2. Not more than 30 days before the Date of Positive Diagnosis for benefits payable under Outpatient Surgery.

Benefit payments will be made directly to You, unless You assign benefits. Proof of Loss must be submitted to Us for each incurred expense.

Under no conditions will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

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

Module 1 - Hospital Benefits

The following benefits are payable per Covered Person, per unit, per day, as described below.

Hospital Confinement

We will pay \$100 per unit, per day, for 90 days for Hospital Confinement for the treatment of Cancer. The maximum number of days We will pay this benefit during a continuous Confinement will not exceed 90 days. Beginning on the 91st day, Our payments for Hospital Confinement will be made under "Extended Benefits."

Extended Benefits

We will pay \$200, per unit, per day, for Hospital Confinement beyond 90 continuous days. This benefit will be paid in lieu of all other benefits under this Certificate, including any attached riders, except for Surgery and Anesthesia which will continue to be payable under their applicable benefit provisions.

Inpatient Drugs and Medicine

We will pay \$15, per unit, per day, per Confinement, for drugs and medicines given to the Covered Person while Hospital Confined.

Attending Physician Benefit

We will pay \$20, per unit, per day, when the attending Physician, other than a surgeon who performed surgery, visits the Covered Person while Hospital Confined.

A "visit" will mean a personal visit by the attending Physician. We will only pay for one visit in any one 24-hour period.

Private Duty Nursing

We will pay \$100, per unit, per day, while Hospital Confined for services by a Private Duty Nurse. Services by a Private Duty Nurse must be:

1. Authorized by the attending Physician; and
2. Provided by a Private Duty Nurse who is not acting as a regular staff member of the Hospital in which the Covered Person is Confined.

Ambulance

We will pay \$100, per unit, per continuous Confinement by a licensed professional ambulance service for:

1. Transportation to a Hospital to which the Covered Person is admitted; and
2. Transportation from a Hospital from which the Covered Person has been released to a different Hospital to which the Covered Person is admitted.

Extended Care Facility

We will pay \$100, per unit, per day, for each day a Covered Person is Confined in an Extended Care Facility. This benefit is limited to the number of days of the prior continuous Hospital Confinement. Confinement in an Extended Care Facility must be at the direction of the attending Physician and must begin within 14 days of the Hospital Confinement.

Government or Charity Hospital

We will pay \$100, per unit, per day, in lieu of all other benefits in this Certificate when the Covered Person is Hospital Confined in a government or charity Hospital.

Confinement must be in a Hospital owned or operated by the United States Government or a Hospital that does not charge the Covered Person for its services. Confinement must be primarily for the treatment of Cancer.

Hospice Care

We will pay \$100, per unit, per day, for a Confinement in a Hospice Center or for Hospice Care at home by a Hospice Team. This benefit is limited to a lifetime maximum of 100 days per Covered Person. Our payments will be based on the following conditions being met:

1. The Covered Person has been given a prognosis as being terminally ill with an estimated life expectancy of 6 months or less; and
2. We have received a written summary of such prognosis by the attending Physician.

We will not pay this benefit while the Covered Person is Hospital Confined.

Module 2 - Surgery Benefits

The following benefits are payable per Covered Person as described below.

Surgery

With the exception of Skin Cancer, We will pay the amount shown on the Surgical Schedule, not to exceed \$1,000 per unit while Hospital Confined. If two or more surgical procedures are performed through the same incision, We will only pay for the procedure having the highest benefit as determined by this provision. If two or more procedures are made in separate incisions, We will pay the highest benefit as the primary procedure and 50% for each of the lesser benefits.

For surgery performed for the treatment of Cancer that does not appear in the Surgical Schedule, We will pay the lesser of:

1. An amount, per unit, determined by multiplying the Work Relative Value Unit obtained from the Medicare Physician Fee Schedule in effect on the date of service by \$25; or
2. \$1,000 per unit.

Anesthesia

We will pay 25% of the surgery benefit for Anesthesia. It must be given by or under the direction of an Anesthesiologist or by an Anesthetist under the direction of a Physician.

Prosthesis

We will pay the Actual Charges, not to exceed \$500, per unit, for a prosthetic device and its implantation. The prosthesis must be authorized by the attending Physician and must require surgical implantation.

Hair Prosthesis

We will pay a one time benefit per Covered Person for the Actual Charges, not to exceed \$50, per unit, for a wig or hairpiece if the Covered Person experiences hair loss as a result of Cancer treatment.

Reconstructive Surgery

We will pay the amount shown, below, for reconstructive surgery, anesthesia, post-operative care, and any other related charges for the general forms of Cancer listed below.

General Form of Cancer	Per Unit
1. Breast Cancer-after simple or total mastectomy-each breast	\$120
2. Breast Cancer-after radical mastectomy each breast	\$170
3. Cancers of the male or female genitalia	\$170
4. Cancers of the head or neck, including oral cancers, but excluding Skin Cancer and malignant melanoma	\$250

Reconstructive surgery must be performed by a licensed plastic surgeon not more than two years following the initial surgery to remove the Cancer. If reconstructive surgery is performed on the same day as the implantation of a prosthetic device, We will pay only for the procedure having the higher benefit value. We will not pay benefits under this provision when they are paid under any other benefit.

Second Surgical Opinion

We will pay \$100, per unit, for the opinion of a second surgeon payable when the prescribed treatment is surgery as determined by the first surgeon. The Covered Person may use this benefit at his or her discretion. None of the other benefits in this Certificate will be affected by this decision. This benefit is payable only after Positive Diagnosis has been made.

A second surgical opinion must be received before surgery is performed. This benefit is not payable for Skin Cancer. We will require a written copy of the initial surgical opinion in addition to the second surgical opinion.

Ambulatory Surgical Center

We will pay the surgical center charges, not to exceed \$150, per unit, per day, for surgery performed at an Ambulatory Surgical Center or at a Hospital when the Covered Person is an Outpatient.

Outpatient Surgery

With the exception of Skin Cancer, surgeries performed on an Outpatient basis are paid at 150% of the scheduled benefit. For Outpatient Surgery performed for the treatment of Cancer that does not appear in the Surgical Schedule, We will pay the lesser of:

1. An amount, per unit, determined by multiplying the Work Relative Value Unit obtained from the Medicare Fee Schedule in effect on the date of service by \$37.50; or
2. \$1,500 per unit.

Skin Cancer (see Surgical Schedule for Melanoma Only)

If Positively Diagnosed with Skin Cancer, We will pay \$75, per unit, per diagnosis for the initial removal of Skin Cancer by a Physician; and \$35, per unit, for each additional removal.

Surgical Schedule

Procedure and Benefit Amount Per Unit

EYE AND EAR

Biopsy of external ear	\$20
Biopsy of cornea	\$40
Iridectomy	\$250
Mastoidectomy	
1. Complete	\$310
2. Radical	\$340
Iridectomy with cyclectomy	\$350

HEAD, NECK & SPINE

Oropharynx biopsy, excisional	\$40
Thyroid biopsy needle	\$40
Laryngoscopy with biopsy	\$80
Pharyngectomy limited	\$470
Laryngectomy:	
1. Subtotal, with bilateral node Dissection	\$760
2. Total, with radical neck dissection	\$960

Procedure and Benefit Amount Per Unit

HEAD, NECK & SPINE (cont'd)

Adrenalectomy, partial or	
Complete thyroidectomy	\$450
1. Subtotal, with limited neck Dissection	\$550
2. Total, with radical neck dissection	\$710
Laminectomy for Intraspinal malignancy	\$560
Excision of Malignant Brain Tumor:	
1. All tumors except meningioma	\$920
2. Meningioma	\$1000
Hemispherectomy:	
1. Partial	\$780
2. Total	\$830

SKIN (MELANOMA ONLY) AND ORAL

Biopsy:	
1. Skin surface	\$20
2. Mouth or tongue	\$40

Procedure and Benefit Amount Per Unit**SKIN (MELANOMA ONLY) AND ORAL (cont'd)**

Excision of malignant lesion:	
1. Skin surface	\$70
2. Lip or mouth with resection	\$80
Glossectomy:	
1. Less than one half of tongue	\$270
2. Complete or total	\$720
3. With radical neck dissection	\$940

THORAX

Breast biopsy:	
1. Needle	\$30
2. Incisional, unilateral	\$80
Lung biopsy, needle	\$50
Thoracoscopy with biopsy	\$150
Bronchoscopy with biopsy	\$80
Lumpectomy, unilateral	\$150
Mastectomy, simple:	
1. Unilateral	\$390
2. Bilateral	\$590
Mastectomy, radical including:	
Axillary lymph nodes, unilateral	\$430
Mastectomy, modified radical With axillary lymph nodes	\$450
Partial mastectomy	\$150
Partial mastectomy with axillary	
Lymphadenectomy	\$350
Lobectomy of Lung total or segmented	\$640
Pneumonectomy	\$680

ABDOMEN AND PELVIS

Liver biopsy	\$50
Colonoscopy with biopsy	\$110
Upper GI Endoscopy with biopsy	\$70
Enterectomy: resection of small intestine with anastomosis	\$520
Gastrectomy:	
1. Partial	\$610
2. Total, with intestinal anastomosis	\$850
Hepatectomy, partial lobectomy	\$970
Colectomy, partial with colostomy	\$560
Colectomy, total abdominal, with ileostomy or ileoproctostomy	\$750
Esophagectomy	\$1000
Pancreatectomy, Whipple Type	\$1000
Esophagomyotomy:	
1. Abdominal approach	\$550
2. Thoracic approach	\$570

UNIARY TRACT

Cystoscopy with biopsy	\$70
Ureteral endoscopy with biopsy	\$170
Renal biopsy needle	\$70

Procedure and Benefit Amount Per Unit**UNIARY TRACT (cont'd)**

Cystectomy:	
1. Partial, simple	\$430
2. Complete	\$680
3. Complete, with uretero-cutaneous Transplant	\$880
Urethrectomy, total with cystostomy	\$340
Nephrectomy, radical with excision of regional lymph nodes	\$590
Cystotomy with resection of bladder tumor	\$340
TURB	\$240

RECTUM

Proctosigmoidoscopy with biopsy	\$30
Rectal biopsy, incisional	\$100
Proctectomy, complete	\$760

MALE GENITALIA

Biopsy of Penis, cutaneous	\$50
Prostate biopsy	
1. Non-incisional	\$70
2. Incisional	\$120
Biopsy of Testis, incisional	
1. Unilateral	\$90
2. Bilateral	\$130
Orchiectomy, simple:	
1. Unilateral	\$130
2. Bilateral	\$200
Amputation of Penis	
1. Partial	\$270
2. Complete	\$360
Prostatectomy, radical	\$760
TURP	\$140

FEMAL GENITALIA

Biopsy of Vulva	\$30
Biopsy of Vaginal Mucosa	\$30
Cervical biopsy	\$60
Trachelectomy, partial, with dilation and Curettage	\$130
Vaginectomy	\$390
Vaginectomy:	
1. Partial	\$370
2. Complete	\$490
Oophorectomy	\$200
Uterine Myomectomy, abdominal Approach	
Vulvectomy, radical with excision of regional lymph nodes	\$620
Hysterectomy:	
1. Total abdominal	\$430
2. Radical abdominal	\$770
Dilation and Curettage	\$90

Procedure and Benefit Amount Per Unit**GENERAL AMPUTATIONS**

Finger, each	\$150
Toe, each	\$90
Foot, each	\$220
Arm, each	\$250
Lower leg, each	\$280
Thigh	\$330
Interpelviabdominal	\$610

Procedure and Benefit Amount Per Unit**MISCELLANEOUS**

Muscle biopsy, excisional:	
1. Superficial	\$40
2. Deep	\$60
Bone marrow aspiration with biopsy	\$30
Superficial lymph node biopsy needle	\$30
Sequestrectomy for osteomyelitis:	
1. Scapula or clavicle, with suction or irrigation	\$180
2. Humeral head to surgical neck, with suction irrigation	\$250
Laparotomy (exploratory procedure)	\$310
Splenectomy:	
1. Laparoscopic	\$420
2. Partial or total	\$490

Module 3 - Radiation and Chemotherapy Benefits

The following benefits are payable per Covered Person as described below.

Radiation and Chemotherapy

Treatments - We will pay the Actual Charges, per 12-Month Benefit Period, for radiation or chemotherapy treatments authorized by a Radiologist, Chemotherapist, or Oncologist. The maximum benefit under this provision per Covered Person for any 12-Month Benefit Period will not exceed a total of \$5,000, per unit, regardless of the treatment or combination of treatments received in that period.

Under this provision, We will not pay related expenses for: prescribed medications for side effects, physical exams, checkups, laboratory or diagnostic tests, treatment consultations and planning, or any similar such expenses. Radiation or chemotherapy does not include laser or stereotactic surgery.

Associated Expenses - We will pay \$250, per unit, per 12-Month Benefit Period for the following radiation or chemotherapy-related expenses: treatment consultations and planning, adjunctive therapy, radiation management, chemotherapy administration, physical exams, checkups, and laboratory or diagnostic tests. We will only pay for this benefit when such charges have been submitted to Us and authorized by a Radiologist, Chemotherapist, or Oncologist. Transportation expenses are not included as associated expenses.

Blood, Plasma, Platelets, Bone Marrow Transplant, and Stem Cell Transplant

We will pay the Actual Charges, not to exceed a total of \$5,000, per unit, per 12-Month Benefit Period, for:

1. Blood, plasma, and blood components;
2. Bone Marrow Transplant; or
3. Stem Cell Transplant.

We will not pay for the cost of donated blood if the Covered Person does not incur a charge for that blood. The maximum benefit under this provision for any 12-Month Benefit Period will not exceed a total of \$5,000, per unit, regardless of the treatment or combination of treatments received in that period.

Associated Expenses - We will pay \$250, per unit, per 12-Month Benefit Period, for Blood, Plasma, Platelets-related expenses, administration of blood, plasma and blood components, transfusions, processing and procurement, or cross-matching, treatment consultations and planning, physical exams, checkups, and laboratory or diagnostic tests. We will only pay for expenses incurred for the items listed when such expenses have been submitted to Us and authorized by the Covered Person's Physician. Transportation and Lodging expenses are not included as associated expenses.

New or Experimental Treatment

We will pay the Actual Charges, not to exceed \$5,000, per 12-Month Benefit Period, beginning with the first day of benefit under this provision for experimental or investigational treatments of Cancer. This Certificate defines experimental or investigational treatment to be:

1. Drugs or chemical substances approved by the United States Food and Drug Administration for the experimental use on humans; and
2. Surgery or therapy endorsed by either the National Cancer Institute or the American Cancer Society for experimental studies.

The following restrictions and limitations will apply to this benefit:

1. Experimental treatment must be received in a Hospital in the United States or in one of its territories; and
2. The attending Physician has authorized the treatment.

Module 4 - Wellness and Miscellaneous Benefits

The following benefits are payable per Covered Person, and per unit, except for the Non-Local Transportation, Family Member Lodging, the Outpatient Lodging, and the Waiver of Premium, which are payable as described below.

Wellness Benefit

We will pay \$50 per unit, per Calendar Year, for the following Cancer screening tests: mammograms, Pap smears, flexible sigmoidoscopy, prostate-specific antigen tests, chest x-rays, hemocult stool specimen, ultra sounds, CEA, CA125, biopsy, thermography, colonoscopy, serum protein electrophoresis, bone marrow testing, and blood screenings.

Services must be under the supervision of or recommended by a Physician, and a charge must be incurred.

Magnetic Resonance Imaging (MRI) Scans

In addition to the Wellness Benefit, We will pay \$50, per unit, per Calendar Year, for an MRI Scan for a Covered Person who is deemed by a Physician to be at a higher than normal risk of developing breast cancer. Services must be under the supervision and recommended by a Physician, and a charge must be incurred.

Non-Local Transportation

If the prescribed treatment for the Covered Person is not available locally, within a 50 mile radius of the Covered Person's residence, and a non-local Hospital Confinement within the United States is authorized by the attending Physician, We will pay transportation expenses for the Covered Person and for one adult member of Your Immediate Family to be with the Covered Person during such Confinement. Our payments for such transportation expenses will be as follows:

1. The Actual Charge for one round trip by Common Carrier; or
2. Forty cents (\$.40) per mile for one round trip by private vehicle. Mileage is to be measured by the most direct route from the individual's residence to the non-local Hospital. We will accept his or her mileage figures if reasonable. We will not pay for mileage less than 100 miles round trip, nor in excess of 750 miles, round trip.

We will only pay this benefit once per period of Hospital Confinement in a non-local Hospital.

Family Member Lodging

We will pay \$50, per unit, per day, with a maximum of 50 days per 12-Month Benefit Period, for Lodging expenses for one adult member of Your Immediate Family to be with the Covered Person when Confined in a non-local Hospital in the United States. The Lodging benefit may be for a motel, hotel or other accommodations acceptable to Us and will be based on the same number of days the Covered Person is Hospital Confined.

Outpatient Lodging

We will pay \$50, per unit, per day, with a maximum of 50 days per 12-Month Benefit Period, for Lodging expenses for the Covered Person receiving radiation or chemotherapy on an Outpatient basis, provided treatment is authorized by the attending Physician and cannot be obtained locally.

Physical or Speech Therapy

We will pay \$25 per unit per day for therapy sessions, limited to one session per day, for:

1. Physical therapy treatments given by a licensed Physical Therapist at: An Institute of Physical Medicine and Rehabilitation, a Hospital, or Your home; or
2. Speech therapy given by a licensed Speech Pathologist/Therapist.

Physical therapy or speech therapy must be given on an Outpatient basis only; unless, the primary purpose of Your Hospital Confinement is for treatment of Cancer other than with physical therapy or speech therapy.

At Home Nursing

We will pay \$50 per unit per day, limited to the number of days of prior Hospital Confinement, for private nursing care and attendance by a nurse at home. At home nursing services must be required and authorized by the Attending Physician and must begin within 14 days after Confinement as an inpatient in a Hospital.

Waiver of Premium

If the Insured has been Positively Diagnosed with Cancer and is Totally Disabled for a period of 60 consecutive days beginning on the Date of Total Disability due to such Cancer, We will waive each premium that becomes due after such 60 day period as long as the Insured is Totally Disabled.

During any period for which We have waived a premium, this Certificate will be subject to all of its other applicable provisions. Our waiver of premiums will end on any date premium would ordinarily be due when the Insured is not Totally Disabled. Upon the end of Total Disability, the Insured must resume payment of premiums.

This provision does not apply to Total Disability which begins on or after the Insured's 70th birthday.

Module 5 - Cancer Maintenance Therapy Benefits

The following benefits are payable per Covered Person as described below.

We will pay Actual Charges, not to exceed a total of \$1,000, per unit, per 12-Month Benefit Period, for:

1. Cancer Suppressive Therapy - drugs used to keep Cancer in check or after acute chemotherapy treatment.
2. Hematological Drugs - drugs aimed to boost cell lines such as white blood cell counts, red blood cell counts, and platelets.
3. Anti-Nausea Drugs - drugs used to reduce the symptoms brought about as a result of chemotherapy or radiation.
4. Motility Agents - drugs used to improve motility or treat side effects caused by chemotherapy or radiation.

We will not pay benefits under this provision when they are paid under any other benefit.

The maximum benefit under this provision for any Twelve-Month Benefit Period will not exceed a total of \$1,000 per unit, regardless of the treatment or combination of treatments received in that period.

EXCLUSIONS AND LIMITATIONS

This Certificate provides benefits only for Cancer as defined herein, which is Positively Diagnosed while this Certificate is in force. It does not provide benefits for any other illness or disease.

1. We may reduce or deny a claim or void the Certificate for loss incurred by a Covered Person:
 - a. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected our acceptance of the risk; or
 - b. At any time for fraudulent misstatements in the Application.
2. We will only pay for loss as a direct result of Cancer. Proof of Positive Diagnosis must be submitted to Us for each new claim. We will not pay for any other disease or incapacity that has been caused, complicated, worsened or affected by, or as a result of, Cancer.
3. If a covered Hospital Confinement is due to more than one covered disease or condition, benefits will be payable as though the Confinement or expense were due to one disease or condition. If a Hospital Confinement or expense is also due to a disease or condition that is not covered, benefits will be payable only for the part of the Hospital Confinement or expense due to the covered disease or condition.
4. Under no condition will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

Pre-Existing Condition Limitation - No benefits are provided during the first 12 months for any Cancer that has been diagnosed, treated, or for which the Covered Person has incurred expense or has taken medication within 12 months prior to the Effective Date of such person's coverage.

PREMIUMS

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

We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, We will give at least a 31-day advance written notice to the Policyholder, or to You if the Portability Option is in effect. If an increase takes place on other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

If the premiums increase because a change in benefits increases Our liability, premium rates may be changed on the date that Our liability is increased, without regard to any premium rate guarantee.

TERMINATION OF INSURANCE

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

1. The last day of the payroll deduction period during which You cease to be eligible for coverage;
2. The end of the last period for which premium payment has been made to Us;
3. The last day of the payroll deduction period during which You terminate employment;
4. The date the Policy terminates; 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 end of the last period for which premium payment has been made to Us;
3. The date the Dependent no longer meets the definition of Dependent;
4. The date the Policy is modified so as to exclude Dependent coverage; or
5. The date You send Us a written notice that You want to cancel Your Dependent's coverage.

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

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

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

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

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

PORTABILITY OPTION

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. If You stop paying the premiums under this option, this coverage will continue, subject to the terms of the Grace Period.

CLAIMS PROVISIONS

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

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

Notice of Claim - Written notice of claim must be given to Us at Our Administrative Office, or to Our agent. Such notice should be made within 30 days after any loss covered by the Policy. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

Payment of Claim Benefits - Benefits may be assigned to the provider(s) of such benefits. Otherwise, all benefits payable under the Policy will be paid to You. Accrued benefits that are not paid at Your death will be paid to Your Spouse, or if there is no Spouse, then to Your estate. We may pay up to \$1,000.00 of such benefit to one of Your relatives at Our discretion. Such payment 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. We will pay for such examination. In case of death, We may request an autopsy where it is not forbidden by law.

Proof of Loss - Satisfactory 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 90 days after the termination of the period for which We are liable. For any other loss, proof must be sent within 90 days after the date of such loss.

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

Time of Payment of Claims - Benefits for a covered loss will be paid after We receive satisfactory written Proof of Loss.

GENERAL PROVISIONS

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

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

Entire Contract - The Entire Contract consists of the Policy, this Certificate, any attached Amendments, Endorsements, or Riders, the Policyholder's Application, and Your Application.

Grace Period - A Grace Period of 31 days will be allowed for each premium payment after the first premium is paid. 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. You must still pay all unpaid premium. This includes the premium due for the Grace Period.

If coverage is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If coverage is canceled 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 and/or Certificate:

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

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

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

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

Time Limit on Certain Defenses

Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after this Certificate has been in force during Your lifetime for two years from the Effective Date of coverage. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts would be 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.

Pre-Existing Conditions - No claim for loss incurred or disability that starts after 12 months from the Effective Date will be reduced or denied because a physical condition, not excluded by name or specific description before the date of loss, had existed before the Effective Date of coverage.

When Notice is to be 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")

AMENDMENT

This Amendment is attached to and made a part of the Contract, as defined below.

DEFINITIONS

The following definitions are added:

Contract - The Policy for Cancer Only Insurance and any Certificate, if applicable, to which this Amendment is attached.

Chemotherapy - Drugs and cytotoxic chemical substances which are used as curative or therapeutic treatment to destroy, reduce, or control malignant cancer cells. The United States Food and Drug Administration must approve such drugs or therapies specifically for use as anti-cancer treatment or therapy.

Radiation Therapy - The use of ionizing radiation as curative or therapeutic treatment to destroy, reduce or control malignant cancer cells. The United States Food and Drug Administration must approve such drugs or therapies specifically for use as anti-cancer treatment or therapy.

BENEFIT PROVISIONS

The following benefit provisions have been revised as follows:

Module 1 - Hospital Benefits

Hospital Confinement - First sentence - Delete reference to "90 days" for Hospital Confinement. This sentence now reads:

We will pay \$100 per unit, per day, for Hospital Confinement for the treatment of Cancer.

Module 3 - Radiation and Chemotherapy Benefits

New or Experimental Treatment - First sentence - Add the words "per unit" after \$5,000. This sentence now reads:

We will pay the Actual Charges, not to exceed \$5,000, per unit, per 12-Month Benefit Period, beginning with the first day of benefit under this provision for experimental or investigational treatments of Cancer.

Module 4 - Wellness and Miscellaneous Benefits

The first paragraph has been revised to delete reference to each benefit as being "per unit" or "not per unit" as follows:

The following benefits are payable per Covered Person:

This Amendment does not waive, alter, or extend any condition or provision of the Contract, except to the extent shown above. It is subject to all the terms and limitations of the Contract. This Amendment takes effect and expires concurrently with the Contract to which it is attached and is signed for the Company at Our Home Office.



General Counsel and Secretary



President

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")

TEXAS AMENDMENT

This Amendment is attached to and made a part of the Contract, as defined below, for residents of the State of Texas.

DEFINITIONS

The following definition is added to this Amendment:

Contract - The Policy for Group Cancer Only Insurance and any Certificate, if applicable, to which this Amendment is attached.

The definition of **Child** is amended as follows:

1. By removing the phrase "dependent upon You for more than 50% of his or her support and maintenance" and replacing it with "dependent upon You for his or her support."; and
2. By adding that a Dependent Child includes a stepchild or a child under a medical support order issued under Chapter 154 Family Code or enforceable by a court in this State.

The definition of **Positive Diagnosis/Positively Diagnosed** is amended by removing the following sentence:

The Pathologist's judgment for establishing the diagnosis will be based solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor or tissue specimen.

PREMIUMS

The second paragraph of the **Premiums** section of the Contract is amended to provide that a notice of a premium increase will be given at least 60 days, not 31 days, before the increase.

GENERAL PROVISIONS

The following provision is added to the **General Provisions** section of the Contract:

Payment Under The Texas Medical Assistance Act - If You are a resident of Texas, the benefits under this Contract will not be reduced or denied because such benefits are covered by The Medical Assistance Act of 1967, as amended. Benefits will be paid to the Texas Department of Human Resources for the actual cost of medical expenses it pays through medical assistance for a person, child, or children insured by this Contract, if the Covered Person would otherwise be entitled to payment of benefits for such medical expenses. Benefits so paid will, in no event, exceed benefits otherwise payable under this Contract. Any benefits payable for expenses not paid by such Department will be paid as provided in this Contract.

This Amendment does not waive, alter, or extend any condition or provision of the Contract, except to the extent shown above. It is subject to all the terms and limitations of the Contract. This Amendment takes effect and expires concurrently with the Contract to which it is attached and is signed for the Company at Our Home Office.



General Counsel and Secretary



President



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

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

Administrative Office: PO Box 869094, Plano, TX 75086-9817

ENDORSEMENT

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

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

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

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

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

General Counsel and Secretary

Accepted by: _____

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

Date: _____

TRANSAMERICA LIFE INSURANCE COMPANY

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

FIRST OCCURRENCE RIDER

This Rider is attached to and made part of the Contract, as defined below, as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the Contract will prevail.

While this Rider is in force, We will pay benefits described in "What We Will Pay" section of this Rider when the Covered Person is Initially Positively Diagnosed with Cancer, other than Skin Cancer, subject to all of its provisions, conditions, exceptions, and limitations.

DEFINITIONS

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

Contract - The Policy for Group Cancer Only Insurance or any Certificate, if applicable, to which this Rider is attached.

Effective Date - The Effective Date of the Contract or the date shown for this Rider if added to the Contract at a later date.

Initial Positive Diagnosis/Initially Positively Diagnosed - A first time ever Positive Diagnosis made by a Pathologist based on a microscopic examination of fixed tissue or preparations from the hemic system either during life or post mortem (i.e., a pathological diagnosis). The Pathologist's judgment for establishing the diagnosis will be based solely on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor or tissue specimen. We will accept a clinical diagnosis in lieu of a pathological diagnosis only when:

1. The pathological diagnosis cannot be made;
2. Medical evidence substantially documents the diagnosis; and
3. Definitive treatment is received for the Cancer.

WHAT WE WILL PAY

When a Covered Person has been Initially Positively Diagnosed with Cancer (excluding Skin Cancer), and while this Rider is in force, We will pay a one time benefit of \$1,000 per unit. The number of units selected by the Policyholder for each benefit is shown on the Schedule of Benefits. This benefit is payable only once per lifetime per Covered Person and is in addition to any other benefits payable under the Contract.

Benefit payment will be made directly to You, unless You assign benefits. Proof of the Initial Positive Diagnosis of Cancer must be submitted to Us.

WHAT WE WILL NOT PAY

Benefits are not payable:

1. For expenses incurred prior to the Effective Date of this Rider;
2. During the first 12 months for any Cancer diagnosed within 12 months prior to the Effective Date of such person's coverage;
3. For any other illness or disease other than internal Cancer; and
4. For Skin Cancer or any Cancer excluded from coverage by name or specific description.

We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:

1. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected Our acceptance of the risk; or
2. At any time for fraudulent misstatements in the Application.

WHEN THIS RIDER STARTS

This Rider becomes effective on the same date as the Contract Date unless We inform the Insured in writing of a different date.

WHEN THIS RIDER ENDS

This Rider will terminate for any one of the following reasons which occurs first:

1. The Contract terminates;
2. Failure to pay the renewal premium before the end of the Grace Period; or
3. Our receipt of the Policyholder's written request to terminate this Rider.

Termination due to Item 3 will be on the next renewal date, after Our receipt of the written notice, or any later specified date, if the mode of premium payment is monthly. Otherwise, it will be on the date of our receipt of such written notice, or any later date as indicated by the Policyholder. Any premium paid in advance of the termination date due to Item 3 will be refunded to the Insured.

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

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

INTENSIVE CARE RIDER

This Rider is attached to and made part of the Contract, as defined below, as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. Except as shown in this Rider, the provisions of the Contract will prevail.

While this Rider is in force, We will pay benefits described in "What We Will Pay" section of this Rider for loss from sickness or injury resulting from the Covered Person's Confinement in an Intensive Care Unit or a Step Down Unit on or after the Effective Date, subject to all of its provisions, conditions, exceptions, and limitations.

DEFINITIONS

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

Contract - The Policy for Group Cancer Only Insurance or any Certificate, if applicable, to which this Rider is attached.

Effective Date - The Effective Date of the Contract or the date shown for this Rider if added to the Contract at a later date.

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

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

ICU includes intensive cardiac and coronary care units, neonatal ICUs, and burn ICUs, if such units meet the conditions in this definition. ICU does not include any of the following lesser treatment units: private or semi-private rooms, private monitored/telemetry rooms, observation units, surgical recovery units, or other lesser treatment units.

Period of Intensive Care Confinement - A period of Hospital Confinement when the Covered Person is Confined to the ICU or a Step Down Unit and charged the Intensive Care or Step Down Unit rate for each day of such Confinement. If 30 days or less separates two Periods of Intensive Care Confinement, the second Period of Intensive Care Confinement will be considered a continuation of the first.

Step Down Unit - A specially designed area of the Hospital that provides medical care restricted to those patients who are critically ill or critically injured, providing a level of care just under that of an Intensive Care Unit. Step Down Unit includes: progressive care units; subacute intensive care units; and intermediate care units. This does not include lesser treatment units, such as: private or semi-private rooms; private monitored/telemetry rooms; observation units; or surgical recovery units.

WHAT WE WILL PAY

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

Daily Indemnity - We will pay \$100, per unit, for each day the Covered Person is Confined in an ICU. We will pay 50% of this Daily Indemnity Benefit for treatment in a Step Down Unit when the Covered Person is Confined on an inpatient basis. During any one Period of Intensive Care Confinement, Our payments will not exceed 45 days for sickness or injury.

Ambulance - We will pay the Actual Charges for transportation by a licensed ambulance service, not to exceed \$200 per unit, per Period of Intensive Care Confinement, to a Hospital for admission to an ICU or a Step Down Unit for a covered Confinement.

Ambulance transportation in excess of 100 miles from the point of origin must be to the nearest Hospital which contains an ICU and provides necessary medical care. We will not pay this benefit when it is paid under the Contract.

Benefit payments will be made directly to You, unless You assign benefits. Proof of Loss must be submitted to Us for each incurred expense.

WHAT WE WILL NOT PAY

1. We will not pay any benefits for loss resulting from:
 - a. Specifically excluded diseases or conditions in the Contract or in this Rider; or
 - b. An attempted suicide while sane or insane or an intentionally self-inflicted injury; or
 - c. Any act of war either declared or undeclared; or
 - d. Alcoholism or drug addiction; or
 - e. Mental or nervous disorders; or
 - f. An overdose of drugs, narcotics, hallucinogens, unless administered on the advice of a Physician; or
 - g. Intoxication, or being under the influence of any intoxicant or narcotic, unless administered on the advice of a Physician; or
 - h. Injury received while engaging in an illegal occupation or activity.
2. We may reduce or deny a claim or void this Rider for loss incurred by a Covered Person:
 - a. During the first 2 years from the Effective Date of such coverage for any misstatements in the Application which would have materially affected our acceptance of the risk; or
 - b. At any time for fraudulent misstatements in the Application.
3. We will pay only one daily indemnity benefit per day.
4. With respect to the benefits offered by this Rider, the "Time Limit on Certain Defenses" provision in the Contract will apply from the Effective Date of this Rider.

Under no conditions will We pay any benefits for losses or medical expenses incurred prior to the Effective Date.

WHEN THIS RIDER STARTS

This Rider becomes effective on the same date as the Contract Date unless We inform the Insured in writing of a different date.

WHEN THIS RIDER ENDS

This Rider will terminate for any one of the following reasons which occurs first:

1. The Contract terminates; or
2. Failure to pay the renewal premium before the end of the grace period; or
3. Our receipt of the Policyholder's written request to terminate this Rider.

Termination due to Item 3 will be on the next renewal date, after Our receipt of the written notice, or any later specified date, if the mode of premium payment is monthly. Otherwise, it will be on the date of our receipt of such written notice, or any later date as indicated by the Policyholder. Any premium paid in advance of the termination date due to Item 3 will be refunded to the Insured.

Signed for the Company at Our Home Office to take effect on the Rider Effective Date.



General Counsel and Secretary



President

COMPENSATION DISCLOSURE NOTICE TO ALL POLICYHOLDERS

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

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

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

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

For up to date information regarding our compensation practices, please consult our website at: www.transamericaemployeebenefits.com.



Transamerica Life Insurance Company
 Home Office: Cedar Rapids, IA
 Administrative Office: P.O. Box 869094
 Plano, TX 75086-9817

**Life and Health
 Group Application
 and Agreement**

Name of Group ("you, your"): Three Rivers ISD	Tax ID Number: 74-6002404	SIC Code: 8299	Website Address: https://www.trisd.org//
Street Address: 351 South School RD	City: Three Rivers	State: TX	ZIP Code: 78071
Contact Name: Angelia Anderson	Email Address: aanderson@trisd.org	Phone #: 361-786-3603 ext.103	Fax #:
Nature of Group: Elementary and Secondary Schools	# of Employees/Members: 130	# Eligible for Coverage: 130	# of Years in Existence: 104

You hereby authorize Transamerica Life Insurance Company, our authorized agents or our enrollers (collectively referred to as we, us, or our) to offer each of your eligible employees/members the opportunity to purchase insurance coverage as described in this form. This authorization is based upon the following agreements:

- We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
- The initial enrollment shall take place from 8/3 to 8/6. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
- Unless otherwise agreed upon by you and us, you will collect premiums from your participating employees/members. You will forward the premiums to us within 15 days after you receive the monthly bill. You will maintain records of all premiums collected from your employees/members while this agreement remains in force and for two years after it terminates. During this period, you will make these records available for inspection and audit by us during normal business hours. If premium contributions collected by you, your employees, or your vendors are misappropriated, you will reimburse us for our entire loss, including attorney fees and expenses incurred in collection, to the extent permitted by the laws of your state. For New Hampshire Policyholders, we are required by law to complete any premium audits within 120 days after termination of the Policy

4. Do benefit selections vary by class? No Yes (define classes below)

Definition of Class 1:	
Definition of Class 2:	
Definition of Class 3:	
Definition of Class 4:	

5. Eligibility for insurance:

- a. Employer Groups - eligible employees are defined as those who work at least 17 hours per week for you, and have been so employed for at least 1 days.
- | Class | Class 2 | Class 3 | Class 4 |
|-------|---------|---------|---------|
| 17 | | | |
| 1 | | | |
- b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws.
 For New Hampshire - Member Groups are not eligible to purchase our Accident and Health products

6. Is dependent coverage being offered? Yes No

7. Is coverage being offered through a Section 125 plan? Yes No

If "yes", which product(s): Cancer Plan Start Date: 09/01/2021 Plan Anniversary Date 08/31/2022

8. Is coverage being offered replacing existing coverage? Yes No

If "yes", which products? Cancer and Hospital Indemnity

I have read the Fraud Warning for my state shown on Page 2 of this form.

I understand and agree that this application will be made part of each group master policy issued as a result of this application. The Group listed above will be named as the Policyholder for each group master policy. I agree that no insurance will be effective until approved by us at our administrative office.

For New Hampshire Policyholders - I agree to the offering of the selected products in the Insurance Selections section for the eligible employees.

For New Hampshire Policyholders - All policies (except life) provide limited benefits. If accepted for coverage, review your policy carefully.

Signed in (City/State) Three Rivers / Texas This 16th Day of (Month/Year) May 2021

Signature of Officer: Angelia K Anderson Business Manager
 Email Address: aanderson@trisd.org

Print Name and Title of Officer
 For Florida - Is coverage being offered replacing existing coverage? Yes No

DocuSigned by:
 If "yes", which products?

David Perry 6/2/2021 dperry@fbmc.com

Signature of Licensed Agent/Producer Email Address
David Perry **TR032214A**

Print Name of Licensed Agent/Producer Agent/Producer Number License Number

Fraud Warning

Alabama

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arkansas and Maryland

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

California

The falsity of any statement in the application for any policy covered by this chapter shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

District of Columbia, Louisiana and Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Florida

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Kansas

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.

Kentucky

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which is a crime.

Massachusetts and Oregon

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, commits a fraudulent insurance act which may be a crime and may subject such person to criminal and civil penalties.

New Jersey

I understand that any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. I represent that all statements made on or attached to this application are true and complete to the best of my knowledge and belief.

North Carolina

I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, is guilty of a crime (Class H felony), which may be subject to criminal and civil penalties.

Oklahoma

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Puerto Rico

Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Tennessee and Washington

It is a crime to knowingly present false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Virginia

I understand that any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Vermont

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, any information concerning any fact material thereto, may be committing a fraudulent insurance act which may be a crime subject to criminal and civil penalties.

For Maine, Pennsylvania and All other states

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Billing Information

Billing Name (if other than group name) FBMC Benefits Management			
Billing Address: 3101 Sessions Road	City: Tallahassee	State: FL	ZIP Code: 32303
Billing Contact Name: Emily Faimoa	Email Address: efaimoa@fbmc.com	Phone #: 850-425-6200	Fax #:
Billing Address is: <input type="checkbox"/> Group Policyholder <input checked="" type="checkbox"/> Third Party Administrator <input type="checkbox"/> Premium Collection Agency (Requires a Premium Collection Agreement)			
Pay periods per year: 12	Payments will be remitted: _____ ter each deduction <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
Payroll deductions per year: 12	Premium amount on bill should reflect: <input type="checkbox"/> Levelized amount over 12 months <input checked="" type="checkbox"/> Actual amount of deductions		
First payroll deduction date: 09/20/2021	Preferred billing sequence: <input checked="" type="checkbox"/> Alphabetical <input type="checkbox"/> Social Security Number <input type="checkbox"/> Employee/Member ID		
First bill due date: 10/1/2021	Preferred Billing Method: <input checked="" type="checkbox"/> Paper <input type="checkbox"/> Website <input type="checkbox"/> Self-Bill	Multiple Billing Locations: <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes (attach listing)	

Please use billing worksheet**Insurance Selections***(Product and Rider availability subject to state approval)*

Participation Requirement: Each group master policy requires a minimum of 2 covered lives or the state minimum, whichever is greater in order to be issued and remain in force. Any group master that falls below this requirement may be terminated, subject to the notice requirements in the master policy. Special underwriting offers may require higher participation in order to continue receiving the special underwriting offer for new insureds.

Master Contract Delivery: Electronic Delivery or Paper (US Mail) Delivery

Group Universal Life Insurance – TransElite Group Contribution? Yes No Requested Effective Date:
If yes, list amount or %:

Coverage: High Face Amount High Accumulation Value ***Attach a copy of the Rate Sheet***
Age Band Rates: Yes No

Accelerated Death Benefit for Terminal Illness/Condition in all states except LA, MA, OH, WA.

Waiver of Monthly Deductions for Layoff included in all states except CT, MA, TN, PR, VT, WA.

ACCEPT	DECLINE	
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Condition: <input type="checkbox"/> 25% <input type="checkbox"/> 50% (Not available in CA, CT, FL, LA, MA, NJ, OH, PA, WA)
<input type="checkbox"/>	<input type="checkbox"/>	ADB for Chronic Condition Rider (Living Benefit Rider) (Not available in CA, MA)
<input type="checkbox"/>	<input type="checkbox"/>	Extension of Benefits Rider (Not available in CA, CT, FL, MA, MD, NJ, OH, PA, TN)
<input type="checkbox"/>	<input type="checkbox"/>	Benefit Restoration Rider (Not available in CA, CT, FL, MA, MD, OH, PA, TN)
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment (Accidental Death in VT) (Not available in MN)
<input type="checkbox"/>	<input type="checkbox"/>	Automatic Face Amount Increase Option: <input type="checkbox"/> \$1 for 10 years OR <input type="checkbox"/> \$2 for 5 years <input type="checkbox"/> All Employees <input type="checkbox"/> Employee Option
<input type="checkbox"/>	<input type="checkbox"/>	Child Level Term Insurance Rider
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Monthly Deductions for Total Disability

Group Interest Sensitive Whole Life – Trans\$ure Group Contribution? Yes No Requested Effective Date:
Available as an Individual policy in VT. If yes, list amount or %:

Coverage: Money Purchase Defined Benefit ***Attach a copy of the Rate Sheet***

Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.

Waiver of Premium for Layoff included in all states except MA, MN, VA, and VT.

ACCEPT	DECLINE	
<input type="checkbox"/>	<input type="checkbox"/>	Accelerated Death Benefit for Critical Care: <input type="checkbox"/> 25% <input type="checkbox"/> 50% <input type="checkbox"/> 75% <input type="checkbox"/> 100% (Not available in CT, FL, MA, NJ)
<input type="checkbox"/>	<input type="checkbox"/>	ADB for Chronic Condition Rider (Living Benefit Rider) (Not available in CA, MA)
<input type="checkbox"/>	<input type="checkbox"/>	Extension of Benefits Rider (Not available in CA, CT, FL, MA, MD, NJ, OH, PA, TN)
<input type="checkbox"/>	<input type="checkbox"/>	Accidental Death & Dismemberment (Accidental Death in VT) (Not available in MN)
<input type="checkbox"/>	<input type="checkbox"/>	Child Level Term Insurance Rider (Not available in VA)
<input type="checkbox"/>	<input type="checkbox"/>	Waiver of Premium for Total Disability

<input type="checkbox"/> Individual Accident Insurance – AccidentSelect <i>Product not available in CT, FL, GU, MA, MN, NJ, OR, VI, VT, or WV.</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:									
Coverage: <input type="checkbox"/> Plan I <input type="checkbox"/> Plan II											
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:15%;">Accept</th> <th style="width:15%;">Decline</th> <th></th> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Accident Only Disability Income Rider <i>(Not available in PA)</i></td> </tr> <tr> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td>Sickness Only Disability Income Rider <i>(Not available in CO, MD, SC or VA) (Accident & Sickness Disability Rider in MN)</i></td> </tr> </table>	Accept	Decline		<input type="checkbox"/>	<input type="checkbox"/>	Accident Only Disability Income Rider <i>(Not available in PA)</i>	<input type="checkbox"/>	<input type="checkbox"/>	Sickness Only Disability Income Rider <i>(Not available in CO, MD, SC or VA) (Accident & Sickness Disability Rider in MN)</i>		
Accept	Decline										
<input type="checkbox"/>	<input type="checkbox"/>	Accident Only Disability Income Rider <i>(Not available in PA)</i>									
<input type="checkbox"/>	<input type="checkbox"/>	Sickness Only Disability Income Rider <i>(Not available in CO, MD, SC or VA) (Accident & Sickness Disability Rider in MN)</i>									

<input type="checkbox"/> Work Stride: Managing Cancer at Work By John Hopkins Medicine	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
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<input type="checkbox"/> TopDoc Connect	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date:
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<input checked="" type="checkbox"/> Group Cancer Insurance – CancerSelect Plus <i>Product not available in MN.</i> <i>Available as an Individual policy in CT, FL, ID, MD, MT, NJ, PR, UT, WA</i> <i>Available to large groups (51+) only in MA.</i>	Group Contribution? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <i>If yes, list amount or %:</i>	Requested Effective Date: 09/01/2021
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Coverage:

		Plan 1	Plan 2	Plan 3
Module 1 – Hospital Benefits		1.00 Units	2.00 Units	Units
Module 2 – Surgery Benefits		1.00 Units	2.00 Units	Units
Module 3 – Radiation and Chemotherapy Benefits		2.00 Units	3.00 Units	Units
Module 4 – Wellness and Miscellaneous Benefits		1.00 Units	1.00 Units	Units
Module 5 – Cancer Maintenance Therapy Benefits		1.00 Units	2.00 Units	Units
Accept	Decline	Optional Riders		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	First Occurrence Rider <i>(Lump Sum Diagnosis Rider in SD)</i>		
<input checked="" type="checkbox"/>	<input type="checkbox"/>	1.00 Units	2.00 Units	Units
<input checked="" type="checkbox"/>	<input type="checkbox"/>	Intensive Care Rider <i>(Not available in CT, MA, NH, NJ, VT or WA)</i>		
<input type="checkbox"/>	<input checked="" type="checkbox"/>	Units	Units	Units
		Units	Units	Units

<input type="checkbox"/> Group CI Insurance – CriticalEvents <i>Product not available in CO, FL, GA, MN</i>	Group Contribution? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, list amount or %:</i> <i>If yes, offering Employee Buy-Up?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No	Requested Effective Date:
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Self-Administered Benefit <input type="checkbox"/>	I Acknowledge receipt of Self-Administration Guide <input type="checkbox"/>
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	Plan 1	Plan 2	Plan 3
Dependent Coverage <i>(only 50% available for Employer Paid cases)</i>	<input type="checkbox"/> 50% <input type="checkbox"/> 100%	<input type="checkbox"/> 50% <input type="checkbox"/> 100%	<input type="checkbox"/> 50% <input type="checkbox"/> 100%
Rate Structure <i>(Composite is available for Employer Paid only; Attained Age is not available in NJ)</i>	<input type="checkbox"/> Issue Age <input type="checkbox"/> Attained Age <input type="checkbox"/> Composite	<input type="checkbox"/> Issue Age <input type="checkbox"/> Attained Age <input type="checkbox"/> Composite	<input type="checkbox"/> Issue Age <input type="checkbox"/> Attained Age <input type="checkbox"/> Composite
First Occurrence <i>(First Ever is not available in: CT, IN, MA, MD, NH, NJ, NC, PA, SD, WA)</i>	<input type="checkbox"/> First Ever <input type="checkbox"/> First after Effective Date	<input type="checkbox"/> First Ever <input type="checkbox"/> First after Effective Date	<input type="checkbox"/> First Ever <input type="checkbox"/> First after Effective Date
<input type="checkbox"/> Cancer Benefit Rider	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Occupational HIV Benefit Rider <i>(Not available in CA, OR, PR)</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Recurrent Critical Illness Benefit Rider <i>(Benefit Selection: 0%, 25%, 50%, 75%, 100%)</i>	%	%	%
<input type="checkbox"/> Wellness Benefit Rider	\$	\$	\$

<input checked="" type="checkbox"/> Hospital Indemnity – HospitalSelect III HSA Plan <small>Not available in DC, NH, NV</small>	Group Contribution? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <small>If yes, list amount or %:</small>	Requested Effective Date: 9/1/2021																																																												
Self-Administered Benefit <input type="checkbox"/>	I Acknowledge receipt of Self-Administration Guide <input type="checkbox"/>																																																													
Do you offer a medical plan with at least a \$1,000 deductible? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <small>(Product only available if you answer "Yes")</small>																																																														
Coverage: (Attach Plan Design)	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:50%;">Class 1</th> <th style="width:50%;">Class 2</th> <th style="width:50%;">Class 3</th> <th style="width:50%;">Class 4</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">\$ 100.00</td> <td style="text-align: center;">\$ 100.00</td> <td style="text-align: center;">\$</td> <td style="text-align: center;">\$</td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/> 31 Days <input type="checkbox"/> \$_____</td> <td style="text-align: center;"><input checked="" type="checkbox"/> 31 Days <input type="checkbox"/> \$_____</td> <td style="text-align: center;"><input type="checkbox"/> 31 Days <input type="checkbox"/> \$_____</td> <td style="text-align: center;"><input type="checkbox"/> 31 Days <input type="checkbox"/> \$_____</td> </tr> <tr> <td style="text-align: center;">\$ 750.00</td> <td style="text-align: center;">\$ 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<input checked="" type="checkbox"/> Intensive Care Indemnity Benefit Rider <small>(Can't exceed 2 times the Base Benefit)</small> Calendar Year Maximum <small>(Not available in NJ)</small>																																																														
<input type="checkbox"/> Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement <small>(Not available in CO, CT, MA, MO, NJ)</small>																																																														
<input type="checkbox"/> Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days <small>(Not available in CT, MA, ND, NJ, PA)</small>																																																														
<input type="checkbox"/> Critical Illness Indemnity Benefit Rider Dependent Benefit Percentage <small>(Not available in CA, CO, CT, KS, MA, NJ, PA)</small>																																																														
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<input type="checkbox"/> Add Preexisting Conditions & Normal Pregnancy Limitations Rider <small>(Not available in NH)</small>																																																														
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