TRANSAMERICA®
Employee Benefits

Check company which issued policy:
☐ Transamerica Life Insurance Company
☐ Transamerica Premier Life Insurance Company

Request for Automatic ACH/Bank Draft Premium Payment

I (we) authorize the Company designated above to initiate entries to debit my (our) account described below:

Policy Number		
Bank Routing Number _____	Account No. _____	☐ Checking ☐ Savings
Financial Institution's Name		Draft Date Must be 1st – 25th
Financial Institution's Address		
City	State	Zip code

Attach a voided check or savings slip to this authorization.

This authority is to remain in full force and effect until the Company has received notification from me (or either one of us) of its termination In such time and manner as to afford the Company a reasonable opportunity to act on it.

Account holder Signature	_____	Signature	_____
Account holder Full Name (Printed)	_____	Full Name (Printed)	_____
Date	_____	Date	_____
Telephone Number	_____	Telephone Number	_____

Return Completed Form To: Transamerica Employee Benefits, P.O. Box 8063, Little Rock, Arkansas 72203-8063 Phone: (800) 322-0426

TEB-BankDraft-073014

Direct Answers to your Questions About Automatic (ACH/Bank Draft) Premium Payment

Q. What is Automatic Premium Payment? **A.** Automatic premium payment (or ACH) is a payment method where your bills are paid automatically from your checking or savings account. You don't have to write checks!

Q. How will I know if the amount of my payment changes? **A.** Our standard procedure is to notify you at least 30 days in advance of any changes in your premium amount.

Q. What if I change banks or accounts? **A.** Just call us at 1-800-322-0426. We will send you a new authorization form to fill out with the new account information. This change usually takes a minimum of two weeks, so please allow enough lead time to complete this change

Q. What is the difference between ACH and Bank Draft? **A.** Essentially none. ACH is the new term used, and method of deducting premium payments automatically from your checking or savings account.

Q. When are Automatic Premium Payments taken out of my account? **A.** On the due date that is shown on your policy. You never have to worry about forgetting a premium payment or mailing it in time!

Q. What if I try Automatic Premium Payment and don't like it? **A.** You can cancel your authorization for automatic payments at any time by contacting us at 1-800-322-0426. We can place your policy on a semi-annual or annual direct billing method.

Q. I have my pay deposited automatically into my bank account. Is Automatic Premium Payment anything like Direct Deposit of Payroll? **A.** Yes! It's the same process in reverse. Instead of deposits being made to your account, payments are made from it. Both Direct Deposit and Automatic Premium Payment are made through an automated clearing house (ACH), a national electronic payment system.

Q. How can you take money out of my account? **A.** Only with your authorization. No one is allowed to collect payments from your account automatically unless you specifically authorize it.

Q. If I don't write checks, how do I keep my checkbook balance straight? **A.** Your payment is made at a pre-established time each month, so you can deduct it from your check record then.

Q. Is Automatic Premium Payment risky? I don't want mistakes made in my bank account. **A.** Automatic premium payments may actually be less risky than check payments. They can't be lost, stolen or destroyed in the mail, and they have an extremely high rate of accuracy. We don't expect any mistakes. But if you ever suspect a problem, call 1-800-322-0426 to get it resolved.

Q. Without cancelled checks, how can I prove I made my payments? **A.** Your bank statement gives you an itemized list of automatic payments. It's your proof of payment. It also makes reconciling your checking or savings account easy.

Q. How do I sign up for Automatic Premium Payment? **A.** Complete and sign the attached authorization form and return it to us in the postage paid envelope. We will set your policy up on automatic payment on the next premium due date after receipt of your completed authorization.

TRANSAMERICA
Employee Benefits

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

CANCER OR SPECIFIED DISEASE POLICY
Instructions and Check-List for Submitting a Claim

To help us process your claim as quickly as possible, you must provide us with all the necessary information. Below is a check-list of the items we need to begin reviewing your claim. While these items are typically all that is needed, we may request additional information to process your claim.

For an Initial Claim Submission:

- ☐ Pathology Report from your Doctor, if your claim is for cancer
- ☐ Attending Physician's Statement for your Doctor to complete (page 2 of 4 in enclosed Claim Package)

The following documents that you need to complete:

- ☐ Claimant's Statement (page 1 of 4)
- ☐ Required Fraud Warning Statements (page 3 of 4)
- ☐ Authorization for the Release of Health Information (page 4 of 4)

Please be sure that you provide all information requested on these documents completely and accurately and sign and date each document.

For an Initial Claim Submission and All Subsequent Claim Submissions:

- **The following information from your Doctor/Medical Provider/Hospital:**
  - ☐ Itemized Statements reflecting the procedures or treatments from the Doctor or medical provider (preferable on the Form CMS-1500) or the hospital. The itemized statement should include the following:
    - For chemotherapy and prescription drugs:
      - Description of drugs used
      - Procedure codes
      - Number of units of each drug
    - For radiation therapy:
      - Description of procedures performed
      - Procedure codes
      - Number of units of each treatment
- **If your procedure or treatment was also covered by Medicare, Medicaid or any other insurance, please provide:**
  - ☐ Information showing actual charges of your treatment such as a copy of all Summary Notices from Medicare or Medicaid or Explanation of Benefits from your other insurance.
  - ☐ Statements from your Doctor/Medical Provider/Hospital showing payments or adjustments from Medicare, Medicaid or your other insurance.

If you need help when completing your claimant's statement or have questions about what documents need to be submitted, our Claims Customer Service representatives will help you. Please call Monday through Friday between 7:00 AM and 6:00 PM, Central Standard Time at 800-251-7254.

Please return completed documents to the following address:

Transamerica Employee Benefits
P.O. Box 8043
Little Rock, AR 72203-804

Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company
Administrative Office: P.O. Box 8043
Little Rock, AR 72203-8043
1-800-251-7254
7 a.m. – 6 p.m. CST
Fax: 866-586-6528

Cancer/Specified Disease Claim Package

By furnishing this form, the Company does not admit that there is any insurance in force and does not waive any of its rights or defenses.

CLAIMANT'S STATEMENT

1. Insured's Full Name	2. Date of Birth	3. Policy or Certificate Number	4. Social Security Number

5. Address (*include city, state and zip code*)	6. Phone Number
7. Employer	**8. Work Phone Number**

9. Patient's Full Name	10. Date of Birth	11. Relationship to Insured

If additional space is needed for any question, please use an additional sheet of paper and attach to this form.

1. Nature of injury or illness	2. When have you had this same or similar condition?

3. When did symptoms first appear or accident occur? If an injury, explain fully how and where accident occurred.	4. Date first treated/diagnosed

5. Name and address of physician (list all physicians consulted)

6. Do you have Medicare? ❒ Yes ❒ No Do you have Medicaid? ❒ Yes ❒ No Do you have other health insurance? ❒ Yes ❒ No If yes, what company?

7. Have you been confined to a hospital for this condition? ❒Yes ❒ No Admission date: Discharge Date:	8. Please give name and address of hospital.
9. Were you confined in an Intensive Care Unit during this hospital stay? ❒ Yes ❒ No If yes, for how many days?	10. If you had surgery, please give the name and address of the surgeon
11. If you were unable to work due to this condition, please give dates. From To	12. When do you expect to resume your usual duties?
13. If applying for waiver of premium, give dates of total disability. From To	14. Have you ever been treated for or diagnosed as having had a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to the effective date of this policy? ❒ Yes ❒ No If yes, when?

15. Please give the name and address of the physician and/or hospital who treated you for this previous condition.

I hereby certify that all information submitted in connection with this claim is true and correct to the best of my knowledge and belief, and I agree that all information and materials subsequently submitted by me or on my behalf for this or any subsequent claim will be true and correct.

Claimant's Signature: _____ Date: _____

ATTENDING PHYSICIAN'S STATEMENT

1. Insured's Full Name	2. Policy or Certificate Number
3. Patient's Full Name	4. Patient's Date of Birth

5. Are you being paid by Medicare? ❒ Yes ❒ No Are you being paid by Medicaid? ❒ Yes ❒ No Are you being paid by other health insurance? ❒ Yes ❒ No If yes, what company?

6. Diagnosis? (Please use ICD 9 Codes)	7. When did symptoms first appear or accident happen?	8. When did the patient first consult you for this condition?

9. If the patient previously had medical attention, please provide the physician's/hospital's name and address.

10. Has the patient ever had the same or similar condition? ❒ Yes ❒ No (If yes, state when and describe)	11. Describe any other disease or infirmity affecting present condition.
12. List surgical procedure(s), if any, and include the date of the procedure(s). (Please use current CPT codes.)	13. List the dates of treatment.
14. If the patient was hospitalized, please give the name and address of the hospital and dates of confinement.	15. Give number of days of ICU confinement.
16. Was Private Duty Nursing required and authorized by you? ❒ Yes ❒ No (If yes, give dates)	17. Is the patient still under your care for this condition? ❒ Yes ❒ No If discharged, please give date _____
18. If the patient has been referred to another physician, please give the name and address.	19. Please give dates of total disability for this condition. From To

20. Has patient ever been treated for a heart attack, heart trouble or any abnormal condition of the heart; cancer; or diabetes prior to this time? ❒ Yes ❒ No If yes, please advise when and name and address of doctor/hospital treating patient.

21. Please list conditions and corresponding dates for which you previously treated this patient within the past five years.

Date	Physician's Name – Print	Signature	Degree	Phone Number ( )

Street address	City	State	Zip	Tax Identification Number

REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.

Claimant's signature Date

FOR RESIDENTS OF ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Claimant's signature Date

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Claimant's signature Date

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

Claimant's signature Date

FOR RESIDENTS OF DELAWARE, IDAHO, INDIANA or OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Claimant's signature Date

FOR RESIDENTS OF DISTRICT OF COLUMBIA, LOUISIANA or RHODE ISLAND: 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 fines and confinement in prison.

Claimant's signature Date

FOR RESIDENTS OF FLORIDA: 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.

Claimant's signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both

Claimant's signature Date

FOR RESIDENTS OF MAINE, TENNESSEE or VIRGINIA: It is a crime to knowingly provide 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.

Claimant's signature Date

FOR RESIDENTS OF 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.

Claimant's signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

Claimant's signature Date

FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20.

Claimant's signature Date

FOR RESIDENTS OF NEW YORK: 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 act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Claimant's signature Date

FOR RESIDENTS OF PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Claimant's signature Date

FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: 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, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Claimant's signature Date

TRANSAMERICA
Employee Benefits

Name of Insurance Company (select one):

☐ **Transamerica Life Insurance Company**

☐ **Transamerica Premier Life Insurance Company**

If no Company is selected, the appropriate box will be checked by the Administrative Office.

Administrative Office: P.O. Box 8063
Little Rock, Arkansas 72203-8063

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. **Description of the information that may be used or disclosed:** This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. **Exception: psychotherapy notes require a separate signed authorization.**
4. **The information will be used or disclosed only for the following purpose(s):** The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

Description of Personal Representative's Authority or Relationship to Patient/Insured _____

Policy of Contract Number _____

Claimants should retain a copy of this signed document for their records

TRANSAMERICA
Employee Benefits

Check company which issued policy:
☐ Transamerica Life Insurance Company
☐ Transamerica Premier Life Insurance Company

Request for Policy Service

1. Policy Owner and Insured Information

Policy Owner Social Security No.	Policy Owner Name (Last, First, M.I.)
Insured Social Security No.	Insured Name (Last, First, M.I.)

Policy No.	Employer Name	SD No.

2. Name Changes

Change name of ☐Insured ☐Owner ☐Payor ☐Beneficiary

From _____ To _____

Reason for Change ☐Marriage*** ☐Divorce ☐Correction ☐Other _____

3. Policy Owner Changes

☐Record the following Transfer of Ownership ☐Change Owner Address

New Owner Name _____ Social Security No. _____

Address _____ Daytime Phone No. _____

Email Address _____ Evening Phone No. _____

All right, title and interest in this policy are transferred to the new owner. This transfer is subject to any policy loans and collateral assignments. The change of ownership does not change the beneficiary. Any existing owner's designee or contingent owner is revoked.

4. Billing Changes

New Premium Mode ☐Pre-Authorized checking ☐Direct Bill

New Premium Frequency ☐Monthly ☐Quarterly ☐After Tax ☐Other _____

Change Planned Periodic Payment To $ _____

5. Reduction In Benefits

☐Reduce face amount to $ _____ *(may be subject to company imposed surrender penalties)*

☐Change Planned Periodic Premium for reduced face amount (see #4)

☐Cancel Accidental Death Rider ☐Cancel Waiver Provision ☐Cancel Children's Term Rider

☐Other _____

6. Beneficiary Changes

I hereby revoke any and all prior beneficiary designations and existing settlement agreements, if any, and elect to change the beneficiary(ies) under the above numbered policy as follows:

Primary Beneficiary(ies): For multiple beneficiaries, payment will be made in equal shares unless otherwise noted below.

Full Name (as it should appear on company records)	%	Street Address	City/State/Zip	Relationship	Date of Birth

Contingent Beneficiary(ies): Receives proceeds only if all Primary Beneficiaries predecease the Insured. For multiple beneficiaries, payment will be made in equal shares unless otherwise noted.

Full Name (as it should appear on company records)	%	Street Address	City/State/Zip	Relationship	Date of Birth

It is understood and agreed that, unless otherwise directed, proceeds will be paid in accordance with the policy provisions.

Spouse or equivalent, as defined by governing state law. ***Marriage or equivalent, as defined by governing state law.

7. Signatures

I/We understand and agree that my/our signature(s) below shall apply to each request which has been checked on this form and further agree that no request will become effective which is not checked. I/We agree that these changes shall become part of the policy. I/We request that any provisions in said policy requiring its endorsement to effect the change requested be waived and that these changes be effective upon completion and execution of this form and approval hereof by the company at its Administrative Office. I/We certify that no insolvency or bankruptcy proceedings are now pending against me/us.

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

Current Policy Owner _____ Witness _____

Policy Owner Marital Status ☐Married ☐Single

Spouse _____ Witness _____

Assignee (if applicable) _____ Witness _____

FOR ADMINISTRATIVE OFFICE USE ONLY

The above requested policy changes are herby acknowledged and recorded on the books of the Company indicated above. Endorsement of such change on said policy is hereby waived.

Date Recorded _____ By _____

Instructions

Item #1: Complete this section for all requests. Enter policy owner name and social security number, insured name and serial number, and policy or certificate number. Always include the name of all Insured parties and Employer's name. Please provide us with the Salary Deduction case number (if available).

Item #2: Complete this section only if you are requesting a name change. (Not used to transfer ownership)

Item #3: Complete this section only if you are requesting to transfer ownership or change address of current owner. Be sure to provide all information as requested.
****This form can only be used to transfer ownership of individually owned policies. For all other policies you must complete Form TEB-Transfer.**

Item #4: Complete this section only if you are requesting to change your billing mode or frequency. For automatic bank draft, you will need to complete form **TEB-BankDraft**.

Item #5: Complete this section only if you are requesting to reduce your benefits/coverage.

Item #6: Complete this section only if you are requesting to change your designated beneficiaries. If you are selecting multiple beneficiaries, be sure to include the percentage amount that you would like for each beneficiary to receive, otherwise payment will be made in equal shares. If the proposed beneficiary is a married woman, use her given name and husband's surname and include maiden name in parenthesis (e.g., Mary Joan Jones (Smith)).

Item #7: Complete this section for all requests. The following signatures are required:

(a) Policy Owner (If there are 2 or more co-owners, the signatures of each co-owner are required)

(b) Spouse** of Policy Owner (*If Married, Spouse** of Policy Owner must sign if residence is in one of the community property states of: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin.*)

(c) Assignee (If any)

(d) **EACH SIGNATURE MUST BE WITNESSED BY A DISINTERESTED PARTY**. (A disinterested party is anyone of age who is not the insured or the beneficiary.)

ALL SIGNATURES MUST BE WRITTEN IN INK AND WRITTEN EXACTLY AS THE NAME IS GIVEN IN THE POLICY OR ASSIGNMENT.

General Notice

For policies/certificates with a Minimum Monthly Premium, reducing your premium payments may require additional premium on the Minimum Monthly Premium Date to keep your policy/certificate in force. In the event your policy/certificate is a Modified Endowment Contract (MEC), amounts received (including loans, assignments, partial surrenders and/or pledges) prior to the death of the Insured may be fully taxable, and taxable amounts received before the owner is age 59-1/2 may be subject to a 10% tax penalty. Under the Technical and Miscellaneous Revenue Act of 1988 (TAMRA), a life insurance contract becomes a MEC when the actual premiums paid exceed a specified 7-pay premium limit or when certain changes are made to policy benefits, including reductions in face amount. Transamerica Employee Benefits does not offer tax or legal advice. Because tax laws are subject to change and different interpretations, we recommend that you seek counsel from a qualified tax advisor.

Return Completed Forms to:

Transamerica Employee Benefits
Administrative Office
P.O. Box 8063
Little Rock, AR 72203-8063
Phone: (888) 763-7474
Fax: (866) 945-8691
www.transamericaemployeebenefits.com

**Spouse or equivalent, as defined by governing state law. ***Marriage or equivalent, as defined by governing state law