



# **NEW YORK DISCLOSURE PACKET**

**THIS DISCLOSURE PACKAGE IS YOURS TO KEEP  
PLEASE READ THE ATTACHED DOCUMENTS**

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**TRANSAMERICA FINANCIAL LIFE INSURANCE COMPANY**  
**ADMINISTRATIVE OFFICE: P.O. BOX 93003, HURST, TEXAS 76053**  
**1-866-655-4422**

**LONG TERM CARE DISCLOSURE STATEMENT FOR**  
**INDIVIDUAL POLICY FORM TFL 1-FP (NY) 402**  
**RETAIN THIS OUTLINE FOR YOUR RECORDS**

("We," "Us," or "Our" means the Company. "You" or "Your" means the Policyholder.)

**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.**

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

**CAUTION**

The issuance of this long term care insurance coverage is based upon the answers to the questions on the application. A copy of the application will be included in Your Policy. If 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: Transamerica Financial Life Insurance Company, P.O. Box 93003, Hurst, Texas 76053. Our toll free number is shown above.

**1. POLICY DESIGNATION**

The Policy is an individual Policy of insurance which was issued in the State of New York.

**2. PURPOSE OF DISCLOSURE STATEMENT**

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

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

If You are not satisfied with Your Policy, You may return it to Us at Our Administrative Office in Hurst, Texas or Your agent within 30 days after You receive it and You will receive a full refund of premiums. Premiums paid for periods after Your death will also be refunded. If You should send Us a written request to cancel Your coverage, 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.

**4. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company. Neither Transamerica Financial Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

**5. LONG TERM CARE COVERAGE**

Policies of this category are designed to provide coverage for not less than twenty-four (24) consecutive months on an expense-incurred, indemnity, or prepaid or other basis and provides coverage for all levels of care in a nursing home and home care benefits.

This Policy provides coverage for actual charges incurred for covered long term care expenses, subject to policy limitations, elimination periods, and other requirements.

This Policy offers a minimum of twenty-four (24) months' worth of benefits for long term care as required by New York Insurance Regulation. The Policy also includes benefits that are not required by New York Insurance Regulation, such as the Assisted Living Facility Benefit. Your Schedule page will indicate which benefits are not required by New York Insurance Regulation. 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 Nursing Home and/or Home Care Benefits, You should manage Your benefits accordingly.

## 6. **BENEFITS AVAILABLE UNDER THIS POLICY**

### **BENEFIT DESCRIPTIONS**

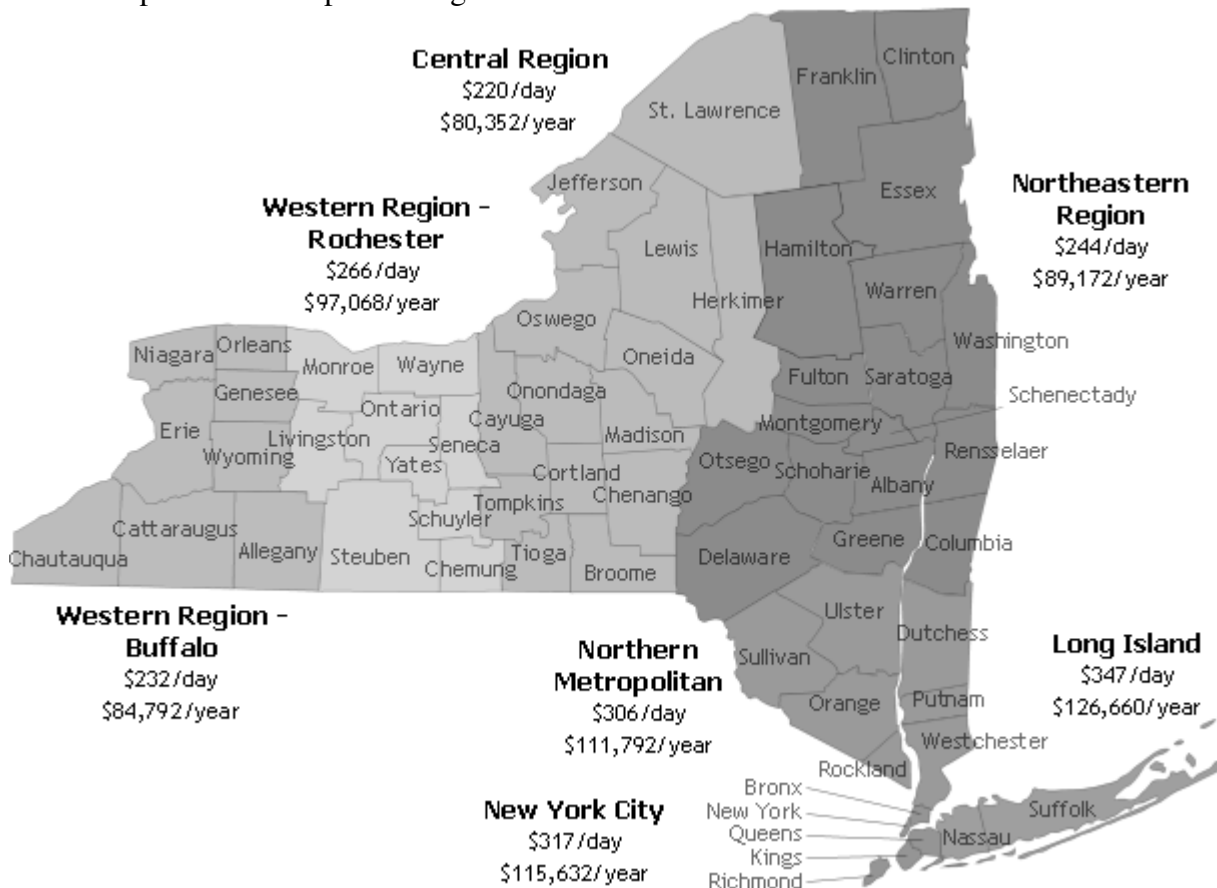
**This Disclosure Statement provides a brief description of the benefits available under this Policy. Your insurance agent is obligated to assist You in deciding which combination of coverage options is best suited to meet Your particular needs and financial situation. The benefits You select will be indicated on Your application and the Schedule page of Your Policy.**

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

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 the Policy.

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. **Metropolitan Area** means 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.

The most-recent average rates for care in a Nursing Home for both the New York City-Metropolitan and Upstate Regions of the state are listed below:



The benefits subject to the Maximum Benefit You selected will be indicated on the Schedule page of the Policy.

To qualify for benefits, the Elimination Period You selected (unless otherwise indicated) must be satisfied and the Benefit Eligibility requirements must be met.

**ELIGIBILITY FOR THE PAYMENT OF BENEFITS**

To be eligible for benefits, 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:

- 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 severe Cognitive Impairment; or
- 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 page of the Policy, 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 the federal law to be considered a Chronically Ill Individual. Meeting this requirement is necessary in order for the Policy to qualify for favorable tax treatment under federal law.

Activities of Daily Living are: (1) Bathing; (2) Continence; (3) Dressing; (4) Eating; (5) Toileting; and (6) Transferring, as defined in the Policy.

**Following is a description of the coverage available for care and services covered under each benefit. All benefit maximums are as indicated on Your application and the Schedule page of the Policy.**

## **BENEFITS**

### **Nursing Home Benefit:**

We will pay the actual charges incurred for each day an Insured Person is confined in a Nursing Home, up to the Maximum Daily Benefit.

### **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:

- 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
- 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 limited to the Maximum Number of Days per Calendar Year shown on the Schedule page of the Policy.

### **Assisted Living Facility Benefit:**

We will pay the actual charges incurred for room and board, not to exceed the charges for a one-bedroom unit, and for the necessary Maintenance and Personal Care Services for each day an Insured Person is confined in a licensed, certified, or registered Assisted Living Facility, up to the Maximum Daily Benefit.

### **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:

- 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
- 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 limited to the Maximum Number of Days per Calendar Year shown on the Schedule page of the Policy.

### **Home Care Benefit:**

We will pay the actual charges incurred for each day an Insured Person receives Home Care, up to the Maximum Daily Professional Services Benefit or the Maximum Daily Basic Services Benefit. 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.

**Adult Day Care Benefit:**

We will pay the actual charges incurred for each day an Insured Person receives Adult Day Care provided by and at an Adult Day Care Center, up to the Maximum Daily Adult Day Care Benefit. Adult Day Care must be received for at least 4 hours during any day for which benefits are payable.

**Hospice Care Benefit:**

If an Insured Person has no reasonable prospect of cure and, as estimated by his or her Doctor, has a life expectancy of 6 months or less, We will pay the actual charges incurred for each day an Insured Person receives Hospice Care provided by a Hospice Care Provider, up to the Maximum Daily Benefit. We will not pay for more than 180 days of Hospice Care.

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

**Care Coordination Benefit:**

In addition to other benefits paid under the Policy, We will pay for the Care Coordinator, selected from Our list, to initially assess and develop a Plan of Care. Thereafter, We will pay for the covered Care Coordination services of the Care Coordinator for as long as an Insured Person meets or is expected to meet the Benefit Eligibility requirements and he or she is receiving or is expected to receive other benefits payable under the 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 Coordinator will coordinate appropriate services and monitor the delivery of such services including:

- development of the initial comprehensive, face-to-face assessment of person's functional and cognitive capacity;
- development, completion, implementation and coordination of the Plan of Care;
- monitoring of services provided under the Plan of Care;
- completion of a comprehensive reassessment of the Plan of Care, as needed; and
- discharge from the requirements under the Plan of Care, when appropriate.

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:

- home health care services;
- durable medical equipment and supplies;
- emergency medical call system;
- companion services;
- shopping services; and
- 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.

**ADDITIONAL AVAILABLE BENEFITS IF THE INSURED PERSON IS RECEIVING THE CARE COORDINATION BENEFIT.** The benefits You select will be indicated on Your application and the Schedule page of Your policy. The Care Coordinator must approve the provider of the care, services or training. Prior to any modification or installation, We must agree to the modification or installation.

**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 provided in a Nursing Home, Assisted Living Facility, or the Insured Person's Home. We will not pay more than the Maximum Daily Benefit.

The Respite Care Benefit is not subject to, nor will it satisfy, the Elimination Period. Benefits for Respite Care will not be payable when other benefits, except for Care Coordination, are payable under the Policy. Respite Care is limited to the Maximum Number of Days per Calendar Year shown on the Schedule page of the Policy.

**Therapeutic Device Benefit:**

We will pay the actual charges incurred for rental or purchase of a Therapeutic Device to be used in an Insured Person's Home, up to the Maximum Lifetime Therapeutic Device Benefit shown on the Schedule page of the Policy. We will decide whether a rental or a purchase of the Therapeutic Device would be more appropriate.

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

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

**Home Modification Benefit:**

We will pay the actual charges incurred, up to the Maximum Lifetime Home Modification Benefit shown on the Schedule page of the Policy, 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.

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

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

**Medical Alert System Benefit:**

We will pay for a Medical Alert System either the actual monthly rental and/or monitoring charges incurred, up to the Monthly Medical Alert System Benefit, or the actual purchase cost. We will decide whether a rental or a purchase of the Medical Alert System would be more appropriate. We will not pay more than the Maximum Medical Alert System Benefit. The Monthly Medical Alert System Benefit and the Maximum Medical Alert System Benefit are shown on the Schedule page of the Policy.

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

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

**Caregiver Training Benefit:**

We will pay the actual charges incurred, up to the Maximum Lifetime Caregiver Training Benefit shown on the Schedule page of the Policy, for Caregiver Training for an Insured Person or a Volunteer Caregiver to assist an Insured Person in the proper use and care of a therapeutic device or in an appropriate care giving procedure. 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:**

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

- multiplying the Maximum Daily Basic Services Benefit by 30;
- 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.

**OTHER AVAILABLE BENEFITS****Alternative Payment Benefit:**

Once an Insured Person has been certified to meet the Benefit Eligibility requirements and We have received a Plan of Care, We will pay You the Monthly Benefit shown on the Schedule page of the Policy 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 and services provided under the Policy upon Your request at claim time.

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 this Policy, in lieu of this Benefit.

**Waiver of Premium Benefit:**

When an Insured Person meets the Benefit Eligibility requirements, has satisfied the Elimination Period (if applicable) and is receiving Nursing Home, Assisted Living Facility, Home Care, Adult Day Care, or Alternative Payment Benefits, We will automatically change Your Premium Paying Mode to monthly and not require the payment of Your monthly premium. 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.

**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 when We are no longer waiving the premiums for Your Spouse's policy.

The 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.

**Lifetime Waiver of Premium Benefit:**

After an Insured Person has been continuously confined in a Nursing Home for the Consecutive Day Waiting Period shown on the Schedule page of the Policy, We will not require payment of any future premium that would otherwise come due for benefits in force on the date such waiver begins.

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.

**Simple Benefit Increase Option:**

We will increase every dollar benefit amount annually on each anniversary of the effective date of this option. The dollar benefit amounts will increase annually by the percentage shown on the Schedule page of the Policy or by endorsement of the original dollar benefit amounts in effect on the effective date of this option (without regard to any claims paid).

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.

Your premiums will be higher, but they will not increase due to a change in age or the automatic benefit increase. Below is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

**Compound Benefit Increase Option:**

We will increase every dollar benefit amount annually on each anniversary of the effective date of this option. The dollar benefit amounts will increase annually by the percentage shown on the Schedule page of the Policy or by endorsement of the current dollar benefit amounts in effect (without regard to any claims paid).

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.

Your premiums will be higher, but they will not increase due to a change in age or the automatic benefit increase. Below is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.

**Step-Rated Compound Benefit Increase Option:**

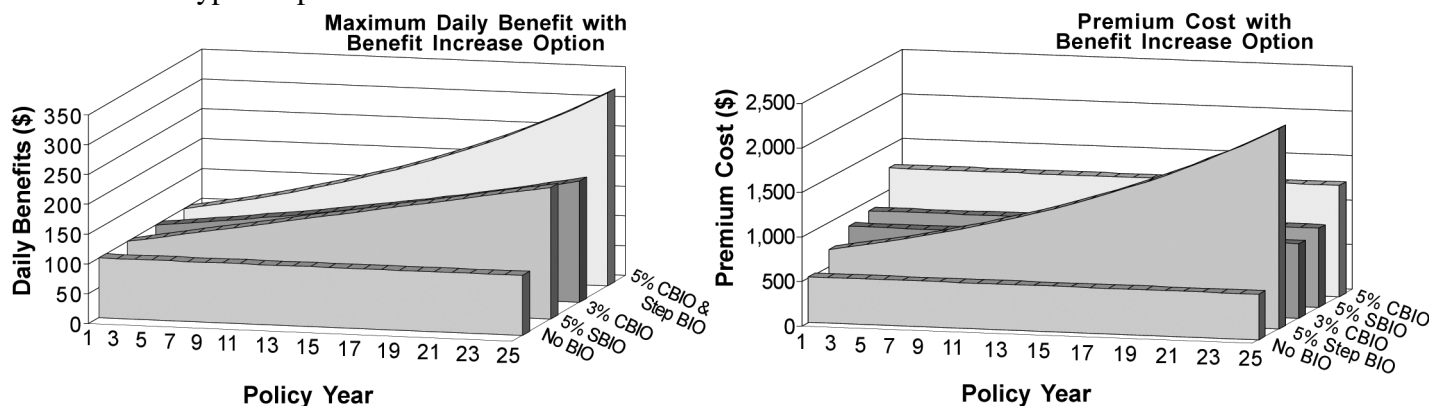
In consideration of future increases in premium amounts, We will increase every dollar benefit amount annually on each anniversary of the effective date of this option. The dollar benefit amounts will increase annually by the Benefit Increase Percentage shown on the Schedule page of the Policy or by endorsement of the current dollar benefit amounts in effect (without regard to any claims paid).

Your current premium will be increased by the Premium Increase Percentage shown on the Schedule. The increase in premium will occur at the Premium Increase Frequency shown on the Schedule, as long as this option is in force.

At any time, You can notify Us in writing to terminate the Step-Rated Compound Benefit Increase Option. The increases in dollar benefit amounts and resulting premium increases will stop on the next anniversary of the effective date of this option following the date We receive Your notice to terminate this option. Your attained dollar benefit amounts and premium amount will remain at the then current attained level. Your premiums remain subject to Our right to increase premiums.

If You choose to terminate the Step-Rated Compound Benefit Increase Option, You will have the option to then purchase a 5% Compound Benefit Increase Option which has a level premium, or to purchase any other benefit increase option available at the time You choose to terminate the Step-Rated Compound Benefit Increase Option. Your benefit level under the new option will begin at the level it had attained under the Step-Rated Compound Benefit Increase Option and the premium charged for the new benefit increase option will be at Your then attained age. Your premiums remain subject to Our right to increase premiums. A Step-Rated Compound Benefit Increase Option result in premium increases that occur automatically after issuance of the benefit. There may be other Compound Benefit Increase Options available that do not result in automatic premium increases after issuance of the benefit.

Below is a graphic comparison of the benefit levels of a policy that increases benefits over the policy period with a policy that does not increase benefits. A similar graphic comparison illustrates premiums for those types of policies.



**Deferred Benefit Increase Option:**

If You did not select a Benefit Increase Option at the time of application, You will have the opportunity, if no Insured Person has incurred a prior claim under the Policy, to add the Simple or Compound Benefit Increase Option, without evidence of insurability, within the 90-day period prior to the first, the third, or the fifth anniversary dates of the Policy.

The additional premium required for the Benefit Increase Option will be based on the ages of each Insured Person on the anniversary date of the Policy ending the 90-day period when the option is exercised. Increases in benefits will begin on the anniversary date of the Policy one year after the anniversary date ending the 90-day period when the option was exercised.

**Return of Premium:**

If this benefit has been continuously in force from its Effective Date, a benefit will be paid after You have died. Benefits will also be paid 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.

**Paid-Up Provision:**

In the event You discontinue premium payment prior to the end of the Premium Paying Period You selected, a percentage of the dollar benefit amounts under the Policy will become paid-up. The percentage payable of the dollar benefit amounts will then be as follows:

<b>If Premiums Are Paid To:</b>	<b>Percentage of Benefits Paid-Up:</b>
5 or more Years Prior to End of Premium Paying Period	0%
4 Years Prior to End of Premium Paying Period	20%
3 Years Prior to End of Premium Paying Period	40%
2 Years Prior to End of Premium Paying Period	60%
1 Year Prior to End of Premium Paying Period	80%
End of Premium Paying Period	100%

**Nonforfeiture Benefit – Shortened Benefit Period:**

After Your coverage has been in effect for at least 3 full years, this Benefit provides for the coverage to continue on a limited basis if it would have otherwise Lapsed for nonpayment of premium.

The daily benefit amounts available will be the same amounts available at the time the coverage would have Lapsed. The total benefit amount in force under this Benefit will be equal to all of the premium paid, excluding waived premiums, for all coverage combined, including this Benefit.

The minimum benefit provided under this Benefit will be equal to 30 times the Nursing Home Maximum Daily Benefit at the time of Lapse.

**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.

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

**7. GENERAL EXCLUSIONS AND LIMITATIONS**

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

- resulting from alcoholism or drug addiction, unless as a result of a narcotic prescribed by a Doctor; or
- arising out of suicide, attempted suicide or intentionally self-inflicted injury; or

- 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
- received outside the United States and its possessions, or Canada; or
- for which benefits are provided under any state or federal workers' compensation, employer's liability or occupational disease law; or
- that are not included in an Insured Person's Plan of Care; or
- rendered by a member of an Insured Person's Immediate Family, unless:
  - ❖ he or she is a regular employee of an organization which is providing the treatment, service or care; and
  - ❖ the organization receives the payment for the treatment, service or care; and
  - ❖ he or she receives no compensation other than the normal compensation for employees in his or her job category.

The 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.

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

**8. RELATIONSHIP OF COST OF CARE AND BENEFITS**

Because the costs of long term care services will likely increase over time, You should consider whether and how the benefits of this plan may be adjusted.

If a Benefit Increase Option has been selected, Your benefits will increase as explained under the Benefit Increase Option section.

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

**Renewability:** We guarantee to renew the Policy as long as premiums are paid on time.

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

- the date coverage under the Policy Lapses; or
- the date of Your death; or
- the date the Maximum Benefit has been exhausted; or
- the next Policy monthly anniversary following Our receipt of Your written request to cancel Your 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 the Policy, it will end on the next Policy monthly anniversary following Your requested future cancellation date.

**Right to Change Rates:** 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.

10. **ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS**

Once insurance goes into force, coverage is provided for Insured Persons clinically diagnosed as having Alzheimer's disease or related degenerative and dementing illnesses.

11. **PREMIUM**

Your total annual premium is \$\_\_\_\_\_, which includes \$\_\_\_\_\_ for the Included Benefits and \$\_\_\_\_\_ for the Elected Benefits You selected.

The Premium Paying Mode You select will impact Your overall cost of insurance. You should compare all the Premium Paying Modes available and choose the one that works best for Your financial and budgetary needs.

12. **ADDITIONAL FEATURES**

This coverage is medically underwritten. It is very important for all the questions on the application to be completed fully and correctly. If Your answers fail to include all material medical information requested, We may have the right to deny benefits or rescind the Policy.

**[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 Maximum Benefit, if certain requirements are met. This includes any increases to the Maximum Benefit that may have occurred under a Benefit Increase Option. The amounts applied to the restoration will only be applicable to the Nursing Home Benefit for subsequent Nursing Home stays.

**Requirements for Restoration of 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 of the Policy. 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.]

**[Full Restoration of 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 period during which We have been paying benefits, We will restore such benefit amounts that We paid to the remaining Maximum Benefit, if the Insured Person meets certain requirements. 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 available for subsequent stays or care subject to the restored Maximum Benefit.

**Requirements for Full Restoration of 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 of the Policy. 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.]

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

### **Long-Term Care Insurance:**

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

### **Medicare:**

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

### **Medicaid:**

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

### **Shopper's Guide:**

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

### **Counseling:**

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

**AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION**

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

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

- 1) **Person(s) or group(s) of persons authorized to use or disclose the information:** Any physicians, medical practitioners, hospitals, clinics, laboratories, long-term care facilities, medical or medically-related facilities, pharmacies, insurance companies (including Transamerica), and insurance support organizations such as the Medical Information Bureau.
- 2) **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** Transamerica and its authorized representatives, including agents and insurance support organizations.
- 3) **Description of the information that may be used or disclosed:** This authorization specifically includes the release of *all information related to my health* (except psychotherapy notes) *and my insurance policies and claims*, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as AIDS.
- 4) **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my application for long term care insurance with Transamerica and, if a policy is issued, for evaluating contestability and eligibility for benefits and for the continuation or replacement of the policy.

**STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:**

- I understand that health information about me provided to Transamerica is protected by federal privacy regulations and that Transamerica will only use and disclose such information as described in its Notice of Health Information Privacy Practices. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations, the disclosed information may no longer be protected by those regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides Transamerica with the right to contest a claim under the policy or the policy itself, by sending a written revocation to Transamerica Financial Life Insurance Company, Underwriting Supervisor, P.O. Box 93003, Hurst, TX 76053. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- I understand that I am entitled to receive a copy of this signed authorization.
- This authorization will expire 24 months from the date signed.

Applicant's Name: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_ Effective Date: \_\_\_\_\_

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

## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

This Health Insurance Portability and Accountability Act (HIPAA) authorization must be fully completed and signed as a condition of applying for insurance with Transamerica Financial Life Insurance Company (“TFLIC”). Your application may not be accepted without a signed authorization.

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

- I. **Person(s) or group(s) of persons authorized to use and/or disclose the information:**  
MIB, Inc., formerly Medical Information Bureau (“MIB”), a non-profit membership organization of life, health, long term care and disability insurance companies, which operates an information exchange on behalf of its members, and TFLIC.
- II. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:**  
TFLIC and its authorized representatives, including agents, reinsurers, service providers and other insurance support organizations including, but not limited to, MIB.
- III. **Description of the information that may be used and/or disclosed:**  
This authorization specifically includes the release and disclosure of my entire medical record and any other health information concerning me (excluding psychotherapy notes) and my insurance policies and claims, including, but not limited to those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse treatment information or information regarding communicable or infectious conditions, such as Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), other matters such as hazardous activities, character and general reputation, finances, occupation, information collected by a consumer reporting agency about my credit history, credit worthiness, credit standing and credit capacity, avocation(s), motor vehicle driving record(s), and personal traits.
- IV. **The information will be used and/or disclosed only for the following purpose(s):**  
For the purpose of underwriting my application for long term care insurance with TFLIC and, if a policy is issued, for evaluating contestability and for the continuation or replacement of the policy. The information may also be disclosed by TFLIC to MIB in the form of a brief coded report that will be stored for 7 years in the MIB database and may be released by MIB to another MIB member company if I apply for life, health or long term care insurance with that member company or a claim for benefits is submitted on my behalf to a member company. I understand that there may be additional uses and/or disclosures of my health information that are specifically permitted by law without my authorization (*i.e.*, TFLIC may be obligated to disclose health information to government, regulatory and law enforcement entities).

### STATEMENTS OF UNDERSTANDING AND ACKNOWLEDGEMENT:

- I understand that health information about me provided to TFLIC is protected by federal and state privacy regulations and that, in addition to using such information as provided in this authorization, TFLIC will only use and disclose such information as described in its Notice of Health Information Privacy Practices. However, I also understand that, upon disclosure pursuant to this authorization to any person or organization that is not covered by the federal privacy regulations, the disclosed information may no longer be protected by those regulations.
- I understand that I may revoke this authorization, in writing, at any time, except to the extent that action has been taken in reliance on this authorization, or to the extent that other law provides TFLIC with the right to contest a claim under the policy or the policy itself, by sending a notice to Transamerica Financial Life Insurance Company, Underwriting Supervisor, P.O. Box 93003, Hurst, TX 76053. I also understand that my revocation of this authorization will not result in the deletion of codes in the MIB database if such codes are reported by TFLIC while this authorization is in force.
- I understand that this authorization will be valid for 24 months from the date signed.
- I understand that a copy of this authorization will be as valid as the original.
- I understand that I am entitled to receive a copy of this signed authorization.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Individual or  
Individual's Personal Representative

\_\_\_\_\_  
Description of Authority of Personal  
Representative (if applicable)

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

**DISCLOSURE NOTICES**  
**MEDICAL INFORMATION BUREAU AND FAIR CREDIT REPORTING**

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

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

Transamerica Financial Life Insurance Company or its reinsurers may also release information in this file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

An investigative consumer report may be obtained as part of the normal procedure for processing your application. These reports are made available by independent sources known as consumer reporting agencies and their reports typically contain information from third parties and you related to your health, character, general reputation, mode of living and personal characteristics. You have the right, upon request, to be informed of the name and address of the agency if a report is requested in connection with your application. Also, you may request to be interviewed in connection with this report and you have the right to make a written request to receive additional information concerning the nature and scope of the investigation. To make this request, write to: Transamerica Financial Life Insurance Company, LTC Administrative Office, Underwriting Department, P. O. Box 93003, Hurst, TX 76053.

## HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

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

Effective April 14, 2003, this Notice of Privacy Practices is applicable to the long term care insurance business of Transamerica Financial Life Insurance Company. This notice refers to the Company by using the terms "us", "we" or "our".

**Our Pledge and Obligation:** We are committed to protecting your personal health information. This notice will tell you about the ways in which we may use and disclose your personal health information for payment, health care operations, and other circumstances as either required or permitted by law. *Except as outlined below, we will not use or disclose your personal health information without your written authorization.*

We are required by law to: safeguard your personal health information; give you this Notice of our duties and privacy practices; and abide by the terms of this Notice as long as it remains in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this Notice, and to make the new Notice effective for all personal health information maintained by us. In the event of a material change, a revised Notice will be sent to all of our policyholders.

### USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

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

**For Claim Processing and Payment Related Purposes:** We may make uses and disclosures of your personal health information as necessary for benefit verification and claim processing purposes. For instance, we may use information regarding long term care services you receive from service providers such as nursing homes, assisted living facilities, and home health care agencies to process and pay claims.

Examples of our payment related purposes also includes our collection of premium, coordinating reinsurance, and care coordination activities

**For Business Operations:** We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include underwriting, premium rating, customer service, reinsurance, compliance, fraud prevention and reporting, auditing, agent commission reconciliation, and other activities related to the issuance, renewal, replacement, or continuation of your long term care insurance coverage.

- **Collection of Information:** To properly underwrite and administer your insurance coverage, we collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization we may also collect or verify information by contacting information sources such as Consumer Reporting agencies (like the Medical Information Bureau); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.
- **Business Associates:** Certain services are performed through contracts with outside persons or organizations, such as underwriting support services, actuarial services, legal services, care coordination services, etc. At times it may be necessary for us to disclose your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. We obligate business associates by contract to appropriately safeguard the privacy of your information.

- **Agents:** Your agent is our business associate. For customer service purposes, your agent is notified of certain coverage-related matters. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent is notified on their monthly statement that your policy remains in force for as long as you continue to pay your premium.
- **Family and Friends Involved in Your Care:** We may from time to time disclose your personal health information to certain family members, friends, and others who are involved in your care or in the payment of your care in order to not hinder that person's involvement. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your written authorization. If you have designated a person to help prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.
- **Health-Related Benefits or Services:** We may contact you to provide information about health-related benefits and services that may be of interest to you. We will not use your personal health information for marketing non-health products without your authorization.
- **Mergers and Acquisitions:** Your personal health information may also be disclosed as a part of a potential sale, merger or acquisition involving our business in order to make an informed business decision regarding any such prospective transaction.

**Other Uses and Disclosures for Public Health, Government Oversight, or Similar Activities:** We are permitted or required by law to make certain other uses and disclosures of your personal health information without your authorization.

- We may release your personal health information for any purpose allowed by law;
- We may release your personal health information to law enforcement officials as allowed by law to report wounds and injuries and crimes;
- We may release your personal health information for public health activities, such as permitted reporting of disease, injury, death, and for required public health investigations;
- We may release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- Unless otherwise permitted by law or your written authorization, we will only disclose enrollment, disenrollment and summary health information with your employer for administrative purposes, such as payroll deduction of the employee portion of the premium;
- We may release personal health information relating to your participation in a group health plan or whether you are enrolled or disenrolled in a group health plan to your plan sponsor;
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations (such as investigations into consumer complaints), or civil or criminal proceedings;
- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request;
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities;

- We may release your personal health information to non-affiliated organizations or persons such as, other insurance institutions, agents, insurance support organizations, or law enforcement and governmental authority as necessary to prevent criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage; and
- We may release your personal health information to our parent company and affiliates in conjunction with health care operation purposes.

As allowed by law, we may also use or disclose your personal health information for research purposes; for specialized government functions; or for workers' compensation purposes or other similar purposes.

## RIGHTS THAT YOU HAVE

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

**Right to Access.** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies and postage and, in certain cases, may deny your request.

**Right to Confidential Communications.** You have the right to request that we send communications of health information to you by alternative means or to alternative locations, if all or part of that information could endanger you. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests.

**Right to Amend.** You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.

**Right to an Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; you may be charged a reasonable fee for each subsequent accounting you request within the same 12-month period.

**Right to Request Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your personal health information for payment, or health care operations by notifying us of your request for a restriction in writing. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate in writing any agreed-to restriction by sending such termination notice to us at the address given below.

**Right to Revoke Your Authorization.** If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance of such authorization, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.

**Right to a Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

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

## COMPLAINTS

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

## CONTACTING US

To file a complaint or to make a request as described in the section entitled "RIGHTS THAT YOU HAVE," please send your written request to: Transamerica Financial Life Insurance Company, P O Box 93003, Hurst, Texas 76053. Requests should be directed to our Customer Service Department, and Complaints should be sent to the attention of the Complaint Coordinator. Please be sure to include the following information:

- your full name,
- address,
- date of birth,
- policy number, and
- the nature of your request or complaint.

**FOR FURTHER INFORMATION:** For additional information regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy policies, please write to us at the address shown above or contact our Customer Service Department toll-free at 1-866-655-4422.

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

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF  
ACCIDENT AND HEALTH INSURANCE AND THE PURCHASE OF  
MULTIPLE ACCIDENT AND HEALTH POLICIES**

**Note: If you are replacing any insurance with this long-term care policy, this form must be completed.**

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

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

**Statement to the applicant by the agent:**

I have reviewed your current accident and health insurance coverage and find that the indicated replacement, or the additional coverage of the type and amount applied for, is appropriate for your needs. My conclusion has taken into account the following considerations, which I call to your attention:

1. If you are replacing existing long-term care insurance, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. You should be aware that the premium rate for the replacement policy may be higher than what you are paying for the existing policy that you plan to replace. If the premium for your existing policy is based on your age when it was issued, you have built up equity in that policy which may be lost if you terminate it.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all the information has been properly recorded.

\_\_\_\_\_  
*Agent's Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Agent's Name (please print)*

\_\_\_\_\_  
*SS#*

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature of Applicant*





