



Home Office:
440 Mamaroneck Ave
Harrison, NY 10528
A Stock Company

Long Term Care Division
Administrative Office
Mailing Address:
P.O. Box 93003
Hurst, TX 76053
Telephone: (866) 655-4422

CONGRATULATIONS AND WELCOME!

Thank you for selecting Transamerica Financial Life Long Term Care Coverage. Welcome to our large and growing family of Transamerica Financial Life policyholders.

We recognize that Long-Term Care insurance is an important part of your financial planning. This product provides you and your family the added security of knowing that should you be faced with the very high costs commonly associated with Long-Term Care, you will have financial and referral resources available to better support you in making the right choices for your needs. And, it helps to protect the financial future that you and your family have worked so hard to build.

We are pleased to enclose your Policy, which is the contract between us that describes in detail each benefit that you purchased. When you applied for this Policy, you were provided with a marketing brochure and an Outline of Coverage. The Outline of Coverage describes more benefits than the marketing brochure. You selected the benefits you desired to purchase based on the choices in the marketing brochure rather than the Outline of Coverage, as not every benefit described in the Outline of Coverage was available in the coverage plans offered to you. During your 30-day Free Look Period, you should carefully review your Application and Policy to be certain that you are satisfied with the coverage that has been issued to you.

As a reminder, your policy is Guaranteed Renewable, which means that as long as the premium is paid when due, we cannot cancel your policy. However, this does not mean that premium rates are guaranteed to remain at their present level. Although we cannot single you out for a rate increase, we can change your premium based on our experience with all insureds in your same premium class. Of course, your rates cannot be raised during the rate guarantee period reflected on the schedule page of your policy.

We have included on the back of this letter a copy of the Company's Notice of Privacy Policy for your reference. This notice is informational and does not require a response.

A WORD OF CAUTION: Beware of anyone who encourages you to replace this coverage without allowing you time to carefully investigate the replacement proposal. Insist on time to review the proposal, and I encourage you to contact your agent who can help you to review the proposal.

We look forward to serving you for the many years to come. And again, welcome to our family.

Sincerely,

A handwritten signature in black ink that reads "Tonya L Gray". The signature is written in a cursive, flowing style.

Tonya L Gray
Director of Policyholder Services, Transamerica Financial Life

NOTICE OF PRIVACY POLICY

Information Only - No Response Necessary

At Transamerica Financial Life Insurance Company, protecting your privacy is very important to us. We want you to understand what information we collect and how we use it. We collect and use “nonpublic personal information” in order to provide our customers with a broad range of financial products and services as effectively and conveniently as possible. We treat nonpublic personal information in accordance with our Privacy Policy.

What Information We Collect and From Whom We Collect It

We may collect nonpublic personal information about you from the following sources:

- Information we receive from you on applications or other forms;
- Information about your transactions with us, our affiliates, or others; and
- Information we receive from non-affiliated third parties, including consumer reporting agencies and other insurance support organizations.

“Nonpublic personal information” is nonpublic information about you that we obtain in connection with providing a financial product or service to you. This information may be collected in person, by mail, fax, or by other electronic means as permitted by law or in accordance with express authorization from you.

What Information We Disclose and To Whom We Disclose It

We do not disclose any nonpublic personal information about you to either our “affiliates” or non-affiliates, except as permitted or required by law. We may disclose the nonpublic personal information we collect, as described above, to persons or companies that perform services on our behalf. We may also disclose your name, contact information and information about your transactions with us or our affiliates, such as your policy coverage, to other financial institutions with which we have joint marketing agreements. We may also disclose nonpublic personal information about you to credit reporting agencies and other insurance support organizations for use in connection with an insurance transaction or to prevent fraud. Nonpublic personal information about you that we obtain from a report prepared by an insurance support organization may be retained by the insurance support organization and disclosed to other persons.

“Our affiliates” are companies with which we share common ownership and which offer life and health insurance and pension and savings products.

Your Right to Verify Accuracy of Information We Collect

Keeping your information accurate and up to date is very important to us. You may access and correct nonpublic personal information about you that we collect except for information relating to or in anticipation of a claim or a criminal or civil proceeding.

Our Security Procedures

We restrict access to the nonpublic personal information about you and only allow disclosures to persons and companies as permitted by law to assist in providing products or services to you. We maintain physical, electronic, and procedural safeguards to protect the nonpublic personal information about you. Should your relationship with us end, we will maintain and only disclose nonpublic personal information that we have about you in accordance with this Privacy Policy.



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This Policy is intended to be a qualified long term care insurance contract under section 7702B(b) of the Internal Revenue Code of 1986, as amended. If, in the future, it is necessary to make changes to this Policy to bring it into compliance with federal or state tax qualification requirements, these changes will be offered to You and You may accept or reject them.

THIS IS A LONG TERM CARE POLICY. PLEASE READ IT CAREFULLY.

We are pleased to issue this Policy to You. It has many important features. We urge You to read it carefully. It is issued in exchange for Your application and payment of the Initial Premium.

THIS POLICY IS GUARANTEED RENEWABLE FOR LIFE

Your timely payment of premiums is all that is needed to keep this Policy in force until benefits have been exhausted. We cannot cancel or refuse to renew this Policy if the premium is paid on time. To renew during the Premium Paying Period, You must pay any premium due on or before the Premium Due Date and it must be received by Us at Our Administrative Office prior to the expiration of the Grace Period. Please read carefully the Grace Period provision in this Policy. We have no unilateral right to make any change in any provision of this Policy while this insurance is in force, except to change the premiums as explained below.

WE HAVE A RIGHT TO CHANGE PREMIUMS

We can change Your premiums based on Your premium class, subject to approval by the New York Superintendent of Insurance. Premium class means a population segment classified by Our actuaries as having similar characteristics, such as issue age, issue year, rate classification, and selected benefit options or other criteria. Any change will apply to all policies in the same class as Yours issued in New York. The change in premium may occur only after the Rate Guarantee, if any, has expired and only during the Premium Paying Period shown on the Schedule. We must give You at least 30 days written notice before We change Your premiums. Your premiums will not increase due to a change in Your age or health. The State of New York retains jurisdiction of all policies delivered or issued for delivery in New York, regardless of a later change of residence by You. Such a policy will be considered a New York policy for rating purposes.

30-DAY RIGHT TO EXAMINE YOUR POLICY

You have 30 days from the day You receive this Policy to examine and return it to Us if You decide not to keep it. You do not have to tell Us Your reason for returning the Policy. Simply return it, within 30 days of its receipt, to Us at Our Administrative Office, or to the agent or office through which it was purchased and We will refund the full amount of any premium paid and the Policy will be void from the start.

IMPORTANT CAUTION ABOUT THE APPLICATION

The issuance of this Policy is based upon the answers to the questions on the application. A copy of the application is attached. If Your answers fail to include all material medical information requested, We may have the right to deny benefits or rescind the Policy. The best time to clear up any question is now, before a claim arises! If, for any reason, any of the answers are incorrect, incomplete or untrue, contact Us at Our Administrative Office. Our address and toll-free number are shown above.

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

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY: If an Insured Person is eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us.


SECRETARY


PRESIDENT

**LONG TERM CARE INSURANCE POLICY
GUARANTEED RENEWABLE - NON-PARTICIPATING**

SAMPLE

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SCHEDULE

Policy Number: 061040486
 Policyholder: JOHN DOE

Effective Date: 5/3/2010
 Policyholder's Age: 45

Premium Paying Mode: Annual
 Initial Premium: \$800.36

Premium Paying Period: Lifetime
 Mode Premium: \$800.36

Our toll free number: (866) 655-4422

Note: The benefits shown on this Schedule are those that You elected and which became effective on the Effective Date of this Policy. Any changes to Your coverage, including the addition or deletion of benefits and their respective effective dates, will be shown by endorsement.

BENEFITS

REQUIRED NUMBER OF ACTIVITIES OF DAILY LIVING

2

Benefits subject to the Maximum Benefit are the:

- | | |
|--|--------------------------------|
| Nursing Home (NH) Benefit | Therapeutic Device Benefit** |
| NH - Bed Reservation Benefit** | Home Modification Benefit** |
| Assisted Living Facility (ALF) Benefit** | Medical Alert System Benefit** |
| ALF - Bed Reservation Benefit** | Caregiver Training Benefit** |
| Home Care and Adult Day Care** Benefits | Monthly Home Care Benefit** |
| Hospice Care Benefit** | Alternative Payment Benefit** |
| Respite Care Benefit** | |

Maximum Benefit	\$146,000.00
Elimination Period	90 Days

Benefits for Home Care and Adult Day Care are not subject to, nor will they satisfy, the Elimination Period.

Nursing Home Benefits	Included
Maximum Daily Benefit	\$100.00

NH – Bed Reservation Benefit**	
Maximum Number of Days per Calendar Year	60 Days

Restoration of Nursing Home Benefits	Included
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Assisted Living Facility Benefits**	Included
Maximum Daily Benefit	\$100.00

ALF – Bed Reservation Benefit**	
Maximum Number of Days per Calendar Year	60 Days

Home Care and Adult Day Care Benefits	Included
Maximum Daily Professional Services Benefit	\$200.00
Maximum Daily Basic Services Benefit	\$100.00
Maximum Daily Adult Day Care Benefit**	\$100.00

Hospice Care Benefit**	Included
Maximum Daily Benefit	\$100.00

Care Coordination Benefit	Included
Maximum	Unlimited
Respite Care Benefit**	Included
Maximum Daily Benefit	\$100.00
Maximum Number of Days per Calendar Year	30 Days
Therapeutic Device Benefit**	Included
Maximum Lifetime Therapeutic Device Benefit	\$5,000.00
Home Modification Benefit**	Included
Maximum Lifetime Home Modification Benefit	\$5,000.00
Medical Alert System Benefit**	Included
Monthly Medical Alert System Benefit	\$50.00
Maximum Medical Alert System Benefit	\$5,000.00
Caregiver Training Benefit**	Included
Maximum Lifetime Caregiver Training Benefit	\$1,000.00
Monthly Home Care Benefit**	Elected-Premium \$43.68
Alternative Payment Benefit**	Included
Monthly Benefit	\$1,000.00
ADDITIONAL BENEFITS	
Waiver of Premium Benefit	Included
Joint Waiver of Premium	Elected-Premium \$11.62
Lifetime Waiver of Premium	Included
Consecutive Day Waiting Period	180 Days
Compound Benefit Increase Option	Elected-Premium \$234.70
Percentage	3%
Return of Premium	Elected-Premium \$207.50
Contingent Nonforfeiture Benefit	Included
Rate Guarantee	Included
Period of Time	3 Years
TOTAL PREMIUM FOR INCLUDED BENEFITS	\$282.70
TOTAL PREMIUM FOR ELECTED BENEFITS	\$517.66

**This Policy offers a minimum of twenty-four (24) months worth of benefits for long term care as required by New York Insurance Regulation. This Policy also includes benefits that are not required by New York Insurance Regulation, such as those shown with two asterisks above. You should be aware that use of these non-required benefits may reduce the amount available for required benefits below the twenty-four (24) month minimum and, if You would like to retain twenty-four (24) months' worth of coverage for long term care, You should manage Your benefits accordingly.

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GENERAL PROVISIONS

This section describes: the documents that form this contract; the importance of a truthful application; and other basic rights and obligations.

Entire Contract; Changes

Entire Contract: The entire contract between You and Us will consist of:

- (1) this Policy; and
- (2) the application; and
- (3) any riders, endorsements or amendments made a part of this Policy.

Modifications of Contract: No agent has authority to change or waive any part of this Policy. To be valid, any change or waiver must be:

- (1) in writing; and
- (2) approved by one of Our executive officers; and
- (3) made a part of this Policy by Us.

After this Policy is issued or reinstated, any rider or endorsement must be accepted in writing by You, unless We do not require Your acceptance or if the change is required by law.

Misstatement of Age

If the age of an Insured Person has been misstated, all benefits payable are those which the premium paid would have purchased at the correct age. If the correct age exceeded the maximum age at which We would have issued this Policy, Our liability shall be limited to the refund of all premiums paid for this Policy.

Contesting Coverage

Time Limit on Certain Defenses: When an Insured Person's coverage has been in force less than 6 months, We may rescind the coverage or deny an otherwise valid claim upon a showing of misrepresentation that is material to Our decision to issue You the coverage.

When an Insured Person's coverage has been in force for at least 6 months but less than 2 years, We may rescind the coverage or deny an otherwise valid claim upon showing of misrepresentation that is both material to Our decision to issue You the coverage and which pertains to the conditions for which benefits are sought.

After an Insured Person's coverage has been in force for at least 2 years, such coverage may only be contested upon a showing that the person knowingly and intentionally misrepresented relevant facts relating to his or her health.

Other Provisions

Nonparticipating: This Policy does not participate in Our profits or surplus earnings.

Conformity with Law: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which You reside on such date is hereby amended to conform to the minimum requirements of such statutes.

Time Periods: All time periods begin and end at 12:01 A.M. Standard time at Your Home.

Extension Of Benefits

Termination of this Policy shall be without prejudice to any benefits payable under the Policy if eligibility for such benefits or total disability began while this Policy was in force and continues without interruption after termination. Such extension of benefits beyond the period this Policy was in force is limited to the payment of the Maximum Benefit and is subject to the Elimination Period, all other applicable provisions of the Policy, and in the case of Home Care benefits, is limited to 12 months. We will not, however, pay benefits for new confinements nor for any part of a confinement or service during which the reason for the confinement or service becomes unrelated to the reason for the confinement or service prior to the termination of the Policy. We will not pay the portion of any benefits which are in excess of those benefits We would have paid had this Policy continued in force.

For purposes of this provision, You will be considered to be "totally disabled" if We are given proof, in the form of a Doctor's certification (or other evidence satisfactory to Us) that care covered under this Policy would be appropriate because You are unable to perform at least the Required Number of Activities of Daily Living shown on the Schedule or have a Cognitive Impairment.

**Suspension Of Coverage
During Military Service**

Any Insured Person, who is a member of a reserve component of the armed forces of the United States, including the National Guard, is entitled, upon written request, to have their coverage suspended during a period of active duty. We will suspend coverage when We are notified in writing that they have voluntarily or involuntarily entered into active duty (other than for the purpose of determining physical fitness or training), or their active duty is voluntarily or involuntarily extended during a period when the president is authorized to order a reserve component to active duty. The extended active duty must be at the request and for the convenience of the federal government. However, any period of active duty can be for no more than 5 years.

We will refund any unearned premium received for the period of suspension. Coverage can be resumed upon written application and payment of any required premium within 60 days after termination of the period of active duty. Coverage shall be retroactive to the date of termination of the period of active duty. We will impose no limitations or conditions as a result of a period of active duty, except for a condition which arose during the period of active duty. The condition must be determined by the Secretary of Veterans Affairs to have been incurred in the line of duty. In addition, any Elimination Period not completed by the Insured Person prior to suspension of coverage will be applicable upon resumption of coverage.

EFFECTIVE DATE, PREMIUM PAYMENT AND TERMINATION PROVISIONS

This section explains: when this Policy becomes effective; how and when to pay premiums; the importance of paying premiums on time; what happens if premiums are not paid on time; and when this Policy ends.

The Policy Taking Effect Effective Date and Consideration: This Policy is issued based on the answers to the questions on the application and payment of the Initial Premium. It takes effect on the Effective Date shown on the Schedule, provided the Initial Premium is paid. Any new benefit added and any increase or decrease in benefit amounts will be effective from the effective date shown on the endorsement for such benefit addition, increase or decrease.

Paying Premiums After payment of the Initial Premium, each additional premium, if any, is due at the end of the period for which the prior premium was paid. The Premium Paying Mode shown on the Schedule states how often premiums are to be paid. The Premium Paying Mode You select will impact Your overall cost of insurance. The Premium Paying Period shown on the Schedule states how long premiums are to be paid. Premiums are to be paid to Us at Our Administrative Office.

Any Rate Guarantee is only applicable from the original Policy Effective Date. Any subsequent changes will not have a Rate Guarantee.

What Happens When Premiums Are Not Paid Grace Period: A Grace Period of 31 days following the Premium Due Date is allowed for the payment of each premium, if any, after the Initial Premium. During this period, this Policy will remain in force. At the end of the Grace Period, Your coverage will Lapse as of the last Premium Due Date, subject to the Third Party Notification provision.

Third Party Notification: If You have designated a third party to be notified in the event Your premium is not received by the end of the Grace Period, We will mail a notice to the person(s) You have designated, as well as to You. This Policy will not Lapse until 35 days after the date on the notice We have mailed to You and the third party. You have the right, at any time, to change the third party to be notified by providing Us with written notice of the change.

If You do not designate a third party to be notified in the event Your premium is not received by the end of the Grace Period, Your Policy will Lapse if We do not receive the premium before the Grace Period ends. If You designate a third party to be notified in the event Your premium is not received by the end of the Grace Period, Your Policy will Lapse if We do not receive the premium within 35 days after the date on the notice We mail to the designated third party.

Putting This Policy Back In Force Reinstatement: Once this Policy Lapses, We may or may not put it back in force (reinstate) at Our option. We will require an application for reinstatement, and if the application is approved by Us, this Policy will be put back in force as of the Lapse date, upon payment of all past-due premiums.

Your reinstated Policy will only provide benefits for losses that result from an Injury sustained after the date of reinstatement or Sickness that starts more than 10 days after such date. In all other respects, Your rights and Our rights will be the same as before this Policy Lapsed, unless there are special conditions that apply to the reinstatement. If there are, they will be endorsed on or attached to the reinstated Policy.

Unintentional Lapse: If Your Policy Lapses, We will reinstate Your coverage if:

- (1) We receive the request for reinstatement in Our Administrative Office within 180 days of the last Premium Due Date; and
- (2) We receive Your Licensed Health Care Practitioner's written certification that You were diagnosed, using generally accepted medical diagnostic methods and tests, with Cognitive Impairment or as being unable to perform at least the Required Number of Activities of Daily Living shown on the Schedule at the time the Policy Lapsed. It must be documented in Your Licensed Health Care Practitioner's records that an event had occurred prior to the Lapse that would have resulted in a diagnosis of Cognitive Impairment or inability to perform at least the Required Number of Activities of Daily Living, which made You unable to pay the premium; and
- (3) We receive all past-due premiums for the benefits that were in force at the time the Policy Lapsed.

Coverage will be continuous subject to these requirements. Any claim incurred during the 180-day period will be considered for benefits subject to all other Policy provisions.

When the Policy Terminates

We will not cancel, nonrenew, or otherwise terminate or end this Policy because of age or the deterioration of mental or physical health.

Termination: This Policy will end, subject to any provision to the contrary, as of the earliest of the following:

- (1) the date coverage under this Policy Lapses; or
- (2) the date of Your death; or
- (3) the date the Maximum Benefit has been exhausted; or
- (4) the next Policy monthly anniversary following Our receipt of Your written request to cancel this coverage, if You have not specified a future date for the cancellation in Your written request. If You request in writing a future date for cancellation of this Policy, it will end on the next Policy monthly anniversary following Your requested future cancellation date.

Payment of benefits for loss incurred prior to termination of this Policy will not be affected.

Refund of Premiums

Upon notification of Your death during the Premium Paying Period and while this Policy is in force, We will refund any premiums paid which apply to the Premium Paying Period following death, subject to any provisions to the contrary. We will determine the amount of the refund, if any, by prorating the premiums paid on a monthly basis. We will pay any refunded premiums to Your estate.

Should We receive a written request from You to cancel this Policy, We will refund to You any premiums paid which apply to the Premium Paying Period following the Policy monthly anniversary on which the Policy terminated.

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CLAIMS INFORMATION

This section informs You of: when to tell Us of a claim; what to send to Us; where to send it; how We pay benefits; and other rights and obligations under this Policy.

Telling Us of a Claim

Notice of Claim: We must be notified in writing when there is a claim for benefits. Notice must be received by Us at Our Administrative Office within 60 days of the date the covered loss starts or as soon as reasonably possible. Failure to notify Us within 60 days may result in claim denial. The notice should include at least: the claimant's name, Policy Number, and the address to which the claim form should be sent. Someone else may be authorized to act for the claimant in filing a claim.

How to File a Claim

Claim Forms: When We receive notice of a claim, We will send out a claim form to be used to file Proof of Loss.

The claim form has instructions on how to fill it out and where to send it. Please read the form carefully. Answer all questions and send all required information to the address on the form.

If the claimant or his representative does not get the claim form within 15 days, Proof of Loss can be filed without it by sending Us a letter which describes the occurrence, the nature, and the extent of the loss for which claim is made. That letter must be sent to Us within the time period stated in the next paragraph. At a minimum, the description should tell Us such things as: the claimant's name, address, social security number, and policy number; the type of benefits for which claim is being made; the names and addresses of the medical professionals and care providers who are aware of the claimant's condition or have provided care covered by this Policy; the diagnosis; and the periods for which benefits are being claimed.

When to File a Claim

Proof of Loss: We must receive written Proof of Loss within 90 days after the end of each month for which benefits may be paid. If it was not reasonably possible to give Us written proof in the time required, We will not reduce or deny a claim for being late if the proof is filed as soon as reasonably possible. Unless the claimant is not legally capable, the required proof must always be given to Us no later than one year from the time specified.

How and When Claims are Paid

Time of Payment of Claim: After We receive the proper written Proof of Loss, We will pay benefits for covered services that have been received and are then due:

- (1) monthly, when the loss is expected to result in ongoing benefits; or
- (2) immediately, when Our liability has ended.

Payment of Claims: All benefits will be paid to You in U.S. dollars. However, You may request in writing for payment to be made to someone other than You. You should make this request no later than the time Proof of Loss is filed. We will assume no liability for an assignment of benefits.

Any benefits unpaid at Your death will be paid to Your estate. If benefits are payable to Your estate or to an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such benefits up to \$1,000 to any relative of Yours, or beneficiary deemed by Us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Our Claims Evaluation Process: We will work with the claimant, his or her Licensed Health Care Practitioner, and other caregivers to obtain information about the state of the claimant's health and the degree to which care covered by this Policy is needed. We will then make an objective review of that information to determine whether the claimant qualifies for benefits, and, if so, the level of benefits for which he or she qualifies.

We reserve the right, as part of the review, to do a telephonic or face-to-face assessment or to require the claimant to take a physical examination paid for by Us. Similar assessments and examinations may be required, at reasonable intervals, to determine the claimant's eligibility for continued benefits, but not more often than once every three months.

We may use an outside service to assist in evaluating the claimant's condition. We will pay for any outside services used to assist in the evaluation.

How to Appeal a Claim

Appeal Process: We evaluate a claim based on the provisions of this Policy and the information given to Us. If You do not agree with a claim decision, You may ask for a review. Your request must be in writing to Us and include the names, addresses and phone numbers of any of the following providers who You think We should contact to learn more about the claimant's health and the care received: the Doctors and other health care professionals who treated the claimant and the facilities from which the care or treatment was received. No special form is needed. Your request should be sent to Our Administrative Office within 3 years of the time of filing written Proof of Loss. You may authorize someone else to act for You under this review procedure.

Within 60 days after receiving Your request and the necessary supporting documents, We will send You or Your representative Our decision. Our decision will be in writing with Our reasons stated clearly. We will make available all information directly relating to a denial.

Legal Actions: An Insured Person cannot bring legal action before 60 days after written Proof of Loss has been given to Us, as required by this Policy. An Insured Person cannot bring legal action after 3 years from the time written Proof of Loss is required to be given.

Right of Recovery

We have the right to recover any overpayment made because of an error in the processing of a claim. Also, We will recover by offset any amounts that have not been previously recovered at the time We make another benefit payment.

Change of Beneficiary

You may change Your beneficiary at any time by giving written notice to Us. The effective date of the beneficiary change will be the date the change is received and recorded by Us. If You die before We receive the request, the change will not be effective.

Physical Examinations and Autopsy

We, at Our own expense, shall have the right and opportunity to examine an Insured Person when and as often as We may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

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GENERAL EXCLUSIONS AND LIMITATIONS

This Policy will not pay benefits when an Insured Person is eligible for confinement, treatment, services or care:

- (1) resulting from alcoholism or drug addiction unless as a result of a narcotic prescribed by a Doctor; or
- (2) arising out of suicide, attempted suicide or intentionally self-inflicted injury; or
- (3) provided in a government facility (unless otherwise required by law), services for which benefits are provided under Medicare or other governmental programs (except Medicaid), and services for which no charge is normally made in the absence of insurance; or
- (4) received outside the United States and its possessions, or Canada; or
- (5) for which benefits are provided under any state or Federal workers' compensation, employer's liability or occupational disease law; or
- (6) that are not included in an Insured Person's Plan of Care; or
- (7) rendered by a member of an Insured Person's Immediate Family, unless:
 - (a) he or she is a regular employee of an organization which is providing the treatment, service or care; and
 - (b) the organization receives the payment for the treatment, service or care; and
 - (c) he or she receives no compensation other than the normal compensation for employees in his or her job category.

This Policy will not pay benefits that are prohibited by federal law, including those governing economic and trade sanctions. In addition, it will not pay for services for which benefits are provided under Medicare except for the application of a deductible or coinsurance amount.

The exclusions regarding a member of an Insured Person's Immediate Family and confinement, treatment, services or care received outside the United States and its possessions, or Canada will not apply to the Alternative Payment Benefit provision. Coverage will be provided in accordance with the terms of this Policy for mental conditions, including Alzheimer's disease, Parkinson's disease and senile dementia.

GENERAL DEFINITIONS

This section informs You of some of the special words and phrases used in this Policy. Other words and phrases may be defined in other sections of the Policy. Please see the Definition Information provision in the General Benefit Information section regarding the use of definitions in this Policy.

Doctor	Someone, other than a Nurse, who is legally qualified and licensed as a practitioner of the healing arts and who is operating within the scope of that license. The term "Doctor" does not include: an Insured Person or a member of an Insured Person's Immediate Family; or anyone who has a financial interest in, or is an employee of, a facility, agency, or center administering the Plan of Care.
Home	Any place where an Insured Person resides other than a Nursing Home or a rehabilitation hospital, or hospital or other acute care facility.
Immediate Family	An Insured Person's Spouse and anyone who is related to an Insured Person or his or her Spouse (including adopted, in-law and step-relatives) as a parent, grandparent, child, grandchild, brother, sister, aunt, uncle, first cousin, nephew or niece.
Injury	Any accidental bodily injury an Insured Person sustains after the Effective Date of this Policy.
Insured Person(s)	Anyone who is insured under this Policy and is named on the Schedule page as the Policyholder or an Insured.
Lapse	At the end of the Grace Period, if Your premium is not paid, Your coverage will have terminated as of the last Premium Due Date, subject to the Third Party Notification provision.
Licensed Health Care Practitioner	Any Doctor, registered professional nurse, licensed social worker, or other individual who meets such requirements as may be prescribed by the Secretary of the U.S. Treasury or who meets the requirements of state law or regulation, as appropriate for a tax qualified policy.
Medicare	The "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965 as then constituted or later amended.
Metropolitan Area	The area in the State of New York that is within the corporate limits of the counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, Rockland and Westchester.
Nurse	A person who is duly licensed as either: (1) a Registered Nurse (RN); or

- (2) a Licensed Practical Nurse (LPN); or
- (3) a Licensed Vocational Nurse (LVN).

The term "Nurse" does NOT include:

- (1) an Insured Person; or
- (2) a member of an Insured Person's Immediate Family.

Nursing Services

Care and services which must be provided by a Registered Nurse.

Premium Due Date

Each date a premium is due, after the Initial Premium, in accordance with the terms of this Policy.

Premium Paying Mode

The frequency, as shown on the Schedule, with which premiums are paid.

Policy

This contract between You and Us.

Sickness

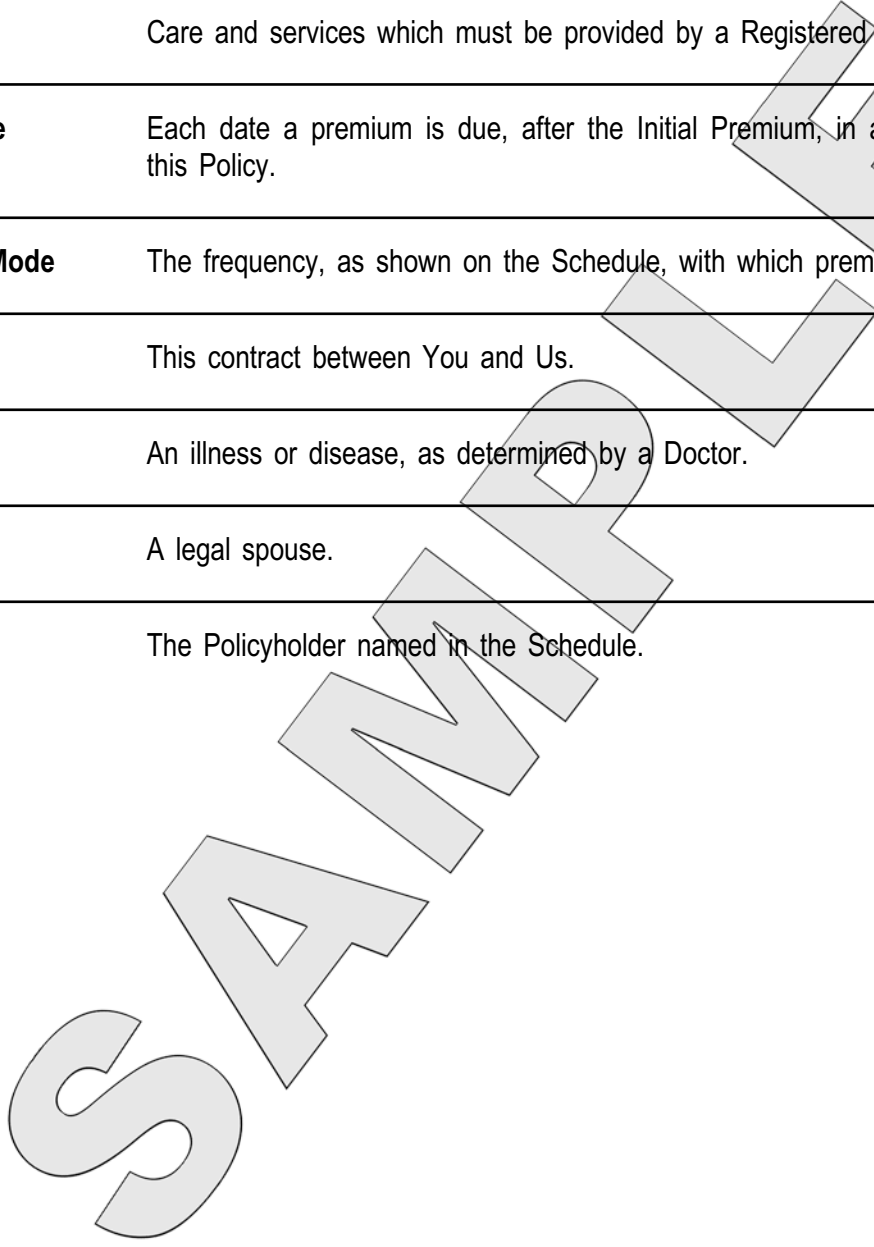
An illness or disease, as determined by a Doctor.

Spouse

A legal spouse.

You, Your, Yours

The Policyholder named in the Schedule.



Nursing Home

Nursing Home means a place which: (1) is legally operated to provide nursing care (skilled, intermediate, custodial) for sick and injured persons at their expense; and (2) is licensed or certified by the appropriate federal, state or local licensing agency and is operating under the scope of such license or certificate in accordance with any federal, state or local laws. If licensing or certification is not required by the state, a nursing home must meet the following requirements: (1) provides, in addition to room and board accommodations, 24 hour nursing service or is under 24 hour on-site supervision by a physician, licensed registered nurse or licensed practical nurse; (2) maintains a daily record of each patient which is available for our review; and (3) administers a planned program of observation and treatment by a physician (other than the proprietor or employee of such facility) which is in accordance with existing standards of medical practice for the injury or sickness causing confinement.

A facility in the State of New York is deemed to meet the above criteria if it operates in accordance with appropriate licensing or certification requirements in the State of New York for a Nursing Home.

A Nursing Home may be either a freestanding facility or a distinct part of a facility such as a ward, wing, unit, or swing bed of a hospital or other institution. If the facility complex to which an Insured Person is confined consists of wards, wings, floors, units, or swing-beds, the area of the facility in which such Insured Person is confined must be licensed as a Nursing Home and the Insured Person's assigned bed must be included as a part of such license.

The term "Nursing Home" does not include, for example: (1) a hospital (except as provided above); (2) a rehabilitation hospital, (3) a place which is primarily for treatment of mental or nervous disorders (except Alzheimer's disease), drug addiction, or alcoholism; (4) a home for the aged; (5) a rest home, community living center, or a place that provides domestic, resident, retirement or educational care; (6) assisted living facilities or program; (7) personal care homes; (8) residential care facilities; (9) adult foster care facilities; (10) congregate care facilities; (11) family and group assisted living facilities; (12) personal care boarding homes; (13) domiciliary care homes; (14) basic care facilities; (15) continuing care retirement community; (16) dementia care facility; (17) enriched housing or adult home; or (18) similar facilities.

Assisted Living Facility

Assisted Living Facility means a facility that is licensed or certified by the appropriate federal or state agency to provide 24 hour a day care and service sufficient to support needs resulting from inability to perform an activity of daily living or severe cognitive impairment and is operating under the scope of such license in accordance with any federal or state laws. If licensing or certification is not required, assisted living facility must meet the following requirements (1) provide 24 hour a day care and services by on-site facility staff sufficient to support needs resulting from the inability to perform an activity of daily living or severe cognitive impairment; (2) has a trained and ready to respond employee on duty in the facility at all times to provide care; (3) provides 3 meals a day and accommodates special dietary needs; (4) has formal arrangements for services of a professional nurse in case of emergency and (5) has appropriate methods and procedures to assist residents in the self-administration of prescribed medications.

Regardless of name, any properly licensed or certified facility providing the services shown above will qualify as an Assisted Living Facility. As an example, this could include adult foster care facilities, congregate care facilities, basic care facilities, residential care facilities, family and group assisted living facilities, personal care boarding homes, domiciliary care homes and personal care homes.

An Assisted Living Facility is not a nursing home, hospital, rehabilitation hospital, or an independent living apartment.

SAMPLE

**Maintenance or Personal
Care Services**

Any care the primary purpose of which is to provide needed assistance with any of the disabilities that cause an Insured Person to meet the requirements of the Benefit Eligibility provision (including the protection from threats to health and safety due to Cognitive Impairment.)

SAMPLE

Home Care

Services provided for care in an Insured Person's Home and while such Insured Person is not confined to any hospital or Nursing Home.

Professional Services are services that are beyond the scope of care that can be provided by a Basic Services provider. The services are for other than monitoring the patient or supervising the patient's care.

Professional Services must be provided by a licensed:

- (1) Registered Nurse (RN); Practical Nurse (LPN); or Vocational Nurse (LVN); or
- (2) speech therapist or audiologist; or
- (3) respiratory therapist; or
- (4) occupational therapist; or
- (5) physical therapist; or
- (6) chemotherapy specialist; or
- (7) nutritional specialist.

Basic Services are services provided by persons other than those included in the definition of Professional Services.

Basic Services are services of:

- (1) a home health aide; or
- (2) a homemaker; or
- (3) a companion.

Home Care Agency

- An entity that provides care and services in accordance with a Plan of Care in an Insured Person's Home; is primarily engaged in providing Home Care services; and
- (1) is licensed by state law or certified by Medicare as a Home Care Agency; or
 - (2) is accredited as a Home Care Agency or as a provider of Home Care services by the National League of Nursing, or the Joint Commission on Accreditation of Healthcare Organizations, or any other associations that have substantially the same accreditation standards; or
 - (3) an entity that is not state licensed or Medicare certified, provided such entity:
 - (a) is a formalized agency that has been organized to provide Home Care, under a Plan of Care, which is supervised and/or monitored at least every 60 days by an on-staff Registered Nurse or licensed social worker;
 - (b) which maintains a written record for each client, including documentation of all services delivered and a Plan of Care.

An agency in the State of New York is deemed to meet the above criteria if it operates in accordance with appropriate licensing or certification requirements in the State of New York as a Home Care Agency.

SAMPLE

Adult Day Care

Services, including health, social and related support services provided by and at an Adult Day Care Center during any part of the day, on less than a 24-hour basis.

SAMPLE

Adult Day Care Center

A facility or organization which is licensed, registered or certified to provide Adult Day Care, if the state in which it is located provides licensing, registration or certification of Adult Day Care Centers.

If licensing, registration, or certification is not required by the state, it is that part (or separate center) of a facility which provides Adult Day Care and meets all of the following requirements:

- (1) it operates at least 5 days a week for a minimum of 5 hours per day and is not an overnight facility; and
- (2) it maintains a written record for each client, which includes a Plan of Care and a record of all services provided; and
- (3) it has established procedures for obtaining appropriate aid in the event of a medical emergency; and
- (4) it has formal arrangements for providing for the services of: (a) a dietitian; (b) a licensed physical therapist; (c) a licensed speech therapist; and (d) a licensed occupational therapist; and
- (5) its staff includes all of the following: (a) a full-time director; (b) one or more nurses in attendance during operating hours for at least 4 hours a day; and (c) not less than 3 full-time staff members.

SAMPLE

ELIGIBILITY DEFINITIONS

Activities of Daily Living (ADLs)

Each of the following six (6) functional areas performed without the assistance of another person is considered an Activity of Daily Living:

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

Cognitive Impairment (including the term "Cognitively Impaired")

Severe deterioration or loss of a person's intellectual capacity as certified by a Licensed Health Care Practitioner and diagnosed using generally accepted medical diagnostic methods and tests that reliably measure impairment in the areas of:

- (1) short or long term memory; and
- (2) orientation as to person (such as who one is and who others are), place (such as one's location) and time (such as day, date and year); and
- (3) deductive or abstract reasoning; and
- (4) judgment as it relates to safety awareness.

Note: Coverage is provided in accordance with the terms of this Policy for Alzheimer's disease and similar forms of senility and irreversible dementia that result in Cognitive Impairment.

Plan of Care

A written, face-to-face, systematic, standardized, and comprehensive assessment of one's functional and cognitive capacity, limitations and needs, strengths, and abilities, specifying the duration, frequency, type and scope of services necessary for care. The Plan of Care must be based on the findings from the Insured Person's comprehensive assessment. The Plan of Care must be prescribed, approved, and signed by a Licensed Health Care Practitioner, and must be confirmed in writing at least once each 60 days. The care and services under the Plan of Care must be required because the person is Cognitively Impaired or is unable to perform the Required Number of Activities of Daily Living shown on the Schedule.

If possible, a copy of the Plan of Care should be sent to Us before the care and services are received, or, at the latest, at the time the first claim under the Plan of Care is submitted. Unless otherwise stated in this Policy, the Plan of Care must be submitted no later than 60 days after the care and services begin and must document by assessment that the Insured Person met the requirements in the Benefit Eligibility provision during that 60-day period.

A Plan of Care must be approved by a Licensed Health Care Practitioner who does not have a financial interest in, or is not an employee of, the facility, agency, center or provider administering such plan.

SAMPLE

BENEFIT ELIGIBILITY

This section describes the requirements that must be met before any benefits provided under this Policy can be paid.

Eligibility for the Payment of Benefits

To be eligible for benefits provided under this Policy, We must receive a Plan of Care that specifies what care is needed. The care must be needed because the Insured Person has been certified within the last 12 months by a Licensed Health Care Practitioner as:

- (1) requiring continual supervision, which may include cueing by verbal prompting, gestures, or other demonstrations, by another person to protect the Insured Person from threats to his or her health or safety, due to Cognitive Impairment; or
- (2) requiring the presence of another person within arm's reach due to the inability to perform at least the Required Number of Activities of Daily Living, shown on the Schedule, for a period of at least 90 days. The other person must be present within arm's reach in order to assist, supervise or prevent injury by physical intervention.

If an Insured Person meets the Benefit Eligibility requirements shown above, he or she will have met the requirements under federal law to be considered a Chronically Ill Individual. Meeting this requirement is necessary in order for this Policy to qualify for favorable tax treatment under federal law.

GENERAL BENEFIT INFORMATION

In order for benefits to be payable, Benefit Eligibility and all confinements, care and services must begin after the Effective Date of this Policy and while Your coverage is in force. All charges must be incurred while the applicable Benefit Section is in force, unless otherwise stated in the applicable Benefit Section.

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

In no event will We pay less than \$100 for each day of Nursing Home confinement in the Metropolitan Area or less than \$70 for each day of Nursing Home confinement outside of the Metropolitan Area. In no event will We pay less than \$50 for each day of Home Care received in the Metropolitan Area or \$35 for each day of Home Care received outside of the Metropolitan Area.

Limitations or Conditions on Eligibility for Benefits

The applicable Elimination Period, benefits and benefit limits are shown on the Schedule. Below is a description of the Elimination Period and some benefit limits.

Elimination Period

If the Schedule and the Benefit Sections indicate that an Elimination Period is applicable to the benefits which are payable, no such benefits will be paid until expenses have been incurred for the number of days shown on the Schedule. You will be financially responsible for the expenses incurred during those days. Benefits subject to the Elimination Period will not be paid during this elimination period. Once enough days have been accumulated to satisfy this Elimination Period, it need never be satisfied again.

The Elimination Period can only be satisfied by days on which the expenses incurred would otherwise be covered under this Policy if there were no Elimination Period. An Insured Person must actually have been confined or received care or services for which an Elimination Period is required on any day used to satisfy an Elimination Period.

Days on which expenses that would also be eligible for coverage under this Policy, except for the Elimination Period, and are reimbursed by Medicare will also be credited toward the Elimination Period.

Maximum Benefit

Benefits subject to the Maximum Benefit are listed on the Schedule.

As shown on the Schedule, the Maximum Benefit payable for all the benefits listed on the Schedule is the total Maximum Benefit dollar amount payable.

When the Maximum Benefit has been paid, no further benefits will be payable, unless otherwise provided in accordance with the terms of another provision of this Policy.

Definition Information

Special words and phrases are given defined meanings in various sections of this Policy. If a definition of a word or phrase is found in any section of this Policy, it shall have the same meaning throughout the Policy. To help You recognize these special words and phrases, the first letter of each word, or word in the phrase, is capitalized wherever it appears.

Benefit Sections

The following sections describe the coverage available for care and services covered under this Policy. Read the benefit provisions carefully. Care Coordination is not required to access benefits under this Policy unless otherwise specified in a benefit section. Premiums for this Policy must be paid when due in order for the coverage to remain in force. Remember, the Schedule will only show the benefits and benefit amounts You elected and We initially issued. Any benefits You subsequently add or delete and any increases or decreases You request in benefit amounts, and their respective effective dates, will be indicated by endorsement and all Policy and benefit provisions, waiting periods and elimination periods will be calculated from the effective date of such increase or addition.

SAMPLE

Nursing Home Benefit

We will pay the actual charges incurred for each day an Insured Person is confined in a Nursing Home subject to:

- (1) the Benefit Eligibility provision;
 - (2) the Elimination Period;
 - (3) the Maximum Daily Benefit;
 - (4) the Maximum Benefit; and
 - (5) care and services must be provided in a facility that meets this policy's definition of a Nursing Home.
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**Nursing Home Bed
Reservation Benefit**

When an Insured Person is absent for any reason (except discharge) during a Nursing Home confinement, the benefit will be one or a combination of the following:

- (1) if the absence occurs after the Elimination Period has been met, We will pay the actual Nursing Home charges incurred for room and board while the room in the Nursing Home is being reserved during each day of the Insured Person's absence, up to the Maximum Daily Benefit; or
- (2) if the absence occurs while satisfying the Elimination Period and room and board charges are incurred from the Nursing Home to hold the room, We will give credit toward the Elimination Period for each day the Insured Person is absent.

This benefit is available for the Maximum Number of Days per Calendar Year shown on the Schedule and subject to the Benefit Eligibility provision.

Restoration of Nursing Home Benefits

This provision only describes how benefits can be restored. The requirements found in the Benefit Eligibility provision, therefore, shall not apply to this provision. This provision, however, is subject to the requirements described below.

Following a Nursing Home confinement for which We have been paying the Nursing Home Benefit, We will restore such Nursing Home Benefit amounts to the remaining applicable Maximum Benefit if certain requirements are met. This includes any increases to the Maximum Benefit that may have occurred under a Benefit Increase Option, if elected. The amounts applied to the restoration will only be applicable to the Nursing Home Benefit for subsequent Nursing Home stays. The restored amount will not exceed the Maximum Benefit payable.

Requirements for Restoration of Nursing Home Benefits

For a period of 180 consecutive days, the Insured Person must not meet the requirements found in the Benefit Eligibility provision for Cognitive Impairment and the inability to perform at least the Required Number of Activities of Daily Living shown on the Schedule page. The 180 consecutive day period begins on the day a Licensed Health Care Practitioner certifies that the Insured Person does not meet the requirements for Benefit Eligibility and such certification is filed with Us. The Policy must remain in force during this time period.

SAMPLE

**Assisted Living Facility
Benefit**

We will pay the actual charges incurred for room and board, not to exceed the charge for a one-bedroom unit, and for the necessary Maintenance and Personal Care Services for each day an Insured Person is confined in an Assisted Living Facility subject to:

- (1) the Benefit Eligibility provision;
- (2) the Elimination Period;
- (3) the Maximum Daily Benefit;
- (4) the Maximum Benefit; and
- (5) care and services must be provided while confined in a facility that meets this policy's definition of an Assisted Living Facility.

**Assisted Living Facility
Bed Reservation Benefit**

When an Insured Person is absent for any reason (except discharge) during an Assisted Living Facility confinement, the benefit will be one or a combination of the following:

- (1) if the absence occurs after the Elimination Period has been met, We will pay the actual Assisted Living Facility charges incurred for room and board while the room in the Assisted Living Facility is being reserved during each day of the Insured Person's absence, up to the Maximum Daily Benefit; or
- (2) if the absence occurs while satisfying the Elimination Period and room and board charges are incurred from the Assisted Living Facility to hold the room, We will give credit toward the Elimination Period for each day the Insured Person is absent.

This benefit is available for the Maximum Number of Days per Calendar Year shown on the Schedule and subject to the Benefit Eligibility provision.

Home Care And Adult Day Care Benefits

Neither Home Care nor Adult Day Care benefits will be payable on any day that an Insured Person is confined as an inpatient in a hospital or Nursing Home. However, such benefits may be payable on a day that the Insured Person is admitted for confinement or discharged following such confinement.

Home Care Benefit

We will pay the actual charges incurred for each day an Insured Person receives Home Care, subject to:

- (1) the Benefit Eligibility provision;
- (2) the Maximum Daily Professional Services Benefit or Maximum Daily Basic Services Benefit;
- (3) the Maximum Benefit; and
- (4) Basic Services must be provided by or through a Home Care Agency, unless the Insured Person is receiving the Care Coordination Benefit. If the Insured Person is receiving the Care Coordination Benefit, Basic Services may be provided by a provider who is licensed or certified as required by the state to provide such services and is approved by the Care Coordinator.

For any day during which an Insured Person receives both Professional and Basic Services, We will pay up to the Maximum Daily Professional Services Benefit.

The Home Care Benefit is not subject to, nor will it satisfy, the Elimination Period.

Adult Day Care Benefit

We will pay the actual charges incurred for each day an Insured Person receives Adult Day Care, subject to:

- (1) the Benefit Eligibility provision;
- (2) the Maximum Daily Adult Day Care Benefit;
- (3) the Maximum Benefit;
- (4) the care or services must be provided by and at an Adult Day Care Center; and
- (5) Adult Day Care must be received for at least 4 hours during any day for which benefits are payable.

The Adult Day Care Benefit is not subject to, nor will it satisfy, the Elimination Period.

Hospice Care Benefit

Definitions

Hospice Care	A coordinated, interdisciplinary program for meeting the special physical, emotional, social and spiritual needs of dying individuals, by providing palliative and supportive services during the illness to individuals who have no reasonable prospect of cure and, as estimated by a Doctor, have a life expectancy of 6 months or less.
Hospice Care Facility	A facility which is licensed or certified by the state in which it is located to provide Hospice Care.
Hospice Care Provider	Any hospital, related institution, Home Care Agency, Hospice Care Facility or other licensed provider which provides Hospice Care.

Hospice Care Benefit	<p>We will pay the actual charges incurred for each day an Insured Person receives Hospice Care subject to:</p> <ol style="list-style-type: none">(1) the Benefit Eligibility provision;(2) the Insured Person must have no reasonable prospect of cure and, as estimated by his or her Doctor, have a life expectancy of 6 months or less;(3) the Maximum Daily Benefit;(4) the Maximum Benefit; and(5) Hospice Care must be provided by a Hospice Care Provider.
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Benefits for Hospice Care are not subject to, nor will they satisfy, the Elimination Period. We will not pay for more than 180 days of Hospice Care.

Care Coordination Benefit

Definitions

Care Coordination	<p>The development of a comprehensive, face-to-face assessment of a person's functional and cognitive capacity. A Care Coordinator will coordinate appropriate services and monitor the delivery of such services including:</p> <ol style="list-style-type: none">(1) development, completion, implementation and coordination of the Plan of Care;(2) monitoring of services provided under the Plan of Care;(3) completion of a comprehensive reassessment of the Plan of Care, as needed; and(4) discharge from the requirements under the Plan of Care, when appropriate.
Care Coordinator	<p>A person contracted by Us who is a Licensed Health Care Practitioner and provides Care Coordination services.</p> <p>"Care Coordinator" will not include anyone who has an ownership interest in or is an employee of any provider of the care or services received.</p>

Care Coordination Benefit	<p>In order to obtain a Care Coordinator, an Insured Person must contact Us at the toll-free number shown on the Schedule and select a Care Coordinator contracted by Us from Our list. The Care Coordinator will objectively review the Insured Person's care needs, address concerns he or she may have and provide advocacy for him or her and the family. While working with the Insured Person, the family, and Doctor, the Care Coordinator will help to establish an individualized Plan of Care. Upon the Insured Person's request, the Care Coordinator will provide him or her with a list of care providers and services in his or her area for the Insured Person to consider. Neither the Care Coordinator nor We will suggest or recommend providers or guarantee the quality of care by any of the providers or services listed. However, it will be a starting point for the Insured Person to use when seeking care directly from these providers. The Care Coordinator will maintain an ongoing relationship with the Insured Person and the family, monitor the Insured Person's progress and, working with his or her Doctor, modify the Plan of Care to adapt to changing needs.</p>
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In addition to other benefits paid under this Policy, We will pay for the Care Coordinator to initially assess and develop a Plan of Care. Thereafter, We will pay for the Care Coordination services of the Care Coordinator for as long as the Insured Person meets or is expected to meet the requirements in the Benefit Eligibility provision and he or she is receiving or is expected to receive other benefits payable under this Policy. If the Care Coordinator determines it is necessary, and if the Insured Person desires, the Care Coordinator will assist the Insured Person in obtaining the services recommended in the Plan of Care. This assistance will be limited to referring the Insured Person to providers and help in coordinating such referrals. There will be no charge to You for the covered Care Coordination services of the Care Coordinator and no amount will be deducted for such covered Care Coordination services from the maximum benefits payable under the Policy.

The Care Coordination Benefit includes the services of the Care Coordinator to arrange for services to assist the Insured Person in remaining at Home, such as:

- (1) home health care services;
- (2) durable medical equipment and supplies;
- (3) emergency medical call system;
- (4) companion services;
- (5) shopping services; and
- (6) transportation services.

The benefits for the covered Care Coordination services provided by the Care Coordinator are not subject to, nor will they satisfy, the Elimination Period.

SAMPLE

Respite Care Benefit

If an Insured Person is receiving the Care Coordination Benefit, this additional benefit is available.

Definition**Respite Care**

Respite or relief for an Insured Person's primary caregiver. Respite Care covers temporary confinements in a Nursing Home, Assisted Living Facility, or care received in an Insured Person's Home.

Respite Care Benefit

If an Insured Person is being cared for by his or her primary caregiver on a continuous basis and such caregiver is not compensated by You for his or her services, We will pay the actual charges incurred for Respite Care, subject to:

- (1) the Benefit Eligibility provision;
- (2) the Respite Care Maximum Daily Benefit;
- (3) the Respite Care Maximum Number of Days per Calendar Year;
- (4) the Maximum Benefit; and
- (5) Respite Care must be provided in a Nursing Home, Assisted Living Facility, or in the Insured Person's Home.

Benefits for Respite Care are not subject to, nor will they satisfy, the Elimination Period.

Benefits for Respite Care will not be payable when other benefits, except for Care Coordination, are payable under this Policy.

Therapeutic Device Benefit

If an Insured Person is receiving the Care Coordination Benefit, this additional benefit is available. To qualify for this additional benefit, the Care Coordinator must approve the provider of the Therapeutic Device.

Definition

Therapeutic Device

Special equipment that is appropriate for an Insured Person's condition and used at his or her Home. The following are examples of types of equipment that may be considered Therapeutic Devices:

- (1) special hospital-style beds;
- (2) crutches;
- (3) wheelchairs;
- (4) infusion pumps; or
- (5) respirators.

A Therapeutic Device does not include any drug, medicine, or equipment implanted in an Insured Person's body, temporarily or permanently. Also, not included is any Home modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Therapeutic Device Benefit

We will pay the actual charges incurred for rental or purchase of a Therapeutic Device subject to:

- (1) the Insured Person receiving the Care Coordination Benefit;
- (2) the Benefit Eligibility provision;
- (3) the Maximum Lifetime Therapeutic Device Benefit;
- (4) the Maximum Benefit; and
- (5) the equipment must be used in the Insured Person's Home.

We will decide whether a rental or purchase of the Therapeutic Device would be more appropriate.

For purposes of the Therapeutic Device definition and the Therapeutic Device Benefit, an Insured Person's Home shall not include an Assisted Living Facility.

The Therapeutic Device Benefit is not subject to, nor will it satisfy, the Elimination Period.

Home Modification Benefit

If an Insured Person is receiving the Care Coordination Benefit, this additional benefit is available. To qualify for this additional benefit, the Care Coordinator must approve the provider, labor, equipment and supplies. Prior to any modification or installation, We must agree to the modification or installation.

Home Modification Benefit We will pay the actual charges incurred for labor, equipment, and supplies for minor modifications to an Insured Person's Home that will enhance his or her ability to perform the Activities of Daily Living and allow the Insured Person to remain in his or her Home safely, subject to:

- (1) the Insured Person receiving the Care Coordination Benefit;
- (2) the Benefit Eligibility provision;
- (3) the Maximum Lifetime Home Modification Benefit; and
- (4) the Maximum Benefit.

Examples of Home modification include such things as: installing a ramp in an Insured Person's Home or installing grab bars in an Insured Person's bathroom and similar accessibility modifications.

Home modification does not include things such as: home repair, cosmetic changes, elevators, exercise rooms, remodeling, installation of a hot tub or swimming pool, or any similar modification. We will not pay for the purchase of any tools. Also, We will not pay for the removal or reversal of any Home modification that was previously covered under this benefit.

For purposes of the Home Modification Benefit, an Insured Person's Home shall not include an Assisted Living Facility.

The Home Modification Benefit is not subject to, nor will it satisfy, the Elimination Period.

Medical Alert System Benefit

If an Insured Person is receiving the Care Coordination Benefit, this additional benefit is available. To qualify for this additional benefit, the Care Coordinator must approve the provider. Prior to any modification or installation, We must agree to the modification or installation.

Definition

Medical Alert System

A communication system installed in an Insured Person's Home that is used solely for the purpose of calling for assistance in the event of a medical emergency.

Medical Alert System Benefit

We will pay for a Medical Alert System either:

- (1) the actual monthly rental and/or monitoring charges incurred up to the Monthly Medical Alert System Benefit; or
- (2) the actual purchase cost.

We will decide whether a rental or a purchase of the Medical Alert System would be more appropriate.

The Medical Alert System Benefit is subject to:

- (1) the Insured Person receiving the Care Coordination Benefit;
- (2) the Benefit Eligibility provision;
- (3) the Maximum Medical Alert System Benefit; and
- (4) the Maximum Benefit.

We will not pay for any charges for normal telephone service, or for a home security system, or any other similar service or device.

For purposes of the Medical Alert System definition and the Medical Alert System Benefit, an Insured Person's Home shall not include an Assisted Living Facility.

The Medical Alert System Benefit is not subject to, nor will it satisfy, the Elimination Period.

Caregiver Training Benefit

If an Insured Person is receiving the Care Coordination Benefit, this additional benefit is available. To qualify for this additional benefit, the Care Coordinator must approve the provider of the training.

Definitions

Caregiver Training

Appropriate training and instruction provided by a person approved by the Care Coordinator to provide the knowledge and skills necessary for:

- (1) the proper use and care of a therapeutic device and/or disposable medical aids, including but not limited to catheters; ostomy bags; or suctioning tubes; or
- (2) the performance of appropriate caregiving procedures, such as changing of wound dressings, repositioning a patient in bed, or giving insulin injections.

Volunteer Caregiver

The person who has the primary responsibility of caring for an Insured Person in his or her Home. A person who is paid for caring for an Insured Person cannot be a Volunteer Caregiver.

Caregiver Training Benefit

We will pay the actual charges incurred for Caregiver Training for an Insured Person or a Volunteer Caregiver to assist an Insured Person, subject to:

- (1) the Insured Person receiving the Care Coordination Benefit;
- (2) the Benefit Eligibility provision;
- (3) the Maximum Lifetime Caregiver Training Benefit;
- (4) the Maximum Benefit; and
- (5) the Caregiver Training must not already be included free of charge by an equipment or supply vendor.

The Caregiver Training Benefit is not subject to, nor will it satisfy, the Elimination Period.

Monthly Home Care Benefit

If an Insured Person is receiving the Care Coordination Benefit, this additional benefit is available. To qualify for this additional benefit, the Care Coordinator must approve the provider of the care or services.

Monthly Home Care Benefit We will pay, in lieu of the Home Care Benefit and Adult Day Care Benefit, the actual charges incurred for Home Care and Adult Day Care on the basis of the services received during each continuous 30-day period rather than on a daily basis, subject to:

- (1) the Insured Person receiving the Care Coordination Benefit;
- (2) the Benefit Eligibility provision; and
- (3) the Maximum Benefit.

The maximum benefit payable during each continuous 30-day period will be limited to an amount calculated by:

- (1) multiplying the Maximum Daily Basic Services Benefit shown on the Schedule by 30;
- (2) plus the number of days Professional Services are received during such 30-day period multiplied by the difference, if any, between the Maximum Daily Professional Services Benefit and the Maximum Daily Basic Services Benefit.

SAMPLE

Alternative Payment Benefit

Once an Insured Person has been certified to meet the requirements found in the Benefit Eligibility provision for Cognitive Impairment or the inability to perform at least the Required Number of Activities of Daily Living as shown on the Schedule and We have received a Plan of Care, We will pay You the Monthly Benefit shown on the Schedule in advance for each calendar month the Insured Person continues to meet those requirements. We will pay this benefit in lieu of all other benefits for care or services provided under this Policy upon Your request at claim time.

If an Insured Person meets the Benefit Eligibility requirements and We receive a Plan of Care for only part of a calendar month, We will prorate the Monthly Benefit payment. We will not pay this Benefit for any time period prior to the time We receive the Plan of Care. We must receive a Plan of Care at least once each 60 days.

This benefit is also subject to the Maximum Benefit. We will not pay this benefit when an Insured Person is confined in a hospital or rehabilitation hospital.

We will stop paying this benefit to You on the day that the Insured Person no longer meets the requirements in the Benefit Eligibility provision. We will also stop paying this benefit if We do not receive a Plan of Care as required or when an Insured Person chooses to receive other benefits payable for care and services that are covered under this Policy.

The Alternative Payment Benefit is not subject to, nor will it satisfy, the Elimination Period.

This benefit provides for formal and informal care and services for home care in lieu of all other benefits for care and services provided under this policy with a minimum of \$25 a day. Since this benefit pays on a per-diem basis under Federal tax law, You may want to consult Your tax advisor for any possible tax consequences.

This is an additional benefit which does not require formal services, and the required nursing home and home care benefits meeting the New York definition of long term care are available, subject to the requirements found in the Benefit Eligibility provision of the Policy, in lieu of this Benefit.

Waiver of Premium Benefit We will automatically change Your Premium Paying Mode to monthly and not require the payment of Your monthly premium when an Insured Person qualifies for the Waiver of Premium Benefit.

To qualify for the Waiver of Premium Benefit, the Insured Person must:

- (1) meet the requirements in the Benefit Eligibility provision;
- (2) satisfy the Elimination Period, if applicable; and
- (3) be receiving Nursing Home, Assisted Living Facility, Home Care, Adult Day Care, or Alternative Payment Benefits.

We will stop waiving the premium when the Insured Person no longer qualifies for the Waiver of Premium Benefit. The Waiver of Premium Benefit will end on the date the Maximum Benefit has been exhausted.

To keep Your Policy in force when the Waiver of Premium Benefit ends or after an Insured Person no longer qualifies for the Waiver of Premium Benefit, premiums must be paid as they become due. Any unearned premiums on deposit with the Company at the time the Waiver of Premium period began will be applied following the end of the Waiver of Premium period.

SAMPLE

Joint Waiver of Premium

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

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

- (1) both You and Your Spouse have coverage in force with Us as a married couple on the same policy form series which includes this Joint Waiver of Premium Benefit; and
- (2) Your Spouse qualifies for and receives the Waiver of Premium Benefit under the same policy form series.

This Joint Waiver of Premium Benefit ends when the Maximum Benefit has been exhausted under either Your Policy or Your Spouse's policy. To keep Your Policy in force when Your Joint Waiver of Premium Benefit ends or We are no longer waiving the premium, premiums must be paid as they become due. Any unearned premiums on deposit with the Company for Your Policy at the time the Waiver of Premium period began will be applied following the end of the Waiver of Premium period.

Premiums will not be waived under this provision if premiums are being waived for Your Spouse under a Lifetime Waiver of Premium provision.

SAMPLE

Lifetime Waiver of Premium After an Insured Person has been continuously confined in a Nursing Home for the Consecutive Day Waiting Period shown on the Schedule, We will not require payment of any future premium that would otherwise come due for benefits in force on the date such waiver begins. During the entire Consecutive Day Waiting Period, the Insured Person must have been confined in a Nursing Home or hospital and have been satisfying the Elimination Period or receiving the Nursing Home Benefit. However, the days during which the Insured Person is confined in a hospital will not be credited toward satisfying the Consecutive Day Waiting Period. We will refund the unearned portion of any premium You have paid.

The premium for any benefit added after the Lifetime Waiver of Premium Benefit begins will not be waived under this provision.

The Lifetime Waiver of Premium Benefit will end on the date the Maximum Benefit has been exhausted.

SAMPLE

**Compound Benefit
Increase Option**

If You elected the Compound Benefit Increase Option, every dollar benefit amount will increase annually on each anniversary of the effective date of this option. Each increase will be equal to the percentage shown on the Schedule or endorsement of the current dollar benefit amounts in effect (without regard to any claims paid). These increases will continue as long as this option is in force, even if an Insured Person is receiving benefits on the date of the increase.

Any benefit amounts You add in order to increase the amount of Your coverage after the effective date of this option will not increase until the amount of the increase has been in effect one full year.

SAMPLE

Return of Premium Benefit

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

The amount of this benefit will be the sum of all premiums paid (excluding any waived premiums) less the amount of any benefits paid pursuant to the terms of the Policy, from the Effective Date of this benefit up to the date of Your death.

Payment of benefits will be made in one lump sum to Your beneficiary. Your beneficiary will be as shown in Your application unless later changed by You. If there is no named or living beneficiary on the date of Your death, the benefits will be paid to Your estate.

You may change Your beneficiary at any time by giving written notice to Us. The effective date of the beneficiary change will be the date the change is received and recorded by Us. If You die before We receive the request, the change will not be effective.

SAMPLE

Rate Guarantee

Premiums for this Policy are guaranteed from the Policy's Effective Date for the period of time shown on the Schedule.

SAMPLE

Contingent Nonforfeiture Benefit

After the expiration of the rate guarantee, if any, if We increase Your premium rates to a level which results in a cumulative increase of the annual premium equal to or exceeding the percentage of Your Initial Premium set forth below and You are unable to afford the increased premium, You may choose one of the two coverage options offered in this provision. We will notify You at least 30 days prior to the due date of the premium reflecting the rate increase.

Your Initial Premium is based on Your age when the Policy was issued, plus the premium for any benefits that You have added since then, and/or minus the premium for any benefits that You have reduced since Your Policy was issued.

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

Coverage Options

If a Trigger for a Substantial Premium Increase should occur and You are unable to afford the increased premium, We will notify You that You may elect to:

- (1) reduce Your current Policy benefits, but not less than an amount that is currently available, so that required premium payments are not increased, or
- (2) convert Your coverage as provided under the Shortened Benefit Period described below. This option must be elected anytime during the 120 days following the Premium Due Date for the increased premium. However, should Your Policy Lapse during this 120-day period, the Shortened Benefit Period will automatically take effect.

Shortened Benefit Period

Your coverage will continue on a limited basis if this option is put into effect.

The daily benefit amounts available will be the same amounts available at the time Your Policy would have Lapsed. The minimum benefit provided under this Shortened Benefit Period will be equal to 30 times Your Nursing Home Maximum Daily Benefit at the time of Lapse.

If You have a benefit increase option of any kind in force, the benefits available will NOT continue to increase.

The maximum benefit amount in force will be equal to all premiums paid, excluding waived premiums, for all Your coverage combined.

All of the eligibility requirements, including waiting periods, elimination periods, or deductible amounts that applied in order for an Insured Person to be eligible for payment of benefits at the time Your coverage would have Lapsed will apply. To the extent that any such eligibility requirements and/or waiting periods were satisfied under Your coverage at the time it would have Lapsed, they will also be satisfied under this Shortened Benefit Period.

The daily benefits payable under Your Policy and this Shortened Benefit Period will not exceed the daily benefits that would have been payable under Your Policy if You had continued paying premiums. The total combined benefits payable under Your Policy and this Shortened Benefit Period will not exceed the total benefits that would have been payable under Your Policy if You had continued paying premiums.

Once the maximum benefit amount in force under this Shortened Benefit Period has been paid, no further benefits will be payable and all coverage will terminate.

If You have a benefit in force that allows coverage to become paid up or premium to be waived for life at some future date, this Contingent Nonforfeiture Benefit will only apply if coverage Lapses before the date the coverage becomes paid up or the waiver of premium begins. Otherwise, this benefit will terminate on the date the coverage becomes paid up or on the date premium is waived for life.

SAMPLE

SAMPLE

AUTHORIZATION FOR THE RELEASE OF INFORMATION TO FAMILY MEMBERS & OTHER INDIVIDUALS

A copy of this authorization will be considered as valid as the original

I hereby authorize the use or disclosure of information about me as described below:

- 1) Transamerica Financial Life Insurance Company has my permission to disclose my personal information to the following people who are involved in my care or the handling of my affairs:

Name of Person:	Description of Relationship:
1) _____	_____
2) _____	_____
3) _____	_____

(List the full name of up to three relatives, friends or other individuals involved in your care to whom you want personal information disclosed.)

- 2) **Description of the information that may be used or disclosed:**

This authorization includes the release of any information regarding the coverage under my long term care insurance policy, any personal information related to my care or benefits, and any other information contained in the Company's records about me or my coverage.

- 3) **The information will be used for the following purpose:**

The information will be disclosed to the individuals named above in Section I. This form will not provide the above-named individuals with the authority to change or modify my policy, or to make any decision related to my care.

STATEMENTS OF UNDERSTANDING:

- I understand that I may refuse to sign this authorization, and my refusal will not affect my eligibility for benefits or the continuation of my coverage.
- I understand that if any person that receives the above information is not a health care provider covered by state or federal privacy regulations, the information described above may be redisclosed by such person and will likely no longer be protected by state or federal privacy regulations.
- I understand that I may revoke the authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, by sending a written revocation to Transamerica Financial Life Insurance Company, P.O. Box 93003, Hurst, TX 76053.
- I understand that this authorization is not a Power of Attorney and does not give the above-named individuals the authority to act on my behalf.
- Unless revoked in writing, this authorization will remain valid for as long as my policy remains in force. My submission of a subsequent version of this authorization will serve to add the named individuals to the original submission. It will not serve as a written revocation.

Name of Policyholder (includes applicant, policyholder, or other insured)

Policy/Certificate Number

Signature of Policyholder

Date

If Personal Representative, please provide explanation and documentation of authority (e.g., power of attorney, court-appointed administrator)

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Signature of Policyholder

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SAMPLE



Home Office:
440 Mamaroneck Ave
Harrison, NY 10528
A Stock Company

Long Term Care Division
Administrative Office
Mailing Address:
P.O. Box 93003
Hurst, TX 76053
Telephone: (866) 655-4422

Delivery Receipt

Insured: JOHN DOE

Policy/Certificate Number: 061040486

Date of Delivery: _____

_____ Policy issued as requested.

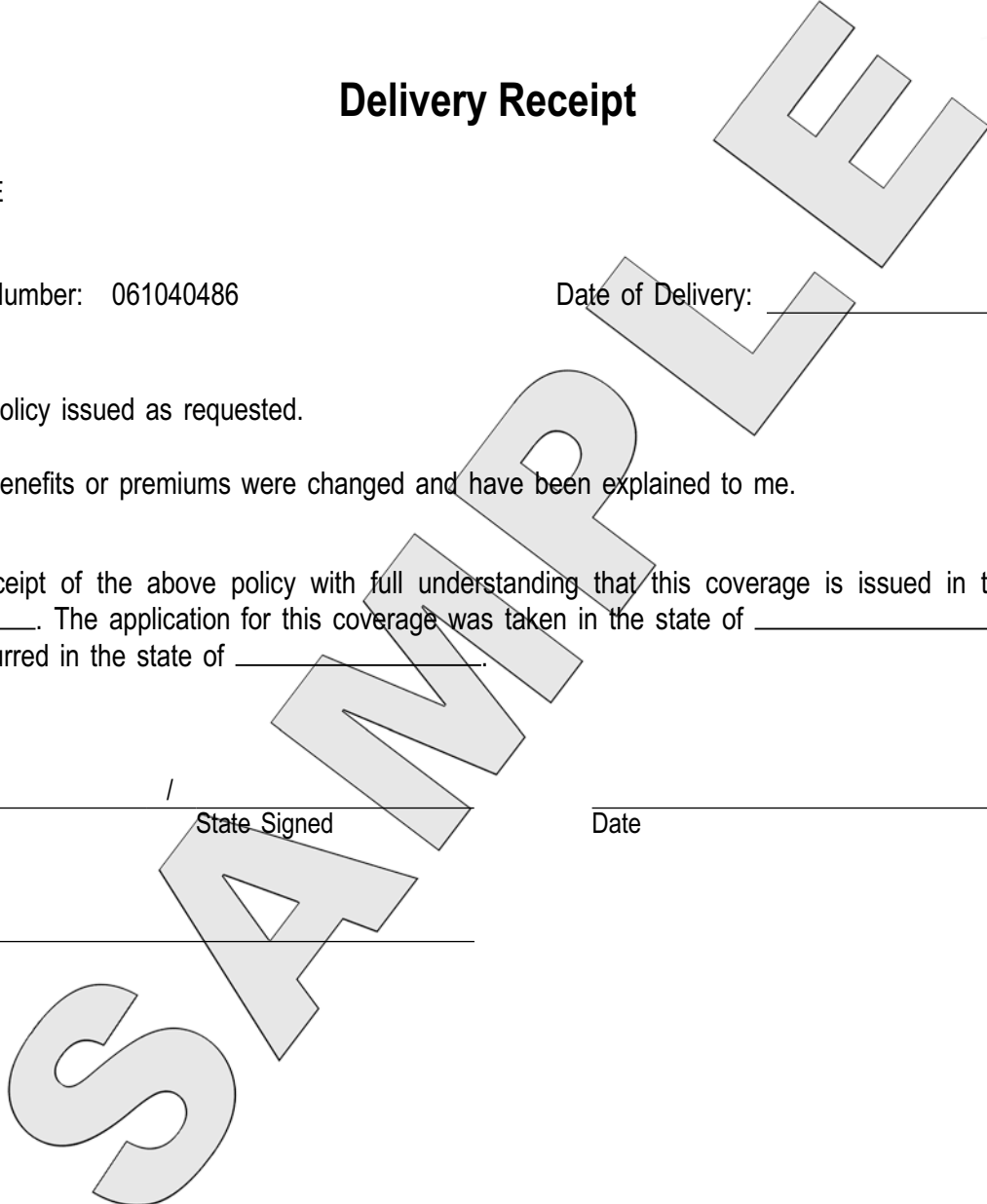
_____ Benefits or premiums were changed and have been explained to me.

I acknowledge receipt of the above policy with full understanding that this coverage is issued in the state of _____ The application for this coverage was taken in the state of _____. Delivery of the policy occurred in the state of _____.

Signature _____ / State Signed

Date _____

Printed Name _____



SAMPLE



Home Office:
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Harrison, NY 10528
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