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

Life and Health Group Application and Agreement

Name of Group (*"you, your"*): Lexington Fayette Urban County Government	Tax ID Number:	SIC Code: 9121	Website Address:
Street Address: 200 East Main Street	City: Lexington	State: KY	ZIP Code: 40507
Contact Name: Kashene Wayne	Email Address: kwayne@lexingtonky.gov	Phone #: 859-258-3066	Fax #: 859-258-3956
Nature of Group: Legislative Bodies	# of Employees/Members: 3100	# Eligible for Coverage:	# of Years in Existence:

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

1. We customarily conduct an annual enrollment program for your eligible employees/members. You will provide us with census data if needed for us to determine proper enrollment eligibility.
2. The initial enrollment shall take place from 10/10/22 to 10/28/22. You will provide us direct access to your employees/members to obtain applications through group meetings and individual interviews in a suitable location on your property during normal business hours, or through other means mutually agreed upon between you and us. Participation in your group must meet our minimum participation requirements. We reserve the right to withdraw from the enrollment and cancel any applications already obtained if these conditions are not satisfied.
3. Unless otherwise agreed upon by you and us, you will collect premiums from your participating employees/members. You will forward the premiums to us within 15 days after you receive the monthly bill. You will maintain records of all premiums collected from your employees/members while this agreement remains in force and for two years after it terminates. During this period, you will make these records available for inspection and audit by us during normal business hours. If premium contributions collected by you, your employees, or your vendors are misappropriated, you will reimburse us for our entire loss, including attorney fees and expenses incurred in collection, to the extent permitted by the laws of your state.
   For New Hampshire Policyholders, we are required by law to complete any premium audits within 120 days after termination of the Policy
4. Do benefit selections vary by class? ☐ No ☒ Yes *(define classes below)*

Definition of Class 1:	Full Time Benefit Eligible
Definition of Class 2:	Part Time Benefit Eligible
Definition of Class 3:	
Definition of Class 4:	

5. Eligibility for insurance:
   a. Employer Groups - eligible employees are defined as those who work at least [hours] hours per week for you, and have been so employed for at least [days] days.

	Class 1	Class 2	Class 3	Class 4
hours per week for you,	40	20		
days.	0	730		

   b. Member Groups - eligible members are defined as members of an eligible class of members, who are in good standing in accordance with your by-laws.
   For New Hampshire - Member Groups are not eligible to purchase our Accident and Health products
6. Is dependent coverage being offered? ☒ Yes ☐ No
7. Is coverage being offered through a Section 125 plan? ☐ Yes ☒ No
   If "yes", which product(s): _____ Plan Start Date: _____ Plan Anniversary Date _____
8. Is coverage being offered replacing existing coverage? ☐ Yes ☐ No
   If "yes", which products? _____

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

I understand and agree that this application will be made part of each group master policy issued as a result of this application. The Group listed above will be named as the Policyholder for each group master policy. I agree that no insurance will be effective until approved by us at our administrative office.
For New Hampshire Policyholders – I agree to the offering of the selected products in the Insurance Selections section for the eligible employees.
For New Hampshire Policyholders – All policies (except life) provide limited benefits. If accepted for coverage, review your policy carefully.

Signed in (City/State) _____ This _____ Day of (Month/Year) _____, _____

Signature of Officer ______________________ Email Address ______________________

Print Name and Title of Officer ______________________

For Florida - Is coverage being offered replacing existing coverage? ☐ Yes ☐ No

If "yes", which products? ______________________

Signature of Licensed Agent/Producer ______________________ Email Address ______________________

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

Fraud Warning

Alabama

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

Arkansas and Maryland

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

California

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

District of Columbia, Louisiana and Rhode Island

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

Florida

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

Kansas

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

Kentucky

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

Massachusetts and Oregon

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

New Jersey

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

North Carolina

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

Oklahoma

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

Puerto Rico

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

Tennessee and Washington

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

Virginia

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

Vermont

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

For Maine, Pennsylvania and All other states

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

Billing Information

Billing Name (if other than group name)			
Billing Address: 200 East Main St.	City: Lexington	State: KY	ZIP Code: 40507
Billing Contact Name:	Email Address:	Phone #:	Fax #:
Billing Address is: ☒ Group Policyholder ☐ Third Party Administrator ☐ Premium Collection Agency *(Requires a Premium Collection Agreement)*			

Pay periods per year: 26	Payments will be remitted: ☒ After each deduction ☐ Monthly ☐ Other ________
Payroll deductions per year: 26	Premium amount on bill should reflect: ☐ Levelized amount over 12 months ☒ Actual amount of deductions
First payroll deduction date:	Preferred billing sequence: ☒ Alphabetical ☐ Social Security Number ☒ Employee/Member ID Last name + Emp ID
First bill due date: 2/1/22	Preferred Billing Method: ☒ Paper ☐ Website ☐ Self-Bill — Multiple Billing Locations: ☒ No ☐ Yes *(attach listing)*

Insurance Selections

(Product and Rider availability subject to state approval)

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

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

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

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

Accelerated Death Benefit for Terminal Illness/Condition in all states except LA, MA, OH, WA.
Waiver of Monthly Deductions for Layoff included in all states except CT, MA, TN, PR, VT, WA.

ACCEPT	DECLINE	
☐	☐	Accelerated Death Benefit for Critical Condition: ☐ 25% ☐ 50%
☐	☐	ADB for Chronic Condition Rider
☐	☐	Extension of Benefits Rider
☐	☐	Benefit Restoration Rider
☐	☐	Accidental Death & Dismemberment
☐	☐	Automatic Face Amount Increase Option: ☐ $1 for 10 years OR ☐ $2 for 5 years ☐ All Employees ☐ Employee Option
☐	☐	Child Level Term Insurance Rider
☐	☐	Waiver of Monthly Deductions for Total Disability

☒ **Group Interest Sensitive Whole Life – Trans$ure**	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:**

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

Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.
Waiver of Premium for Layoff included in all states except MA, MN, VA, and VT.

ACCEPT	DECLINE	
☐	☒	Accelerated Death Benefit for Critical Care: ☐ 25% ☐ 50% ☐ 75% ☐ 100%
☒	☐	ADB for Chronic Condition Rider
☒	☐	Extension of Benefits Rider
☐	☒	Accidental Death & Dismemberment
☒	☐	Child Level Term Insurance Rider
☐	☒	Waiver of Premium for Total Disability

☒ **Group Term Life Insurance – Trans Select**	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA.
Waiver of Premium Due to Layoff or Strike included in all states except CT, MA, MD, NJ, PR, TN, and VA.

	☐ **5 Year Term**	☐ **10 Year Term**	☐ **20 Year Term**
☐ Accelerated Death Benefit for Critical Care:	☐ 25% ☐ 50% ☐ 75% ☐ 100%	☐ 25% ☐ 50% ☐ 75% ☐ 100%	☐ 25% ☐ 50% ☐ 75% ☐ 100%
☐ ADB for Chronic Condition Rider With Extension of Benefits	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Accidental Death & Dismemberment	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Waiver of Premium	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
☒ Child Level Term Rider	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Group Term Life Insurance – VTL**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: Continuation of Coverage and Waiver of Premium included in all states.
Terminal Illness/Condition Accelerated Death Benefit included in all states except FL, OR.

ACCEPT	**DECLINE**	
☐	☐	Accidental Death & Dismemberment

☐ **Self-Administered Group Term Life**	**Group Contribution?** Yes Policyholder pays 100% of the GTL. Supplemental life is paid by the employee	**Requested Effective Date:**

Note: The proposal must be included in new case submission but will not be a part of the policy.

Requested Anniversary Date:

$ Amount collected at time of application, if applicable.
Will employees contribution be ☐ Pre-tax or ☐ Post-tax?
Employees must be actively at work for coverage to become effective.
Coverage is only available to Employees working within the United State or its territories.

	Class 1	**Class 2**	**Class 3**	**Class 4**	**Class 5**
☐ Flat Amount (enter maximum dollar amount) ☐ Salary Multiplier (enter salary multiple range)					
Non-Contributory Dependent Life	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Supplemental Life Insurance Employee	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Supplemental Life Insurance Spouse	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Supplemental Life Insurance Children	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Accelerated Death Benefit for Terminal Illness Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Accidental Death and Dismemberment Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Waiver of Premium Benefit Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Portability Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Continuation of Approved Leave of Absence Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Change of Insurance Carriers Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Benefit Reduction Schedule	☐ Reduction ☐ No Reduction	☐ Reduction ☐ No Reduction	☐ Reduction ☐ No Reduction	☐ Reduction ☐ No Reduction	☐ Reduction ☐ No Reduction

If coverage is replacing existing coverage:

Name of Prior Carrier: Prior Plan Termination Date:
Provide a copy of the prior plan.

☐ **Self-Administered Basic Term Life Insurance**	**Group Contribution?** ☑ Yes **Policyholder pays 100% of Basic Life Insurance**	**Requested Effective Date:**

Coverage: ☐ **With Benefit Reduction** ☐ **Without Benefit Reduction**

Accelerated Death Benefit for Terminal Illness/Condition included in all states except MA and OH.
Waiver of Premium included in all states.

	Class 1	**Class 2**	**Class 3**	**Class 4**
Basic Life Insurance: ☐ Flat Amount ☐ Multiple of Salary/not to exceed	$	$	$	$
☐ Optional Accidental Death & Dismemberment?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Group Accident Insurance – AccidentAdvance**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Coverage: ☐ **24-Hour Coverage** ☐ **Off-the-Job Only Coverage**

For MD or TN only: Are you offering the ☐ group policy or ☐ individual policy

			Plan 1	**Plan 2**	**Plan 3**
Module 1 – Accident Emergency Treatment Benefits			Units	Units	Units
Module 2 – Follow-Up Visits and Physical Therapy Benefits			Units	Units	Units
Module 3 – Initial Accident Hospitalization			Units	Units	Units
Accept	**Decline**	**Optional Riders**			
☐	☐	Accidental Death and Dismemberment Rider	Units	Units	Units
☐	☐	Accident Hospital & ICU Income Rider	Units	Units	Units
☐	☐	Expanded Benefits Rider	Units	Units	Units
☐	☐	Wellness Benefit Rider	Units	Units	Units
☐	☐	Accident Only Disability Income Rider — Elimination Period-0 Days; Benefit Period: ☐ 6 ☐ 12 Months			
☐	☐	Sickness Only Disability Income Rider — Elimination Period: 14 Days; Benefit Period: ☐ 6 ☐ 12 Months			
☐	☐	Spouse Off-the-Job Accident Only Disability Income Rider — Elimination Period-0 Days; Benefit Period: 6 Months			

☐ **Individual Accident Insurance – AccidentSelect**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **Plan I** ☐ **Plan II**

Accept	**Decline**	
☐	☐	Accident Only Disability Income Rider
☐	☐	Sickness Only Disability Income Rider

☐ **Work Stride: Managing Cancer at Work By John Hopkins Medicine**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

☐ **TopDoc Connect**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

☐ **Group Cancer Insurance – CancerSelect Plus**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:

			Plan 1	**Plan 2**	**Plan 3**
Module 1 – Hospital Benefits			Units	Units	Units
Module 2 – Surgery Benefits			Units	Units	Units
Module 3 – Radiation and Chemotherapy Benefits			Units	Units	Units
Module 4 – Wellness and Miscellaneous Benefits			Units	Units	Units
Module 5 – Cancer Maintenance Therapy Benefits			Units	Units	Units
Accept	**Decline**	**Optional Riders**			
☐	☐	First Occurrence Rider *(Lump Sum Diagnosis Rider in SD)*	Units	Units	Units
☐	☐	Intensive Care Rider *(Not available in CT, MA, NH, NJ, VT or WA)*	Units	Units	Units
☐	☐	Specified Disease Rider *(Not available in OR, SD or WA)*	Units	Units	Units

☐ **Group CI Insurance – CriticalEvents**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:* *If yes, offering Employee Buy-Up?* ☐ Yes ☐ No	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

	Plan 1	**Plan 2**	**Plan 3**
Dependent Coverage (only 50% available for Employer Paid cases)	☐ 50% ☐ 100%	☐ 50% ☐ 100%	☐ 50% ☐ 100%
Rate Structure (Composite is available for Employer Paid only; Attained Age is not available in NJ)	☐ Issue Age ☐ Attained Age ☐ Composite	☐ Issue Age ☐ Attained Age ☐ Composite	☐ Issue Age ☐ Attained Age ☐ Composite
First Occurrence	☐ First Ever ☐ First after Effective Date	☐ First Ever ☐ First after Effective Date	☐ First Ever ☐ First after Effective Date
☐ Cancer Benefit Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Occupational HIV Benefit Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Recurrent Critical Illness Benefit Rider (Benefit Selection: 0%, 25%, 50%, 75%, 100%)	%	%	%
☐ Wellness Benefit Rider	$	$	$

☐ **Group CI Insurance – CriticalAssistance Advance**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ***For GA only: Are you offering the* ☐ *group policy or* ☐ *individual policy***

	Plan 1	**Plan 2**	**Plan 3**
Rate Structure	☐ Tobacco Distinct ☐ Uni-Tobacco	☐ Tobacco Distinct ☐ Uni-Tobacco	☐ Tobacco Distinct ☐ Uni-Tobacco
☐ Cancer Benefit Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Occupational HIV Benefit Rider)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Quality of Life Benefit Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Recurrent Critical Illness Benefit Rider	☐ 25% ☐ 50% ☐ 75%	☐ 25% ☐ 50% ☐ 75%	☐ 25% ☐ 50% ☐ 75%

Benefit Amount Paid For By:	Policyholder	Employee
☐ Intensive Care Rider	$	$
☐ Initial Hospitalization for Accidental Bodily Injury Benefit Rider	$	$
☐ Accident Emergency Treatment Benefit Rider	$	$
☐ Wellness Benefit Rider	$	$

☐ **Group CI Insurance – CriticalAssistance Plus**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:

Accept	**Decline**	
☐	☐	Cancer Benefit Rider *(Includes $50 Wellness)*
☐	☐	Occupational HIV Benefit Rider
☐	☐	Quality of Life Benefit Rider
☐	☐	Cancer Screening Wellness Benefit Rider Additional Benefit: ☐ $50 ☐ $100

☐ **Group CI Insurance – CriticalAssistance Select**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **With Benefit Reduction** ☐ **Without Benefit Reduction**

- ☐ Option A – Cancer, Heart Attack, Stroke, End Stage Renal Failure, and Major Organ Transplant
- ☐ Option B – Heart Attack and Stroke Only
- ☐ Option C – Cancer Only
- ☐ Option B and C – Heart Attack, Stroke, and Cancer Only

☐ **Group Short-Term Disability – TransDI Plus IncomeSelect in FL** ***Large Employer Group Only (51+).***	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Coverage: Accelerated Benefit For Terminal Illness Rider included in all states except CT.

		Class 1	Class 2	Class 3	Class 4
Maximum Monthly Benefit is the lesser of: *(Cannot exceed 80% or $5,000)*	Percentage of Salary	%	%	%	%
	Dollar Amount	$	$	$	$
Maximum Benefit Period (3, 6, 12 or 24 Months)		Months	Months	Months	Months
Accident Elimination Period (0, 7, 14, 30, 60, 90 or 180 Days)		Days	Days	Days	Days
Sickness Elimination Period (7, 14, 30, 60, 90 or 180 Days)		Days	Days	Days	Days

Accept	Decline	Optional Riders/Benefits
☐	☐	Accidental Death & Dismemberment Benefit Rider
☐	☐	Hospital Indemnity Benefit Rider
☐	☐	Survivor Benefit Rider
☐	☐	Limited Pre-existing Condition Benefit (25% of the Disability Benefit for up to 6 weeks)
☐	☐	Physical Therapy Rider
☐	☐	Portability Rider
☐	☐	Additional Income Benefit Rider

☐ **Group Short-Term Disability – TransDI Elite**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:

Maximum Monthly Benefit Amount	Guaranteed Issue up to $2,500; Simplified Issue $2,600 to $5,000
Not to exceed	60% of Salary
Maximum Benefit Period	6 Months or 12 Months (Employee Option)
Accident Elimination Period	0 Days
Sickness Elimination Period	14 Days
Accidental Death Benefit Rider	$2,000 Benefit
Occupational Benefit Rider (Not available in WA)	25% of the Disability Benefit Amount
Limited Pre-existing Condition Benefit	50% of the Disability Benefit Amount for up to 12 Weeks of Disability

☐ **Healthiestyou**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

☐ **Group Limited Benefit Indemnity – TransConnect**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:
Do you continuously maintain a medical plan? ☐ Yes ☐ No *(Product only available while you continuously maintain an underlying medical plan)*
How many plans are in force? _____ *(Attach a copy or plan summary of each plan and the most recent billing statement)*

	Class 1	Class 2	Class 3	Class 4
Hospital Inpatient Benefit Amount				
Underlying Medical Plan Deductible				

☐ **Group Limited Benefit Outpatient-Only Indemnity – TransConnect II**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:
Do you continuously maintain a medical plan? ☐ Yes ☐ No *(Product only available while you continuously maintain an underlying medical plan)*
How many plans are in force? _____ *(Attach a copy or plan summary of each plan and the most recent billing statement)*

	Class 1	Class 2	Class 3	Class 4
Benefit Amount				

☐ Hospital Indemnity – HospitalSelect II HSA Plan	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:*	Requested Effective Date:
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Do you offer a medical plan with at least a $1,000 deductible? ☐ Yes ☐ No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design)	**Class 1**	**Class 2**	**Class 3**	**Class 4**
Base: Daily In-Hospital Indemnity Benefit	$	$	$	$
Maximum (choose one): 31 Days per Confinement Dollar Amount per Calendar Year	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage	%	%	%	%
☐ Wellness Indemnity Benefit Rider	$	$	$	$
	Days	Days	Days	Days
☐ Waiver of Preexisting Condition Rider (for non-Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Preexisting Conditions & Normal Pregnancy Limitations Rider (for Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Normal Pregnancy Limitation Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – HospitalSelect II Non-HSA Plan**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Do you offer a medical plan with at least a $1,000 deductible? ☐ Yes ☐ No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design)	**Class 1**	**Class 2**	**Class 3**	**Class 4**
Base: Daily In-Hospital Indemnity Benefit	$	$	$	$
Maximum (choose one): 31 Days per Confinement Dollar Amount per Calendar Year	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage	%	%	%	%
☐ Inpatient Surgical Indemnity Benefit Rider *(Requires confinement)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage	%	%	%	%
☐ Outpatient Surgical Indemnity Benefit Rider	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage	%	%	%	%
☐ Surgical and Anesthesia Indemnity Benefit Rider Daily Inpatient Surgical Benefit Amount: Daily Outpatient Surgical Benefit Amount: 50% of Inpatient Amount Daily Minor Outpatient Surgical Benefit Amount: 10% of Inpatient Amt. Calendar Year Maximum: 1 Day per category	$	$	$	$
Anesthesia Benefit Percentage	%	%	%	%
☐ Ambulance Indemnity Benefit Rider – Daily Ground Benefit Daily Air Ambulance pays 3 times the Daily Ground Benefit Calendar Year Maximum: 3 Days. Lifetime Maximum: 6 Days	$	$	$	$
☐ Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days	$	$	$	$
☐ Inpatient Mental & Nervous Disorder Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days	$	$	$	$
☐ Skilled Nursing Indemnity Benefit Rider Calendar Year Maximum: 60 Days. Lifetime Maximum: 120 Days	$	$	$	$
☐ Wellness Indemnity Benefit Rider	$	$	$	$
	Days	Days	Days	Days
☐ Waiver of Preexisting Condition Rider (for non-Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Preexisting Conditions & Normal Pregnancy Limitations Rider (for Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Normal Pregnancy Limitation Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – HospitalSelect III HSA Plan**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Do you offer a medical plan with at least a $1,000 deductible? ☐ Yes ☐ No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design)	**Class 1**	**Class 2**	**Class 3**	**Class 4**
Base: Daily In-Hospital Indemnity Benefit	$	$	$	$
Maximum (choose one): 31 Days per Confinement Dollar Amount per Calendar Year	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage	%	%	%	%
☐ Wellness Indemnity Benefit Rider	$	$	$	$
	Days	Days	Days	Days
☐ 24-Hour Coverage Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Preexisting Conditions & Normal Pregnancy Limitations Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Normal Pregnancy Limitation Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – HospitalSelect III Non-HSA Plan**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Do you offer a medical plan with at least a $1,000 deductible? ☐ Yes ☐ No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design)	**Class 1**	**Class 2**	**Class 3**	**Class 4**
Base: Daily In-Hospital Indemnity Benefit	$	$	$	$
Maximum (choose one): 31 Days per Confinement Dollar Amount per Calendar Year	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____	☐ 31 Days ☐ $_____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage	%	%	%	%
☐ Inpatient Surgical Indemnity Benefit Rider *(Requires confinement)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage	%	%	%	%
☐ Outpatient Surgical Indemnity Benefit Rider	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage	%	%	%	%
☐ Surgical and Anesthesia Indemnity Benefit Rider Daily Inpatient Surgical Benefit Amount: Daily Outpatient Surgical Benefit Amount: 50% of Inpatient Amount Daily Minor Outpatient Surgical Benefit Amount: 10% of Inpatient Amt. Calendar Year Maximum: 1 Day per category	$	$	$	$
Anesthesia Benefit Percentage	%	%	%	%
☐ Ambulance Indemnity Benefit Rider – Daily Ground Benefit Daily Air Ambulance pays 3 times the Daily Ground Benefit Calendar Year Maximum: 3 Days. Lifetime Maximum: 6 Days	$	$	$	$
☐ Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days	$	$	$	$
☐ Inpatient Mental & Nervous Disorder Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days	$	$	$	$
☐ Skilled Nursing Indemnity Benefit Rider Calendar Year Maximum: 60 Days. Lifetime Maximum: 120 Days	$	$	$	$
☐ Wellness Indemnity Benefit Rider	$	$	$	$
	Days	Days	Days	Days
☐ 24-Hour Coverage Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Preexisting Conditions & Normal Pregnancy Limitations Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Normal Pregnancy Limitation Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – Transamerica Provider Select – HSA**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Do you offer a medical plan with at least a $1,000 deductible? ☐ Yes ☐ No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design)	**Class 1**	**Class 2**	**Class 3**	**Class 4**
Base: Daily In-Hospital Indemnity Benefit	$	$	$	$
Maximum (choose one): 31 Days per Confinement / Dollar Amount per Calendar Year	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$	$	$	$
☐ Wellness Indemnity Benefit Rider	$	$	$	$
	Days	Days	Days	Days
☐ Waiver of Preexisting Condition Rider (for non-Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Preexisting Conditions & Normal Pregnancy Limitations Rider (for Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Normal Pregnancy Limitation Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Hospital/Provider Network: ____

☐ **Hospital Indemnity – Transamerica Provider Select – Non-HSA**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**
Self-Administered Benefit ☐	**I Acknowledge receipt of Self-Administration Guide** ☐	

Do you offer a medical plan with at least a $1,000 deductible? ☐ Yes ☐ No *(Product only available if you answer "Yes")*

Coverage: (Attach Plan Design)	**Class 1**	**Class 2**	**Class 3**	**Class 4**
Base: Daily In-Hospital Indemnity Benefit	$	$	$	$
Maximum (choose one): 31 Days per Confinement / Dollar Amount per Calendar Year	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____	☐ 31 Days ☐ $____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days	$	$	$	$
☐ Inpatient Surgical Indemnity Benefit Rider *(Requires confinement)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage	%	%	%	%
☐ Outpatient Surgical Indemnity Benefit Rider	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage	%	%	%	%
☐ Wellness Indemnity Benefit Rider	$	$	$	$
	Days	Days	Days	Days
☐ Waiver of Preexisting Condition Rider (for non-Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Preexisting Conditions & Normal Pregnancy Limitations Rider (for Self Admin)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Add Normal Pregnancy Limitation Rider	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Hospital/Provider Network: ____

☐ Self-Administered Group Critical Illness	Group Contribution? ☐ Yes ☐ No *If yes, list amount or %:* If yes, offering Buy-Up? ☐ Yes ☐ No	Requested Effective Date:

Note: The proposal must be included in new case submission but will not be a part of the policy.

	Plan 1		Plan 2		Plan 3	
Rate Structure *(Composite is available for ER Paid only)*	☐ **Issue Age** ☐ **Attained Age** ☐ **Composite**		☐ **Issue Age** ☐ **Attained Age** ☐ **Composite**		☐ **Issue Age** ☐ **Attained Age** ☐ **Composite**	
☐ **Dependent Insurance Percentage** **Spouse** **Children**	 ☐ **50%** ☐ **100%** ☐ **50%** ☐ **100%**		 ☐ **50%** ☐ **100%** ☐ **50%** ☐ **100%**		 ☐ **50%** ☐ **100%** ☐ **50%** ☐ **100%**	
☐ **Cardiovascular Disease**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Coronary Artery Disease Requiring Angioplasty/Stent						
Coronary Artery Disease Requiring Bypass Grafts						
Coronary Invasive						
☐ **Heart Attack**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Heart Attack						
Sudden Cardiac Arrest						
☐ **Kidney Failure**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
End Stage Renal Failure		**N/A**		**N/A**		**N/A**
☐ **Major Organ Transplant**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Bone Marrow Transplant						
Major Organ Transplant (except Bone Marrow)						
☐ **Stroke**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Stroke						
Transient Ischemic Attack (TIA)						
☐ **Benign Tumor**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Benign Brain Tumor						
Benign Spinal Cord Tumor						
☐ **Cancer**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Invasive Cancer						
Non-Invasive Cancer						
Skin Cancer						
☐ **Childhood Disease**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Cerebral Palsy		**N/A**		**N/A**		**N/A**
Cleft Lip/Palate		**N/A**		**N/A**		**N/A**
Cystic Fibrosis		**N/A**		**N/A**		**N/A**
Down Syndrome		**N/A**		**N/A**		**N/A**
☐ **Functional Loss**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Sensory Loss		**N/A**		**N/A**		**N/A**
Monoplegia		**N/A**		**N/A**		**N/A**
Quadriplegia, Paraplegia, or Hemiplegia		**N/A**		**N/A**		**N/A**
☐ **Infectious Disease**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Anthrax		**N/A**		**N/A**		**N/A**
Cholera		**N/A**		**N/A**		**N/A**
Rocky Mountain Spotted Fever		**N/A**		**N/A**		**N/A**

Encephalitis/ Bacterial Meningitis		N/A		N/A		N/A
Typhoid Fever		N/A		N/A		N/A
Tuberculosis		N/A		N/A		N/A
Malaria		N/A		N/A		N/A
Osteomyelitis		N/A		N/A		N/A
SARS – CoV-2		N/A		N/A		N/A
☐ **Occupational Exposure**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Human Immunodeficiency Virus (HIV)		N/A		N/A		N/A
Hepatitis		N/A		N/A		N/A
Ebola		N/A		N/A		N/A
☐ **Progressive Disease**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Alzheimer's Disease		N/A		N/A		N/A
Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)		N/A		N/A		N/A
Lupus		N/A		N/A		N/A
Multiple Sclerosis		N/A		N/A		N/A
Parkinson's Disease		N/A		N/A		N/A
Primary Sclerosing Cholangitis (Walter Peyton's Disease)		N/A		N/A		N/A
Other Dementia		N/A		N/A		N/A
☐ **Severe Burns**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Severe Burns						
☐ **Vascular Disease**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**	**1st Occ**	**Recurrent**
Abdominal/Thoracic Aortic Aneurysm						
Carotid Artery Disease						
Cerebral Aneurysm						
Renal Aneurysm						
☐ **Accidental Death and Dismemberment Rider**	**Benefit Amount**		**Benefit Amount**		**Benefit Amount**	
Accidental Death Benefit - Automobile						
Accidental Death Benefit – Public Transportation						
Accidental Death Benefit – Other Causes						
Dismemberment One or more fingers or one or more toes						
One eye, hand, foot, arm, or leg						
Two eyes, hands, or feet						
Two arms or two legs						
Both arms and both legs						
Accidental Sensory Loss						
Accidental Paralysis						
Accidental Coma						
Accidental Burns						
☐ **Hospital Confinement Rider**	**Benefit Amount**		**Benefit Amount**		**Benefit Amount**	
Daily Benefit Amount						
☐ **Second Opinion Benefit Rider**	**Benefit Amount**		**Benefit Amount**		**Benefit Amount**	
Second Opinion Benefit						
☐ **Health Screening Benefit Rider**	**Benefit Amount**		**Benefit Amount**		**Benefit Amount**	
Per Covered Person per Plan Year						

☐ **Self-Administered Group Accident Insurance**	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

NOTE: The proposal must be included in new case submission but will not be a part of the policy.
Only populate bolded sections unless changes approved by Underwriting are reflected in the proposal.

Coverage: ☐ **24-Hour Coverage** ☐ **Off-the-Job Only Coverage**

	Plan 1	**Plan 2**	**Plan 3**
☐ **Initial Treatment & Diagnosis Benefits** Emergency Room, Urgent Care, and Medical Diagnostic Testing Benefit ($100, $125, $150, $175, $200, $225, $250)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Office, Xray and Lab Percentage	☐ **50%** ☐ **100%**	☐ **50%** ☐ **100%**	☐ **50%** ☐ **100%**
Emergency Treatment- ER			
Emergency Treatment- UC			
Major Diagnostic Exam			
Emergency Treatment- Office			
Xray			
Lab Tests			
☐ **Bodily Injury Category 1** ($4,500, $6,000, $7,500, $9,000, $10,500, $12,000)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Hip- Open Fracture			
Hip- Closed Fracture			
Leg- Open Fracture			
Leg- Closed Fracture			
Pelvis- Open Fracture			
Pelvis- Closed Fracture			
Upper Arm- Open Fracture			
Upper Arm- Closed Fracture			
Skull- Depressed Fracture			
Skull- Simple Fracture			
Vertebrae/Vertebral Processes- Open Fracture			
Vertebrae/Vertebral Processes- Closed Fracture			
Shoulder/Shoulder Blade- Open Fracture			
Shoulder/Shoulder Blade- Closed Fracture			
Hip- Open Dislocation			
Hip- Closed Dislocation			
Knee- Open Dislocation			
Knee- Closed Dislocation			
Shoulder/Shoulder Blade- Open Dislocation			
Shoulder/Shoulder Blade- Closed Dislocation			
☐ **Bodily Injury Category 2** ($2,400, $3,200, $4,000, $5,600, $6,400)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Ankle or Foot Open Fracture			
Ankle or Foot Closed Fracture			
Elbow- Open Fracture			
Elbow- Closed Fracture			
Kneecap- Open Fracture			
Kneecap- Closed Fracture			

Lower Jaw- Open Fracture			

Lower Jaw- Closed Fracture			
Upper Jaw- Open Fracture			
Upper Jaw- Closed Fracture			
Hand- Open Fracture			
Hand- Closed Fracture			
Wrist- Open Fracture			
Wrist- Closed Fracture			
Forearm- Open Fracture			
Forearm- Closed Fracture			
Ankle or Foot Open Dislocation			
Ankle or Foot Closed Dislocation			
Hand- Open Dislocation			
Hand- Closed Dislocation			
Elbow- Open Dislocation			
Elbow- Closed Dislocation			
Wrist- Open Dislocation			
Wrist- Closed Dislocation			
Lower Jaw- Open Dislocation			
Lower Jaw- Closed Dislocation			
Collar Bone- Open Dislocation			
Collar Bone- Closed Dislocation			
☐ **Bodily Injury Category 3** ($1,200, $1,500, $1,800, $2,100, $2,400)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Nose- Open Fracture			
Nose- Closed Fracture			
Face- Open Fracture			
Face- Closed Fracture			
Collar Bone- Open Fracture			
Collar Bone- Closed Fracture			
Sternum- Open Fracture			
Sternum- Closed Fracture			
Ribs- Open Fracture			
Ribs- Closed Fracture			
Toe- Open Fracture			
Toe- Closed Fracture			
Heel- Open Fracture			
Heel- Closed Fracture			
Coccyx- Open Fracture			
Coccyx- Closed Fracture			
Finger- Open Fracture			
Finger- Closed Fracture			
Toe- Open Dislocation			
Toe- Closed Dislocation			
Ribs- Open Dislocation			
Ribs- Closed Dislocation			
Finger – Open Dislocation			

Finger- Closed Dislocation			

☐ **Recovery Services Benefits** Follow Up Visit, Physical Therapy, Chiropractic, Acupuncture, Mental Health, and Epidural Benefit ($50, $75, $100, $125, $150)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Percentage for all other Recovery Services Benefits	☐ **50%** ☐ **100%**	☐ **50%** ☐ **100%**	☐ **50%** ☐ **100%**
Follow Up Visit			
Physical Therapy			
Chiropractic			
Acupuncture			
Mental Health			
Pain Management Epidural			
☐ **Hospitalization Benefits** ($600, $900, $1,200, $1,500, $1,800, $2,100, $2,400, $2,700, $3,000)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Ground Ambulance			
Air Ambulance			
Hospital Admission			
ICU Admission			
Accident Daily Hospital Benefit			
Accident Daily ICU Benefit			
Accident Daily ICU Step Down Benefit			
Inpatient Rehabilitation Benefit			
Observation Room			
☐ **Additional Benefits Category 1** ($100, $150, $200, $250, $300, $350, $400, $450, $500)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Concussion- Mild			
Concussion- Moderate/Severe			
Appliance			
Lacerations- No Sutures			
Lacerations- < 7.5 cm			
Lacerations 7.5 – 20 cm			
Lacerations- 20+ cm			
Tendons, Ligaments and Rotator Cuffs			
Arthroscopic Surgery with No Repair			
Tendons, Ligaments and Rotator Cuffs- Repair of one			
Tendons, Ligaments and Rotator Cuffs- Repair of two or more			
Ruptured Discs and Torn Knee Cartilage			
Shaved Cartilage or Arthroscopic Surgery with No Repair			
Ruptured Discs and Torn Knee Cartilage- Repair of one			
Ruptured Discs and Torn Knee Cartilage- Repair of two or more			
Eye Injury- With Surgery Repair			
Eye Injury- Non-Surgical Removal of Foreign Body			
Dental- Repaired with Crowns			
Dental- Extractions			
☐ **Additional Benefits Category 2** ($500, $750, $1,000, $1,250, $1,500, $1,750, $2,000, $2,250, $2,500)	**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Burns- 2nd Degree, 25% - 35%			

Burns- 2nd Degree, > 35%				
Burns- 3rd Degree, 6 -10 sq cm				
Burns- 3rd Degree, 10 – 25 sq cm				
Burns- 3rd Degree, 25 – 35 sq cm				
Burns- 3rd Degree, > 35 sq cm				
Burns- Skin Graft				
Major Surgery				
Exploratory Surgery				
Prosthetic Device- one				
Prosthetic Device- two or more				
Prosthetic Device- Repairs				
Blood, Plasma, Platelets				
Transportation				
Family Lodging				
Residence Modification				
Vehicle Modification				
Coma- Non-Induced				
Coma- Induced				
Coma- Persistent Vegetative State				
Paralysis- Quadriplegia				
Paralysis- Hemiplegia				
Paralysis- Triplegia				
Paralysis- Diplegia				
Paralysis- Monoplegia				
☐ **Accidental Death & Dismemberment** ($5,000 - $100,000 in $5,000 Increments		**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
Common Carrier	Insured			
	Spouse			
	Child			
Auto- Seatbelt and Airbag Deployed	Insured			
	Spouse			
	Child			
Auto- Seatbelt no Airbag	Insured			
	Spouse			
	Child			
Auto- No Seatbelt or Airbag	Insured			
	Spouse			
	Child			
Other Accident Death	Insured			
	Spouse			
	Child			
Transport or Remains				
Surviving Child Education				
Licensed Day Care Center				
Career Enrichment				
Dismemberment- one or more fingers/toes	Insured			
	Spouse			

	Child			
Dismemberment- one eye, hand, foot, arm or leg	Insured			
	Spouse			
	Child			
Dismemberment- two eyes, hands, or feet	Insured			
	Spouse			
	Child			
Dismemberment- two arms or legs	Insured			
	Spouse			
	Child			
Dismemberment- speech and hearing in both ears	Insured			
	Spouse			
	Child			
Dismemberment- both arms and both legs	Insured			
	Spouse			
	Child			
☐ **Wellness Care Rider** ($25, $50, $75, $100, $125, $150)		**Benefit Amount**	**Benefit Amount**	**Benefit Amount**
	Insured			
	Spouse			
	Child			
☐ **Organized Sports Rider**		☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Percentage				

Only populate bolded sections unless changes approved by Underwriting are reflected in the proposal.

Please complete, sign and date this application and return to us at the address listed above.
Make a photocopy for your records.