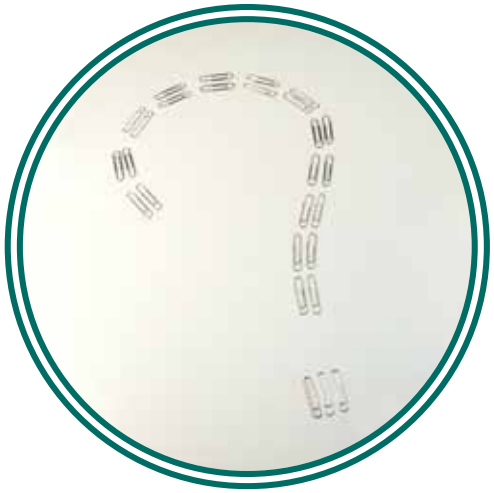
GROUP SHORT-TERM DISABILITY INCOME INSURANCE

Underwritten by Transamerica Life Insurance Company, Home Office, Cedar Rapids, Iowa.



How long can you go without a paycheck?

Short-term disability is income replacement if you are unable to work due to partial or total disability.

You don't need the answer, just a plan.

The Benefits of TransDI® Plus

TransDI Plus helps replace up to 60% of your salary if you are unable to work due to total or partial disability. Benefit amounts are available in $100 increments, enabling you to select the plan that is most appropriate for your needs.

Your employer has established the benefits for TransDI Plus. You must meet the requirements for the contract in order to qualify for coverage.

TransDI Plus has three elements:

- Elimination Period – After you become disabled, there's a **14 day waiting period** for **sickness** and a **14 day waiting period** for **accidents** before your benefits begin.
- Monthly Benefits – While you're totally disabled, you'll receive a fixed monthly income benefit that will not exceed 60% of your monthly salary. Periods of disability of less than one month will be paid at 1/30th the monthly benefit for each day of total disability.
- Benefit Period – Monthly benefits are payable up to **3 months.**

Riders and Provisions Included in Coverage

- Accelerated Benefit for Terminal Illness Rider (Form Series CRDITI00) – If you are diagnosed with a terminal illness for the first time by a physician on or after the effective date of the rider, we will advance up to 12 months of monthly disability benefits.
- Waiver of Premium Provision – If you become disabled you do not have to pay the premiums after 90 consecutive days of total disability or satisfaction of the elimination period whichever is later. Premiums must be paid from the beginning of the total disability to the date the Waiver of Premium begins. The insurer may require proof periodically that you remained disabled during this period.
- Partial Disability Benefit Provision – After being totally disabled, and you are only able to return to work on a limited basis, we will pay up to 50% of the monthly benefit amount beginning the first day following the end of the total disability assuming the partial disability is due to the same accident or sickness that caused the total disability.

AGE	MONTHLY RATE PER $100
18-54	$ 1.63
55-59	$ 2.14
60 +	$ 3.18

TRANSAMERICA WORKSITE MARKETING

Policy form series CPDI0100 and CCDI0100. Forms may vary, coverage available where approved.

Limitations and Adjustments

The following limitations and adjustments apply to the base coverage as well as any optional riders.

The sum of the disability benefits paid to you and the payments you are entitled to receive from the sources described below, may not exceed the covered percent of compensation shown on the contract data page:

1. Group or individual insurance coverage or like coverage for persons in a group;
2. Federal Social Security Act *(includes benefits paid to you and your dependents on account of your disability);*
3. State or federal government disability or retirement plan or increases thereof which begin on or after the date of total disability;
4. Pension plan to which the policyholder or your employer contributes or makes payroll deductions;
5. Salary or wage continuance plans such as sick leave paid for by the policyholder or the employer of the Insured which extend beyond the period stated in the contract data page;
6. Federal Old Age Benefits, or increases which begin on or after the date of total disability, under the Federal Social Security Act on your own behalf; and
7. Workers' Compensation or similar law.

With respect to items (2) and (6) only, unless you show us proof payments under these applicable programs or acts have been applied for but will not be paid, we:

1. Will assume each insured who is covered under the Federal Social Security Act is receiving such payments; and
2. May require you to reapply *(but not more frequently than annually)* once a Social Security denial has been received and all appeals have been pursued. Failure to reapply for benefits when required will result in our estimation of payment under those acts.

Benefits will not be reduced due to a cost of living increase in Social Security if the increase takes place while benefits are payable.

With respect to any and all of the above sources, if a lump sum payment is received by you or your dependents for a period previously paid by us, any resulting overpayment by us will be due us on a lump sum basis. If you have the option of taking retirement benefits on a monthly basis but chooses to receive retirement benefits on a lump sum basis, we may assume he or she is receiving retirement benefits based upon the lowest monthly retirement plan benefit available to him or her prior to lump sum withdrawal.

After application or reapplication has been made for the above applicable income sources, in lieu of our estimating other income, you may complete a Reimbursement Agreement provided by us. The agreement will allow us to provide benefits without estimation of other income and require you to reimburse us for any overpayment as the result of retroactive awards.

The disability benefits payable will never be less than the minimum disability benefit amount set out on the contract data page.

Pre-Existing Conditions

Pre-existing Conditions are sicknesses or physical conditions for which you had treatment, incurred expense, took medication or received a diagnosis or advice from a physician, during the 12-month period immediately before your effective date of coverage.

The term **Pre-existing Condition** also includes any condition that manifests itself in a way that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. If total disability is due to a pre-existing condition, there will be no disability benefits payable for a pre-existing condition until you have been covered continuously for 12 months.

Exclusions

This policy does not cover any loss, fatal or non-fatal, which occurs as a result of:

1. An intentionally self-inflicted injury while sane or insane;
2. Any act of war, declared or undeclared;
3. Commission of a felony;
4. Operating, learning to operate or having any duty in the operation of any device or vehicle intended or designed for flight in the air including boarding, alighting or descending therefrom;
5. Accident or sickness arising out of and in the course of any occupation, either full-time or part-time, for wage or profit. This exclusion applies even if Workers' Compensation is not paid for the on-the-job injury; or
6. An accident sustained or sickness contracted while in the service of the armed forces of any country.

Termination of Insurance

Your insurance coverage will end at 12:01 AM on the earliest of these dates:

1. The date you are no longer eligible for coverage;
2. The date you retire;
3. The date you cease to be in active service;
4. The end of the last period for which premium has been paid, subject to the grace period;
5. The date the policy is terminated.

Termination of the policy or termination of your coverage will have no effect on payment of benefits which begins before the policy is terminated or before your coverage terminates. The policyholder is responsible for continuing to pay the premiums for you until the notice of termination is received by the insurer.

Waiver of Premium will continue until the earliest of the end of your total disability; the end of the maximum benefit period; the end of the period for which benefits would otherwise be payable; the date the coverage terminates; or the date your employment with the policyholder or subscribing employer ends, according to the employer.

This is a brief summary of TransDI® Plus, Group Short-Term Disability Income Insurance benefits. Limitations and exclusions may apply. Refer to the contract, including riders, for complete information.

Producer compensation information is available at transamericaworksite.com.

Transamerica Short Term Disability

Important Information for you to know:

1. **The elimination period refers to how long you must be out of work before benefits apply. The elimination period is 14 days for illness or accident.**
2. **The benefit period refers to how long you will receive benefits from this policy. The benefit duration is up to 11 weeks as long as you are *medically disabled and on approved claim by Transamerica*.**
3. **You can elect benefits up to 60% of your gross monthly salary.**
4. **Your elected benefit *does not increase* as your salary increases. You must complete a new application in order to increase your benefit to match your salary.**
5. **Preexisting conditions apply for the first 12 months you are insured by the policy.**
6. **Pregnancy is covered like any other illness but there are limits as to how long you can be out of work. This is typically a six week period for a normal pregnancy or 8 weeks for a Cesarean minus your 14-day elimination period. Please remember that Transamerica will pay benefits as long as you are medically disabled and on an approved claim by Transamerica.**
7. **All applications are subject to Medical Underwriting by Transamerica**
8. **The application for coverage is attached. Complete all of the information you can on the application.**
9. **Sick time or other sources of income provided by your employer could result in a reduction of benefits.**

The typical claim works like this:

- You have an illness or injury that a physician diagnoses that prevents you from working.
- You file a claim immediately once you can no longer work.
- Your 14 day elimination period begins.
- Any employment missed due to your approved disability after the elimination period is eligible for benefits.
- Any sick time or other sources of income received during the benefit period could result in a reduction in benefits.

Please see your policy for all plan provisions.

How to calculate the monthly cost

1. Divide your annual salary by 12.
   a. If you don't know your annual salary please contact your payroll department

2. Multiply this result by 60% or .60.

3. Round down to the nearest 100.

4. Refer to the rate chart for your premium.

For Example:

If your salary was $35,500, divide by 12, which equals $2958.33 of monthly salary.

Multiply $2958.33 by .60, which equals $1774.99.

Round down to the nearest 100, which equals $1700.

The monthly premium for someone under 55 is $27.71.

Short Term Disability Rate Calculation

14 day Accident /14 day Illness Elimination Period – 11 Week Benefit Period

Monthly Benefit Amount	<55 Years old	55-59	60+
300	$4.89	$6.42	$9.54
400	$6.52	$8.56	$12.72
500	$8.15	$10.70	$15.90
600	$9.78	$12.84	$19.08
700	$11.41	$14.98	$22.26
800	$13.04	$17.12	$25.44
900	$14.67	$19.26	$28.62
1000	$16.30	$21.40	$31.80
1100	$17.93	$23.54	$34.98
1200	$19.56	$25.68	$38.16
1300	$21.19	$27.82	$41.34
1400	$22.82	$29.96	$44.52
1500	$24.45	$32.10	$47.70
1600	$26.08	$34.24	$50.88
1700	$27.71	$36.38	$54.06
1800	$29.34	$38.52	$57.24
1900	$30.97	$40.66	$60.42
2000	$32.60	$42.80	$63.60
2100	$34.23	$44.94	$66.78
2200	$35.86	$47.08	$69.96
2300	$37.49	$49.22	$73.14
2400	$39.12	$51.36	$76.32
2500	$40.75	$53.50	$79.50
2600	$42.38	$55.64	$82.68
2700	$44.01	$57.78	$85.86
2800	$45.64	$59.92	$89.04
2900	$47.27	$62.06	$92.22
3000	$48.90	$64.20	$95.40
3500	$57.05	$74.90	$111.30
4000	$65.20	$85.60	$127.20
4500	$73.35	$96.30	$143.10
5000	$81.50	$107.00	$159.00
5500	$89.65	$117.70	$174.90
6000	$97.80	$128.40	$190.80

Choose your monthly benefit amount not to exceed 60% of your gross monthly salary.
You can choose monthly benefit amounts less than 60%.
Preexisting conditions apply for the first 12 months from the effective date.
Please contact Charles Pareigis at the Drury Group at 791-0128 for all policy details
or email charles@drurygroup.com

TRANSAMERICA® LIFE INSURANCE COMPANY

Transamerica Life Insurance Company *("insurer")*
Home Office: Cedar Rapids, IA
Administrative Office: P.O. Box 8063
Little Rock, AR 72203-8063

IncomeSelect® Employee Application

☑ First Application ☐ Increase Coverage – Certificate # _____

Group Name *Williamson County* Group Number *0K96* Location

Employee (Last, First, M.I.)	☐ Male ☐ Female	Social Security No.	Date of birth
Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee ID
Home address			Work phone/ext.
City	State *TN*	Zip code	Home phone

Payroll Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☑ Monthly ☐ Other_____

I Am Applying For:			Employee Premium per pay period*	Employer Premium per pay period*	**Total Premium per pay period***
☑ Non-Occupational Disability Income Policy	Plan	Monthly Benefit* $	$	$	$

*If increasing coverage, enter the **TOTAL** Monthly Benefit amount and Premium.

Eligibility Questions

1. Are you actively at work on a full time basis and able to perform the regular duties of his/her occupation? (If "No", you are not eligible for coverage) ☐ Yes ☐ No
2. Are you covered by Workers' Compensation Insurance? ☑ Yes ☐ No
3. In the 12 months prior to the application date, have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to accident or illness, except for normal pregnancy? (If "Yes", give details below) ☐ Yes ☐ No

Evidence of Insurability Questions

Employee /

4. Indicate height and weight:
5. Have you had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease? (If "Yes", give details below) ☐ Yes ☐ No
6. In the ten years prior to the application date, have you been treated for, been diagnosed as having, or had any indication, sign or symptom of having any brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, musculoskeletal, neurological, high blood pressure, blood transfusion, complications of pregnancy, diabetes, rheumatoid arthritis condition, drug addiction, alcoholism, cancer or malignancy in any form? (If "Yes", give details below) ☐ Yes ☐ No
7. Have you been recommended for any medical treatment that has not yet been completed? (If "Yes", give details below) ☐ Yes ☐ No

Please provide details of all "Yes" answers to questions 3, 5, 6, and 7. Use additional paper if needed.
For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Question #	Please list: Illness, Injury, Condition, Symptoms, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital

APPLICANT'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. **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, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administrative office. **Lastly, I understand** that completion of this application in no way implies that I will be accepted for insurance coverage.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically-related facility, insurance company, the Medical Information Bureau*, or other organization, institution or person, that has any records or knowledge of me or my health, to give to Transamerica Life Insurance Company, or its reinsurers, any such information.

I understand the information obtained by use of this Authorization will be used by Transamerica Life Insurance Company to determine eligibility for insurance. Any information obtained will not be released by Transamerica Life Insurance Company to any person or organization except to reinsuring companies, the Medical Information Bureau*, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be otherwise lawfully required or as I authorize. **I know** that I may request to receive a copy of this Authorization. **I agree** that a photographic copy of this Authorization shall be as valid as the original. **I agree** that this Authorization shall be valid for two years from the date shown below.

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

Employee's Signature _____ Spouse's Signature (if applicable) _____

AGENT'S STATEMENTS AND AGREEMENTS:

I hereby certify that I have accurately recorded in this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application. **I also certify** that this insurance ☐ does ☑ does not replace any existing health, accident and sickness, or disability insurance coverage.

Licensed Representative's Name *Charles Pareigis* Licensed Representative's Signature _____ Agent # *0112S*

*Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112. Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.