TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
A Stock Company

About Your Insurance - This Certificate explains benefits provided under the Group Master Policy ("Policy") issued to the Policyholder named on the Schedule of Benefits. Please read it closely.

Terms important to understanding this Certificate are defined in the Definitions section or in separate Certificate provisions and are capitalized.

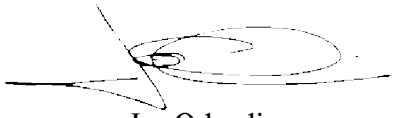
Important Notice - Benefits are payable only as described in this Certificate for a covered loss that occurs while the Covered Person is insured under the Policy.

The Policy may be amended or canceled as stated in its provisions. Such an action may be taken without the consent of or notice to any Covered Person. Premiums are subject to change.

The benefits for Dependents described in this Certificate, if available under the Policy, are applicable only if you are insured, apply for Dependent insurance, receive our approval of such Dependents, and pay the premium required for each Dependent.

This Certificate is signed for us at our Home Office to take effect on the same date insurance becomes effective.

Blake Bostwick
President



Jay Orlandi
Secretary

Group Certificate for Hospital Indemnity Insurance

LIMITED BENEFIT - READ YOUR CERTIFICATE CAREFULLY

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

The insurance policy under which this Certificate is issued is not a policy of Workers' Compensation insurance. You should consult your employer to determine whether your employer is a subscriber to the Workers' Compensation system.

Administrative Office:
2700 W Plano Pkwy, PO Box 869094
Plano, TX 75086-9094
Customer Service: 1-888-763-7474
Email Address: TEBcustresp@Transamerica.com
Web Address: www.transamericaemployeebenefits.com

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SCHEDULE OF BENEFITS

POLICYHOLDER: 99 CENT STORES

GROUP POLICY NUMBER: B100073033

GROUP MASTER POLICY EFFECTIVE DATE: 09-01-2020

GOVERNING JURISDICTION: TEXAS

BENEFIT COVERAGE	BENEFIT PER COVERED PERSON
DAILY IN-HOSPITAL INDEMNITY BENEFIT	
DAILY IN-HOSPITAL INDEMNITY BENEFIT AMOUNT:	$150
MAXIMUM NUMBER OF DAYS PER CONFINEMENT:	31
CALENDAR YEAR MAXIMUM:	NONE

OPTIONAL RIDERS - THE FOLLOWING OPTIONAL RIDERS ARE PART OF YOUR COVERAGE

TRHI10TX-0118 HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER	
BENEFIT AMOUNT PER DAY	$1,000
MAXIMUM NUMBER OF DAYS PER CONFINEMENT	1
MAXIMUM NUMBER OF DAYS PER CALENDAR YEAR	1

TRPX10TX-0118 PREEXISTING CONDITION EXCLUSIONS & LIMITATIONS RIDER

DEFINITIONS

Terms important to understanding this Certificate are defined in this Section and are capitalized in this Certificate.

Accident or Accidental Injury - A sudden, unexpected, and unintended injury that:
1. Is independent of any Sickness;
2. Is caused by or is the result of external means; and
3. Takes place while the Covered Person's insurance is in force.

Active Service - Performing in the usual manner all the regular duties of your occupation on a scheduled work day at the normal place of business or other location as directed by your employer.

If you are not working on a day your insurance would otherwise take effect, you will be considered to be in Active Service on that day only if: (a) you are capable of performing in the usual manner all of the regular duties of your occupation, and (b) you were in Active Service on the last preceding regular work day.

Amendment, Endorsement, or Rider - Any form issued by us which adds, modifies, changes, or deletes any Policy or Certificate provision or benefit.

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

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

Certificate - This document that describes your insurance coverage.

Child - A Child of yours who is under the age of 26 and is:
1. A natural Child; or
2. A legally adopted Child or a Child who has been placed for adoption with you or where you are a party in a suit in which you seek adoption of the Child; or
3. A stepchild or foster Child; or
4. A grandchild who is dependent on you for federal income tax purposes at the time of application; or
5. A Child for whom you have been appointed legal guardian; or
6. A Child for whom you are legally required to provide support.

If applicable, Child will also include children of your Other Adult Dependent in the same manner as a stepchild.

If a Child covered under this Certificate has reached age 26 but is incapable of self-support because of mental or physical impairment, we will continue the Child's insurance under the following conditions:
1. The Child must be incapacitated;
2. We must receive proof of incapacity within 31 days after insurance would otherwise terminate;
3. We may require proof of continued incapacity from time to time, but not more often than once a year after the two-year period following the date the Child attains age 26; and
4. Your insurance must remain in force.

Confinement or Confined - That period of time the Covered Person is admitted into a Hospital as a resident bed patient as established by the records of the Hospital. Confinement does not include that period of time during which a Covered Person is in a Hospital emergency room, an Observation Unit or recovery room, a freestanding surgical facility or an outpatient facility.

Covered Person - You and your Dependents who have been accepted for insurance.

Dependent - Your Spouse, Other Adult Dependent, or Child.

Effective Date - The date the Covered Person's insurance starts under this Certificate.

Enrollment Qualifying Event - The occurrence of a specified event that would allow an eligible employee and his or her eligible Dependent(s) to enroll under the Policy after being first eligible without Evidence of Insurability being required. A specified event means any of the following:
1. An individual becomes an eligible Dependent of the eligible employee through marriage, birth, adoption, or placement for adoption; or
2. The eligible employee or Dependent loses coverage under another hospital indemnity policy.

Evidence of Insurability - The correct and complete answers to the questions in the Application and medical history, if necessary, which will be used by us to base our acceptance of a Late Enrollee.

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

Group Master Policy or **Policy** - The document that is issued to the Policyholder.

Hospital - A licensed institution that has on its premises or in facilities available to it on a contractually prearranged basis and under the supervision of a staff of one or more duly licensed Physicians:
1. Laboratory, X-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians;
2. Permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
3. 24-hour-a-day nursing service by or under the supervision of graduate registered nurses; and
4. A patient's written history and medical records.

Notwithstanding the above, Hospital does not include an institution or that part of an institution operated as:
1. A nursing home;
2. An extended care facility;
3. A skilled nursing facility;
4. A mental institution or a facility for the treatment of mental disorders;
5. A rest home or home for the aged;
6. A rehabilitation center; or
7. A treatment facility for alcoholics or drug addicts.

Immediate Family Member - Anyone related to a Covered Person in the following manner: spouse, daughter, son, stepchild, father, mother, stepparent, sister, brother, stepsister, stepbrother, grandchild, grandparent, father-in-law, mother-in-law, or the spouse of any of these. The term "spouse" includes a common law marriage partner, domestic partner, or civil union partner, if the status of the relationship is legally recognized in the governing jurisdiction.

Insured, you, or your - The employee covered for this insurance.

Late Enrollee - An eligible employee or Dependent who applies for insurance more than 31 days after becoming eligible for coverage. Late Enrollee also includes a former Covered Person who applies for reinstatement after his or her insurance has terminated. A proposed insured will not be considered a Late Enrollee if he or she applies for insurance within 31 days of an Enrollment Qualifying Event.

Observation Unit - A specialized area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician. Such a unit must:
1. Be under the direct supervision of a Physician or registered nurse;
2. Be staffed by nurses assigned specifically to that unit; and
3. Provide care seven days per week, 24 hours per day.

Other Adult Dependent - Your common law marriage partner, domestic partner, or civil union partner, if the status of such relationship is legally recognized in the governing jurisdiction or as otherwise agreed upon between the Policyholder and us.

Physician - A person who is providing services within the scope of his or her license, and is either:
1. Licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
2. Legally qualified and licensed as a medical practitioner and is required to be recognized, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

Policyholder - The entity named on the Schedule of Benefits to whom the Policy is issued.

Policyholder Application - The form completed and signed by the Policyholder to apply for this insurance coverage.

Sickness - Illness or disease which first manifests itself while the Covered Person's insurance is in force and is the direct cause of the loss.

Spouse - Your legally married Spouse.

Transamerica Life Insurance Company, the Company, we, us, or our - The insurer that underwrites this insurance.

ELIGIBILITY AND EFFECTIVE DATE

Insurance will start at 12:01 a.m. on the Effective Date at the main place of business of the Policyholder.

Employee Eligibility - To be eligible for insurance under the Policy, you must:
1. Meet the eligibility requirements listed on the Policyholder Application;
2. Be in Active Service; and
3. Provide satisfactory Evidence of Insurability to us, if required.

Within 31 days of the date enrollment is first offered, you must complete an Enrollment Form and any required premium must be paid. If such enrollment is not made within that 31-day period, you will be considered a Late Enrollee and may be required to submit satisfactory Evidence of Insurability in order for coverage to become effective.

Employee Effective Date - If you meet the Employee Eligibility requirements, your insurance will take effect on the latest of the following dates:
1. The Group Master Policy Effective Date; or
2. As selected on the Policyholder Application, either (a) the first day of the calendar month which coincides with or next follows the date you are eligible for insurance; or (b) your date of hire; provided you are not a Late Enrollee and we have received your first premium payment; or
3. If you are a Late Enrollee, the first day of the calendar month which coincides with or next follows the date you are accepted for insurance; provided you are: (a) eligible on such date; and (b) we have received your first premium payment.

If you do not meet the eligibility requirements on the date your insurance is to take effect, your insurance will take effect on the first day of the calendar month which coincides with or next follows the date you satisfy the requirements.

Dependent Eligibility, if available under the Policy - To be eligible under the Policy, a Dependent must:
1. Meet the definition of a Dependent;
2. Be able to engage in the usual and customary activities of a person of like age and gender who is free of any physical disease or disorder;
3. Not be eligible as an employee under the Policy; and
4. Provide satisfactory Evidence of Insurability to us, if required.

A Dependent will be eligible for such coverage on the later of the following dates:
1. The day you become eligible for coverage; or
2. The day a Dependent first meets the definition of Dependent.

You may elect Dependent coverage by:
1. Enrolling for Dependent coverage within 31 days of the date the Dependent becomes eligible; and
2. Completing any required form for payroll deduction.

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

If you and your Spouse or Other Adult Dependent are both eligible as an employee, any Children may be insured as a Dependent of either you or your Spouse or Other Adult Dependent, but not both.

Dependent Effective Date - Insurance on each Dependent will take effect on the latest of the following dates:
1. The date your insurance becomes effective; or
2. The first day of the calendar month which coincides with or next follows the date the Dependent is eligible for insurance, provided that: (a) the Dependent is not a Late Enrollee; and (b) we have received any additional premium;
3. If a Late Enrollee, the first day of the calendar month which coincides with or next follows the date the Dependent is accepted for insurance, provided that: (a) the Dependent is an eligible Dependent on such date; and (b) we have received any additional premium.

If a Dependent does not meet the eligibility requirements on the date his or her insurance is to take effect, insurance on that Dependent will take effect on the first day of the calendar month which coincides with or next follows the date the Dependent satisfies the requirements.

Insurance for Newborn Child, Newly Adopted Child OR Child Subject to a Newly-Issued Medical Support Order - Insurance for a newborn, a newly adopted Child, a Child for whom you are appointed the legal guardian, or a child for whom you are newly required to provide medical support will become effective automatically on the day he or she is born, the day the Child is placed for adoption with you or where you are a party in a suit in which you seek adoption of the Child, the day a court enters an order appointing you the legal guardian of the Child, or the day a court orders you to provide medical support. The Child will be automatically insured for 31 days. In order to continue the Child's insurance, you must notify us by the end of the 31-day period and pay any additional premium, if applicable.

Insurance for a newly born or newly adopted Child will consist of coverage for Accidental Injury or Sickness of the Child including confinements for medically diagnosed congenital defects and birth abnormalities within the scope of the Policy.

DAILY IN-HOSPITAL INDEMNITY BENEFIT

We will pay the Daily In-Hospital Indemnity Benefit amount shown in the Schedule of Benefits for each day the Covered Person is Confined to a Hospital as the result of a covered Accident or Sickness. This benefit is limited to any maximums shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit or a recovery room. We also will not pay a Daily In-Hospital Indemnity Benefit for a newborn Child's stay in the Hospital unless the newborn Child is Confined to the Hospital and is being treated for Accidental Injury or Sickness.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

EXCLUSIONS AND LIMITATIONS

We do not cover losses caused by, or as a result of, the following:

1. A Covered Person's suicide or attempted suicide.
2. A Covered Person's intentional self-inflicted injury.
3. Rest care or rehabilitative care and treatment.
4. Immunization shots and routine examinations such as: physical examinations, mammograms, Pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
5. Any pregnancy of a Dependent Child, except for complications of a pregnancy, including Confinement rendered to her Child after birth.
6. Routine newborn care. This exclusion does not apply to coverage under the optional Wellness Indemnity Benefit Rider, if attached as part of the contract.
7. A Covered Person's abortion, except for medically necessary abortions performed to save the mother's life.
8. The treatment of:
   a. A Covered Person's mental or emotional disorder. This exclusion does not apply to coverage under the optional Inpatient Mental and Nervous Disorder Indemnity Benefit Rider, if attached as part of the contract.
   b. A Covered Person's alcoholism or drug addiction. This exclusion does not apply to coverage under the optional Inpatient Drug and Alcohol Addiction Indemnity Benefit Rider, if attached as part of the contract.
9. A Covered Person's participation in a riot, or insurrection.
10. Dental care or treatment, except for such care or treatment due to Accidental Injury to sound natural teeth within 12 months of the Accident and except for dental care or treatment necessary due to congenital disease or anomaly.
11. Any Accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Physician or taken according to the Physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Accident occurred).
12. A Covered Person's sex change, reversal of tubal ligation or reversal of vasectomy.
13. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications or Physician's services, unless required by law.
14. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
15. Traveling in or descending from any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip.
16. Any loss incurred while a Covered Person is on active duty status in the armed forces. (If you notify us of such active duty, we will refund any premiums paid for any period for which no coverage is provided as a result of this exception.)

17. An Accident or Sickness arising out of or in the course of any occupation for compensation, wage or profit or for which benefits may be payable under an Occupational Disease Law or similar law, whether or not application for such benefits has been made.
18. A Covered Person's involvement in any war or act of war, whether declared or undeclared.
19. Hospital Confinement of a newborn Child following the Child's birth, unless the newborn Child is being treated for Accidental Injury or Sickness.

Under this Policy, a Physician does not include the following:
1. An Immediate Family Member of any Covered Person; or
2. A practitioner of homeopathic, naturopathic and related medicines.

PREMIUMS

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

Premium Changes - We have the right to change the premium rates on any premium due date in accordance with the terms of the Policy. If the rates are changed, we will give at least a 60-day advance written notice to the Policyholder.

If the premiums increase because a change in benefits increases our liability, premium rates may be changed on the date that our liability is increased, without regard to any premium rate guarantee. If such premium increase takes place on a date other than a premium due date, a pro rata premium for the increase will be due on the next premium due date. The pro rata premium will be for the period from the date of the increase to the next premium due date. If such premium is not paid when due, the insurance will automatically be terminated as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

A change to your premium may also occur if you choose to convert your insurance to a conversion policy after becoming ineligible under this Certificate. See the Conversion Option section for further details.

TERMINATION OF INSURANCE

Your insurance will cease on the earliest of the following dates:
1. The date the Policy terminates;
2. The date you cease to be eligible for insurance;
3. The date of your death;
4. The premium due date on which we fail to receive your premium from the Policyholder, subject to the Grace Period provision; or
5. The date you request your insurance be cancelled, or the date your request is received, whichever is later.

The insurance on a Dependent will cease on the earliest of the following dates:
1. The date your insurance terminates;
2. The premium due date on which we fail to receive your premium from the Policyholder, subject to the Grace Period provision;
3. The date the Dependent Child no longer meets the definition of Child;
4. The date a Covered Spouse or Other Adult Dependent no longer meets the definition of same;
5. The date of the Dependent's death;
6. The date the Policy is modified so as to exclude Dependent insurance; or
7. The date you request your Dependent insurance be cancelled, or the date your request is received, whichever is later.

We may terminate the insurance of any Covered Person who submits a fraudulent claim under the Policy.

Termination of your insurance will not affect any claim which begins before the date of termination.

Extension of Benefits for Total Disability - If a Covered Person is entitled to benefits while Totally Disabled and the Group Policy terminates, benefits will continue until the earliest of:
1. The 91st day following Policy termination; or
2. The date on which the Covered Person is no longer Totally Disabled.

For the purposes of this provision, Total Disability and Totally Disabled mean the following:
1. With respect to the Insured, the complete inability to perform all of the substantial and material duties and functions of his or her occupation and any other gainful occupation in which he or she would earn substantially the same compensation earned before the disability; and
2. With respect to any other Covered Person, confinement as a bed patient in a Hospital.

CONVERSION OPTION

If you lose eligibility for this insurance for any reason other than fraud or nonpayment of premiums or termination of the Group Master Policy, you will have the option to convert this group coverage to a policy we are issuing for the purpose of conversions. You will receive notification of this Option from the Group Policyholder at the time your insurance terminates.

You must complete a written request to convert and pay the first premium to us no later than 31 days after the date of your termination under the Policy. If you are interested, please request an application from the Policyholder and submit to us within 31 days of your termination date. The converted policy will be issued, without Evidence of Insurability, on a policy form then available for conversions, which is most comparable to this Certificate.

The initial premium for the converted policy for the first 12 months and subsequent renewal premiums will be determined in accordance with our table of premium rates as of the converted policy's effective date applicable to the age and class of risk of each person to be insured under the converted policy and to the type and amount of insurance provided.

The effective date of the converted policy will be the day following the termination of insurance under this Certificate.

This Conversion Option is only available for the Insured and the Insured's covered Dependents. It is not available for the Insured's Dependents without the Insured.

CLAIMS PROVISIONS

Notice of Claim - Written notice of claim must be given to us at our Administrative Office. Such notice should be made within 30 days after any loss covered by the contract. If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay, so long as notice is given as soon as reasonably possible.

Claim Forms - Claim forms should be used for filing Proof of Loss. We will send such form to the claimant within 15 days of receipt of notice of claim. If we fail to supply the proper claim forms within 15 days, you can give proof in writing, setting forth the nature and extent of the loss within the time stated in the Proof of Loss provision. You or a personal representative may obtain a claim form by calling our toll-free telephone number listed on the cover page.

Proof of Loss - Due written Proof of Loss must be given to us at our Administrative Office. In case of a claim for loss for which a periodic payment is provided contingent upon continuing loss, such satisfactory written Proof of Loss must be sent within 90 days after the termination of the period for which we are liable. For any other loss, proof must be sent within 90 days after the date of such loss.

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

Payment of Claim Benefits - All benefits payable under your Certificate will be paid to you, unless you have assigned such benefits. Any benefits due that have not been paid at the time of your death will be paid either: (1) to your Spouse or Other Adult Dependent; or (2) if there is no Spouse or Other Adult Dependent, to your estate. Instead of your estate, we may pay up to $1,000 of such benefit to one of your relatives who we consider to be equitably entitled to the benefit. Any remaining such benefits will be paid to your estate.

Payments to the Texas Department of Human Services - After written notice to us at our Home Office, benefits payable on behalf of a Child whose parent is covered by this Certificate must be paid to the Texas Department of Human Services in the following situations:

1. The parent covered under this Certificate is (a) required to pay child support by a court order or court-approved agreement and is a possessory conservator of the Child under a court order issued in Texas, or (b) is not entitled to possession of or access to the Child; and
2. The Texas Department of Human Services is paying benefits on behalf of the Child under Chapter 31 or 32, Human Resources Code; and
3. We are notified, through an attachment to the Notice of Claim at the time the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

Physical Examinations and Autopsy - We have the right to have a Covered Person examined by a Physician of our choice, at our expense, as often as reasonably necessary while a claim is pending. In case of death, we may request an autopsy at our expense where it is not forbidden by law.

Time of Payment of Claims - Benefits for a covered loss will be paid no later than the 60th day after we receive due written Proof of Loss.

We will notify a claimant in writing of the acceptance or rejection of a claim not later than the 15th business day after the date we receive all items, statements, and forms required to secure final Proof of Loss. If we are unable to accept or reject the claim within the period specified, we will, within that same period, notify the claimant of the reasons that we need additional time. We will accept or reject the claim not later than the 45th day after the date we notify a claimant under this provision. We will pay all benefits due under this Certificate not later than the 60th day after the date Proof of Loss is received.

GENERAL PROVISIONS

Assignment - The Insured may assign benefits under this Certificate. We assume no responsibility for the validity or effect of any assignment of this Certificate or any interest in it.

Clerical Error - A clerical error by us will not invalidate insurance otherwise in force, nor continue insurance otherwise not validly in force.

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

Entire Contract; Changes - The Entire Contract consists of the Policy as issued to the Policyholder, the Policyholder Application, the Certificate Provisions, and any attached Amendments, Endorsements, and Riders. Changes to the Policy or this Certificate may only be made in writing signed by an executive officer of the Company. No agent or Policyholder has authority to change the Policy or this Certificate or to waive any of its provisions. Any changes are subject to the laws of the governing jurisdiction.

Grace Period - A Grace Period of 31 days will be allowed for each premium payment after the first premium. Insurance will stay in force during this time. The insurance under the Policy and/or Certificate will terminate on the day after the Grace Period ends if the premium has not been paid. You must still pay all unpaid premium. This includes the premium due for the Grace Period.

If insurance is canceled on a premium due date and the premium has been paid through that date, the Grace Period will not apply. If cancellation is during the Grace Period, you will be liable for any unpaid premium including the pro rata premium for that part of the Grace Period during which insurance was in force. Benefits may be reduced by the amount of any due but unpaid premiums.

Legal Action - No legal action may be brought to recover under the Policy or Certificate within 60 days after written Proof of Loss has been provided to us as required nor more than three years from the time written Proof of Loss is required to be furnished.

Misstatement of Age - If the Insured's age has been misstated, all benefits payable under the policy for any Covered Person will be such amount as the premium paid would have purchased at the Insured's correct age.

Other Insurance With Us - If a Covered Person has more than one hospital indemnity policy, certificate, or similar coverage with us, only one, chosen by you or your estate, will be effective. We will refund all premiums paid for all other such coverage from the date of duplication, less any benefits paid from such date.

Time Limit on Certain Defenses
Misstatements in the Application - We will not use any statement, except fraudulent statements, to void or reduce benefits after your insurance has been in effect for two years. Any such statement would have to be in a signed form. This also applies to all Riders. Any increase in benefit amounts is subject to a new two year contestable period for the increased amount only.

All statements made are considered representations and not warranties. A statement made by the Policyholder or Insured may not be used in any contest under the Policy, unless a copy of the written instrument containing the statement is or has been provided to the person making the statement; or if the statement was made by the Insured and the Insured has died or become incapacitated, the Insured's beneficiary or personal representative.

Notice - Any notice to you will be sent to your last known address.

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
Administrative Office: 2700 West Plano Parkway, P.O. 869094, Plano, TX 75086-9094
(Hereinafter called "the Company," "we," "us," or "our")

TRANSFER INSUREDS RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

DEFINITIONS

Prior Plan means the Policyholder's plan of group insurance, if any, under which you were insured on the day before the Effective Date of the Policy. The Prior Plan must provide the same type of coverage (equivalent coverage) as is provided under the Policy to which this Rider is attached.

Prior Plan Benefits mean the benefits, if any, that would have been paid under the Prior Plan had it remained in effect, and had you continued to be insured under the Prior Plan.

Total Disability means the following:
1. With respect to the Insured, the complete inability to perform all of the substantial and material duties and functions of his or her occupation and any other gainful occupation in which he or she would earn substantially the same compensation earned before the disability; and
2. With respect to any other Covered Person, confinement as a bed patient in a Hospital.

Transfer Insured is an Insured who was insured under the Prior Plan on the day before the Effective Date of the Policy.

CONTINUITY OF COVERAGE

We will provide continuity of coverage as described below if you were covered under the Prior Plan.

If you are a Transfer Insured not in Active Service on the Effective Date of the Policy due to a reason other than a Total Disability, and would otherwise be eligible to become insured under the requirements of the Policy, we will cover you and any eligible dependents for the lesser of what you would receive under this contract or what you would receive under the Prior Plan Benefits until the earliest of:
1. The date you return to Active Service;
2. The end of any period of continuance under the Prior Plan; or
3. The date coverage terminates, according to the provisions of this contract.

Any benefits payable under the conditions described above will be paid by us:
1. As if the Prior Plan had remained in effect; and
2. Will be reduced by any benefits paid or payable by the Prior Plan.

If you are a Transfer Insured but were not in Active Service due to Total Disability on the Effective Date of the Policy, you are not eligible to become insured under this contract. However, if the Prior Plan did not provide an Extension of Benefits for Total Disability, we will apply the Extension of Benefits for Total Disability under this contract, reduced by any benefits actually payable under the Prior Plan.

RIDER EFFECTIVE DATE

This Rider becomes effective on the same date as the contract.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:

1. The date the contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date of the Insured's death; or
3. The date the contract terminates.

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

Jay Orlandi
Secretary

Blake Bostwick
President

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
Administrative Office: 2700 W Plano Pkwy, PO Box 869094, Plano, TX 75086-9094
(Hereinafter called "the Company," "we," "us," or "our")

HOSPITAL CONFINEMENT INDEMNITY BENEFIT RIDER

This Rider is attached to and made part of the contract as of the Rider Effective Date. It is issued in consideration of the Application and payment of any required initial premium. All provisions of the contract not in conflict with the provisions of this Rider apply to this Rider.

BENEFIT

We pay a Hospital Confinement Indemnity Benefit for each day a Covered Person is Confined to a Hospital as the result of the Covered Person's Accidental Injury or Sickness. Confinement must begin while this Rider is in force and must last a minimum of 24 continuous hours from time of admission as a resident bed patient. Each stay in a Hospital must meet the contract's definition of Confinement. The Hospital Confinement Indemnity Benefit amounts and the maximum number of days the benefit is payable in a Calendar Year are shown in the Schedule of Benefits.

We will not pay this benefit for an emergency room stay, an outpatient stay, or a stay in an Observation Unit or a recovery room. We also will not pay a Hospital Confinement Indemnity Benefit for a newborn Child's stay in the Hospital unless the newborn Child is Confined to the Hospital and is being treated for Accidental Injury or Sickness.

Confinement for the same or related condition within 30 days of discharge will be treated as a continuation of the prior Confinement. Successive Confinements separated by more than 30 days will be treated as a new and separate Confinement.

This benefit is paid in addition to the Daily In-Hospital Indemnity Benefit.

RIDER EFFECTIVE DATE

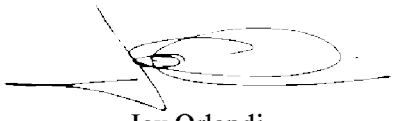
This Rider becomes effective on the same date as the contract unless we inform the Insured in writing of a different date.

TERMINATION

This Rider will terminate on the earliest of the following dates or events:
1. The date the Rider or contract lapses for failure to pay premiums, subject to the Grace Period of the contract;
2. The date the Insured requests termination;
3. The date of the Insured's death; or
4. The date the contract terminates.

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

Blake Bostwick
President



Jay Orlandi
Secretary

TRANSAMERICA LIFE INSURANCE COMPANY

Home Office: Cedar Rapids, IA 52499
Administrative Office: 2700 W Plano Pkwy, PO Box 869094, Plano, TX 75086-9094
(Hereinafter called "the Company," "we," "us," or "our")

PREEXISTING CONDITION EXCLUSIONS & LIMITATIONS RIDER

This Rider is attached to and made a part of the contract to which it is attached. It is issued in consideration of the Application and payment of any required initial premium. The contract is amended as follows:

The **EXCLUSIONS AND LIMITATIONS** section of the contract is amended to add the following limitations:

Preexisting Condition Limitation - No benefits are provided during the first 12 months this insurance is in force for a Preexisting Condition. After this 12-month period, loss due to such Preexisting condition will be payable unless specifically excluded from coverage. This 12-month period is measured from the date insurance becomes effective for each Covered Person.

No claim for a loss that starts 12 months after insurance becomes effective may be reduced or denied because of a physical condition, not excluded by name or specific description before the date of loss, that existed before the Covered Person's insurance became effective.

Preexisting Condition means a Covered Person's disease or physical condition for which medical advice or treatment was recommended by or received from a Physician within 12 months before the date the Covered Person's insurance became effective.

Normal Pregnancy Limitation - No benefits are provided for normal pregnancy during the first 10 months this insurance is in force. Complications from pregnancy are covered the same as any other Sickness.

This Rider does not waive, alter or extend any condition or provision of the contract, except to the extent shown above. It is subject to all the terms and limitations of the contract. This Rider takes effect and expires concurrently with the contract to which it is attached.

This Rider is signed for the Company at our Home Office to take effect on the contract Effective Date.

Blake Bostwick
President

Jay Orlandi
Secretary

TRANSAMERICA
LIFE INSURANCE COMPANY

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"*):	Tax ID Number:	SIC Code:	Website Address:
99 CENT STORES	95-2411605	5331	99only.com
Street Address:	**City:**	**State:**	**ZIP Code:**
23623 Colonial Pkwy	Katy	TX	77493
Contact Name:	**Email Address:**	**Phone #:**	**Fax #:**
Jerry Huang	jerry.huang@99only.com	323-881-1223	
Nature of Group:	**# of Employees/Members:**	**# Eligible for Coverage:**	**# of Years in Existence:**
Variety Stores	15,000	15,000	38

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 7/27/20 to 8/10/20. 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.
4. Do benefit selections vary by class? ☒ No ☐ Yes *(define classes below)*

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

5. Eligibility for insurance:
   a. Employer Groups - eligible employees are defined as those who work at least 20 hours per week for you, and have been so employed for at least 30 days.

Class 1	Class 2	Class 3	Class 4
20			
30			

   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? All product lines

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 – I agree to the offering of the selected products in the Insurance Selections section for the eligible employees/members.

Signed in (City/State) Katy/TX this 17 Day of (Month/Year) 06, 2020

Signature of Officer — Email Address: jerry.huang@99only.com

Jerry Huang VP Treasurer
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: robyn.piper@piperjordan.com

Robyn Piper — NPN 8001659
Print Name of Licensed Agent/Producer — Agent/Producer Number — License Number

Alabama **Fraud Warning**

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.

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

Billing Information

Billing Name (if other than group name)			
Billing Address: 23623 Colonial Pkwy	City: Katy	State: TX	ZIP Code: 77493
Billing Contact Name: Jerry Huang	Email Address: jerry.huang@99only.com	Phone #: 323-881-1223	Fax #:

Billing Address is: ☒ Group Policyholder ☐ Third Party Administrator ☐ Premium Collection Agency *(Requires a Premium Collection Agreement)*

Pay periods per year: 52 - weekly	Payments will be remitted: ☐ After each deduction ☒ Monthly ☐ Other _____
Payroll deductions per year: 52 - weekly	Premium amount on bill should reflect: ☐ Levelized amount over 12 months ☒ Actual amount of deductions
First payroll deduction date: 9/3/2020	Preferred billing sequence: ☒ Alphabetical ☐ Social Security Number ☐ Employee/Member ID
First bill due date: 10/01/2020	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% *(Not available in CA, CT, FL, LA, MA, NJ, OH, PA, WA)*
☐	☐	ADB for Chronic Condition Rider (Living Benefit Rider) *(Not available in CA, MA)*
☐	☐	Extension of Benefits Rider *(Not available in CA, CT, FL, MA,MD, NJ, OH, PA, TN)*
☐	☐	Benefit Restoration Rider *(Not available in CA, CT, FL, MA, MD, OH, PA, TN)*
☐	☐	Accidental Death & Dismemberment *(Accidental Death in VT) (Not available in MN)*
☐	☐	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** *Available as an Individual policy in VT.*	**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% *(Not available in CT, FL, MA, NJ)*
☐	☐	ADB for Chronic Condition Rider (Living Benefit Rider) *(Not available in CA, MA)*
☐	☐	Extension of Benefits Rider *(Not available in CA, CT, FL, MA,MD, NJ, OH, PA, TN)*
☐	☐	Accidental Death & Dismemberment *(Accidental Death in VT) (Not available in MN)*
☐	☐	Child Level Term Insurance Rider *(Not available in VA)*
☐	☐	Waiver of Premium for Total Disability

☒ **Group Term Life Insurance – Trans Select** *Product not available in VT.*	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:** 9/1/2020

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: *(Not available in CT, FL, MA, NJ)*	☐ 25% ☐ 50% ☐ 75% ☐ 100%	☐ 25% ☐ 50% ☐ 75% ☐ 100%	☐ 25% ☐ 50% ☐ 75% ☐ 100%
☐ ADB for Chronic Condition Rider (Living Benefit Rider) *(Not available in CA, LA, MA, MN)* With Extension of Benefits *(Not available in CA, CT, FL, OH, IL, IN, LA, MA, MD, MN, PA, TN, WA)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☒ No
☒ Accidental Death & Dismemberment *(Not available in MN or OH)*	☐ 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** *Product not available in VT.*	**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 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? *(Not available in FL or MN)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☒ **Group Accident Insurance – AccidentAdvance** *Product not available in PR, or WA.* *Available as an Individual policy in FL, MN and MT.*	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:** 09/01/2020
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			10 Units	12 Units	Units
Module 2 – Follow-Up Visits and Physical Therapy Benefits			5 Units	5 Units	Units
Module 3 – Initial Accident Hospitalization			4 Units	4 Units	Units
Accept	**Decline**	**Optional Riders**			
☒	☐	Accidental Death and Dismemberment Rider	5 Units	5 Units	Units
☒	☐	Accident Hospital & ICU Income Rider	9 Units	10 Units	Units
☒	☐	Expanded Benefits Rider *(Not available in NH)*	8 Units	8 Units	Units
☐	☒	Wellness Benefit Rider *(Not available in CO, CT, DC, KS, MA, MN, NH, or VT)*	Units	Units	Units
☐	☒	Accident Only Disability Income Rider *(Not available in CA)*	Elimination Period-0 Days Benefit Period: ☐ 6 ☐ 12 Months		
☐	☒	Sickness Only Disability Income Rider *(Not available in CA, CO, MN, NH, or VT)*	Elimination Period: 14 Days Benefit Period: ☐ 6 ☐ 12 Months		
☐	☒	Spouse Off-the-Job Accident Only Disability Income Rider *(Not available in CA)*	Elimination Period-0 Days Benefit Period: 6 Months		

☐ **Individual Accident Insurance – AccidentSelect** *Product not available in CT, FL, GU, MA, MN, NJ, OR, VI, VT, or WV.*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage: ☐ **Plan I** ☐ **Plan II**

Accept	Decline	
☐	☐	Accident Only Disability Income Rider *(Not available in PA)*
☐	☐	Sickness Only Disability Income Rider *(Not available in CO, MD, SC or VA) (Accident & Sickness Disability Rider in MN)*

☐ **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 – CancerEvents** *Check with Account Management for current state approval information*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

Coverage:

	Plan 1	**Plan 2**	**Plan 3**
Base Cancer Benefits Include: Initial Positive Diagnosis of Cancer Benefit, Active Treatment Benefit, Cancer Scans Benefit, Remission Drug Benefit, Skin Cancer Benefit Lifetime Maximum Benefit	Units	Units	Units
Optional Riders			
☐ Alternative Treatment Rider Alternative Treatments:	Units	Units	Units
☐ Heart Attack and Stroke Rider	Units	Units	Units
☐ Wellness Rider	Units	Units	Units

☐ **Group Cancer Insurance – CancerConnect** *Check with Account Management for current state approval information*	**Group Contribution?** ☐ Yes ☐ No *If yes, list amount or %:*	**Requested Effective Date:**

	Plan 1	**Plan 2**	**Plan 3**
Base Cancer Benefits Include: Active Treatment Benefit, Supportive Cancer Treatment Benefit, Skin Cancer Benefit Alternative Treatments (if Lifetime Maximum benefit is "No", must be 1): Lifetime Maximum Benefit:	Units ☐ Yes ☐ No	Units ☐ Yes ☐ No	Units ☐ Yes ☐ No
Optional Riders			
☐ Alternative Treatment Rider Alternative Treatments:	Units	Units	Units
☐ Initial Diagnosis with Building Benefit Rider	Units	Units	Units
☐ Occupational HIV Benefit Rider	Units	Units	Units
☐ Wellness Rider	Units	Units	Units

☐ **Group Cancer Insurance – CancerSelect Plus** *Product not available in MN.* *Available as an Individual policy in CT, FL, ID, MD,MT, NJ, PR, UT, WA* *Available to large groups (51+) only in MA.*	**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 – Drug-Related Expense 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** *Product not available in CO, FL, GA, MN*	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:* *If yes, offering Employee Buy-Up?* ☐ Yes ☐ No	**Requested Effective Date:** 09/01/2020
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 is not available in: CT, IN, MA, MD, NH, NJ, NC, PA, SD, WA)	☐ 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 *(Not available in CA, OR, PR)*	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No
☒ Recurrent Critical Illness Benefit Rider (Benefit Selection: 0%, 25%, 50%, 75%, 100%)	100 %	%	%
☒ Wellness Benefit Rider	$ 100	$	$

☐ **Group CI Insurance – CriticalAssistance Advance** *Product not available in CO, FL, NJ, VI and WA.* *Available as in Individual policy in CT and MD.* *Available to large groups (51+) only in MA.*	**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 *(Part of Policy in GA)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Occupational HIV Benefit Rider *(Not available in CA, GA, OR, or PR)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Quality of Life Benefit Rider *(Not available in CA, CT, GA, HI, KS, LA, MA, MN, NC, NH, OR, PA, PR, SD, TN, or UT)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Recurrent Critical Illness Benefit Rider *(Not available in MA)*	☐ 25% ☐ 50% ☐ 75%	☐ 25% ☐ 50% ☐ 75%	☐ 25% ☐ 50% ☐ 75%
Benefit Amount Paid For By:		Policyholder	Employee
☐ Intensive Care Rider *(Not available in GA, MD, MN, NH, PR, or VT)*		$	$
☐ Initial Hospitalization for Accidental Bodily Injury Benefit Rider *(Not available in AZ, CA, CT, GA, KS, MA, MD, MN, NH, PA, PR, or VT)*		$	$
☐ Accident Emergency Treatment Benefit Rider *(Not available in CA, CT, GA, KS, MA, MD, MN, NH, PA, PR, or VT)*		$	$
☐ Wellness Benefit Rider		$	$

☐ **Group CI Insurance – CriticalAssistance Plus** Product not available in CT, GA, MN or PR. Available as an Individual policy in FL, MD, MT, NJ, TN, UT and WA. Available to large groups (51+) only in MA.	**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 *(Not available in CA, FL or OR)*
☐	☐	Quality of Life Benefit Rider *(Not available in FL, HI, LA, MA, NC, NJ, OR, PA, TN, UT or WA)*
☐	☐	Cancer Screening Wellness Benefit Rider Additional Benefit: ☐ $50 ☐ $100

☐ **Group CI Insurance – CriticalAssistance Select** *Product not available in CT, GU, MA, MN, MT, NH, PR or WA.* *Available as an Individual policy in FL and MD.*	**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 *(Not available in GA)*
☐ Option C – Cancer Only *(Not available in GA)*
☐ Option B and C – Heart Attack, Stroke, and Cancer Only *(Not available in GA)*

☒ **Group Short-Term Disability – TransDI Plus** - TEXAS **IncomeSelect in FL** ***Large Employer Group Only (51+).*** *Product not available in MT, VT.* *Available as an individual policy in WA.*	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:** 09/01/2020
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	30 %	30 %	%	%
	Dollar Amount	$ 3000	$ 3000	$	$
Maximum Benefit Period (3, 6, 12 or 24 Months)		6 Months	6 Months	Months	Months
Accident Elimination Period (0, 7, 14, 30, 60, 90 or 180 Days)		7 Days	14 Days	Days	Days
Sickness Elimination Period (7, 14, 30, 60, 90 or 180 Days)		7 Days	14 Days	Days	Days

Accept	**Decline**	**Optional Riders/Benefits** *(Optional Riders/Benefits are not available in FL)*
☐	☒	Accidental Death & Dismemberment Benefit Rider
☐	☒	Hospital Indemnity Benefit Rider *(Not available in PR)*
☐	☒	Survivor Benefit Rider
☐	☒	Limited Pre-existing Condition Benefit (25% of the Disability Benefit for up to 6 weeks)
☐	☒	Physical Therapy Rider *(Not available in CO, CT, MN, MT, NH, PR, WA)*
☒	☐	Portability Rider *(Not available in CO, FL, MD, MN, MT, OH, RI, WA)*
☐	☒	Additional Income Benefit Rider *(Available in CA only)*

☐ **Group Short-Term Disability – TransDI Elite** *Product not available in CA, FL, VT or WA.*	**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** *Product not available in CT, GU, KS, MN, MT, NH, NJ, PR, RI, VI and WA.* *Large Employer Group Only (51+) in MA.*	**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** *Product not available in CA, CO, CT, GU, KS, MA, MD, MN,ND, NH, NJ, PR, RI, VI, WA*	**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** *Not available in DC, NH, NV*	**Group Contribution?** ☐ Yes ☒ No *If yes, list amount or %:*	**Requested Effective Date:** 09/01/2020
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	$ 150	$	$	$
Maximum (choose one): 31 Days per Confinement	☒ 31 Days	☐ 31 Days	☐ 31 Days	☐ 31 Days
Dollar Amount per Calendar Year	☐ $_____	☐ $_____	☐ $_____	☐ $_____
☒ Hospital Confinement Indemnity Benefit Rider	$ 1000	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum *(Not available in NJ)*	1 Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum *(Not available in NJ)*	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement *(Not available in CO, CT, MA, MO, NJ)*	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days *(Not available in CT, MA, ND, NJ, PA)*	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage *(Not available in CA, CO, CT, KS, MA, NJ, PA)*	%	%	%	%
☒ Waiver of Preexisting Condition Rider *(Not available in NH)*	☒ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Normal Pregnancy Limitation	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☒ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – HospitalSelect II Non-HSA Plan** *Not available in NH*	**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 *(Not available in NJ)*	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum *(Not available in NJ)*	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement *(Not available in CO, CT, MA, MO, NJ)*	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days *(Not available in CT, MA, ND, NJ, PA)*	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage *(Not available in CA, CO, CT, KS, MA, NJ, PA)*	%	%	%	%
☐ Inpatient Surgical Indemnity Benefit Rider *(Requires confinement)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage *(Not available in CT, MO, NJ)*	%	%	%	%
☐ Outpatient Surgical Indemnity Benefit Rider	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage *(Not available in CO,KS, MA, MO, NJ)*	%	%	%	%
☐ 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 *(Not available in CO, CT, MA, NH, NJ)*	%	%	%	%
☐ 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 *(Not available in CO, MS, NJ)*	$	$	$	$
☐ Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days *(Not available in CT, KS, NJ, PA, VT)*	$	$	$	$
☐ Inpatient Mental & Nervous Disorder Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days *(Not available in CT, KS, MA, NJ, PA)*	$	$	$	$
☐ Skilled Nursing Indemnity Benefit Rider Calendar Year Maximum: 60 Days. Lifetime Maximum: 120 Days *(Not available in CA, CO, KS, MO, NJ)*	$	$	$	$
☐ Waiver of Preexisting Condition Rider *(Not available in NH)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Normal Pregnancy Limitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – HospitalSelect III HSA Plan** *Not available in DC, NH, NV*	**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): 30 Days per Confinement	☐ 30 Days	☐ 30 Days	☐ 30 Days	☐ 30 Days
Dollar Amount per Calendar Year	☐ $_____	☐ $_____	☐ $_____	☐ $_____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum *(Not available in NJ)*	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum *(Not available in NJ)*	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement *(Not available in CO, CT, MA, MO, NJ)*	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days *(Not available in CT, MA, ND, NJ, PA)*	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage *(Not available in CA, CO, CT, KS, MA, NJ, PA)*	%	%	%	%
☐ 24-Hour Coverage Rider *(Not available in GU, ID, MO, RI, WA)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Waiver of Preexisting Condition Rider *(Not available in NH)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Normal Pregnancy Limitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – HospitalSelect III Non-HSA Plan** *Not available in NH*	**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): 30 Days per Confinement	☐ 30 Days	☐ 30 Days	☐ 30 Days	☐ 30 Days
Dollar Amount per Calendar Year	☐ $_____	☐ $_____	☐ $_____	☐ $_____
☐ Hospital Confinement Indemnity Benefit Rider	$	$	$	$
Maximum of 1 Day per Confinement. Calendar Year Maximum *(Not available in NJ)*	Days	Days	Days	Days
☐ Intensive Care Indemnity Benefit Rider *(Can't exceed 2 times the Base Benefit)*	$	$	$	$
Calendar Year Maximum *(Not available in NJ)*	Days	Days	Days	Days
☐ Inpatient Miscellaneous Indemnity Benefit Rider Maximum of 31 Days per Confinement *(Not available in CO, CT, MA, MO, NJ)*	$	$	$	$
☐ Off-The-Job Accidental Injury Indemnity Benefit Rider Maximum of 1 Day per Accident, Calendar Year Maximum 5 Days *(Not available in CT, MA, ND, NJ, PA)*	$	$	$	$
☐ Critical Illness Indemnity Benefit Rider	$	$	$	$
Dependent Benefit Percentage *(Not available in CA, CO, CT, KS, MA, NJ, PA)*	%	%	%	%
☐ Inpatient Surgical Indemnity Benefit Rider *(Requires confinement)*	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage *(Not available in CT, MO, NJ)*	%	%	%	%
☐ Outpatient Surgical Indemnity Benefit Rider	$	$	$	$
Calendar Year Maximum	Days	Days	Days	Days
Anesthesia Benefit Percentage *(Not available in CO,KS, MA, MO, NJ)*	%	%	%	%
☐ 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 *(Not available in CT, MA, NH, NJ)*	%	%	%	%
☐ 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 *(Not available in CO, MS, NJ)*	$	$	$	$
☐ Inpatient Drug & Alcohol Addiction Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days *(Not available in CT, KS, NJ, PA, VT)*	$	$	$	$
☐ Inpatient Mental & Nervous Disorder Indemnity Benefit Rider Calendar Year Maximum: 31 Days. Lifetime Maximum: 60 Days *(Not available in CT, KS, MA, NJ, PA)*	$	$	$	$
☐ Skilled Nursing Indemnity Benefit Rider Calendar Year Maximum: 60 Days. Lifetime Maximum: 120 Days *(Not available in CA, CO, KS, MO, NJ)*	$	$	$	$
☐ Wellness Indemnity Benefit Rider *(Not available in CT, KS, MA, NJ, VT)*	$	$	$	$
	Days	Days	Days	Days
☐ 24-Hour Coverage Rider *(Not available in GU, ID, MO, RI, WA)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Waiver of Preexisting Condition Rider *(Not available in NH)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Normal Pregnancy Limitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Healthiestyou	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

☐ **Hospital Indemnity – Transamerica Provider Select – HSA** *Not available in NH* *Check with Account Management for current state approval information*	**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	☐ 31 Days	☐ 31 Days	☐ 31 Days	☐ 31 Days
Dollar Amount per Calendar Year	☐ $_____	☐ $_____	☐ $_____	☐ $_____
☐ 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				
☐ Waiver of Preexisting Condition Rider *(Not available in NH)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Normal Pregnancy Limitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Hospital/Provider Network: _____

☐ **Hospital Indemnity – Transamerica Provider Select – Non-HSA** *Not available in NH* *Check with Account Management for current state approval information*	**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	☐ 31 Days	☐ 31 Days	☐ 31 Days	☐ 31 Days
Dollar Amount per Calendar Year	☐ $_____	☐ $_____	☐ $_____	☐ $_____
☐ 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	%	%	%	%
☐ Waiver of Preexisting Condition Rider *(Not available in NH)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
☐ Normal Pregnancy Limitation	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Hospital/Provider Network: _____

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