OPEN ENROLLMENT
MAY 7 – 25, 2018

TO: ACTIVE FULL-TIME & ELIGIBLE PART-TIME EMPLOYEES

Open Enrollment will begin on **May 7, 2018** and will end on **May 25, 2018** for the plan year beginning July 1, 2018. This is your once-a-year opportunity to enroll, cancel or changes your health, dental and vision benefits. During this time, you may also add or drop coverage for your eligible spouse and or dependent children. This Open Enrollment period also includes the opportunity to enroll or change coverage with AFLAC and Supplemental Life Insurance Programs, administered by UNUM & TransAmerica.

WHAT YOU NEED TO KNOW

The benefit plan premiums (or rates) for the health, dental and vision plans will not change on July 1, 2018; however, there are a number of health benefit design changes intended to help you obtain the same level of quality and service at reduced costs to you and the State of Delaware. Learn What's New by viewing the online mini-videos or visiting an upcoming health fair.

A Health Plan Comparison Chart is included with this memo. This chart will provide you coverage options, and plan features for each of the four health plans available. A copy of the City of Dover Health Premiums for 15% and 20% employee cost sharing is also included.

Summaries of benefits and coverages for each of the four health plans are available on Public Docs in the Human Resources/2018 Open Enrollment folder P:\Human Resources\2018 Open Enrollment and on the Employment benefits page of the City's website, https://www.cityofdover.com/employment-benefits. You may also request a copy of the summaries from Human Resources via email.

It is important that you complete the SCOB Form only if you cover your spouse on your health plan effective July 1, 2018. A new form *MUST be completed each year during Open Enrollment or your spouse's coverage will be reduced*.

The electronic Spousal Coordination of Benefits form can be found on the Statewide Benefits website at https://cob.ben.omb.delaware.gov/. On the initial screen, select "Participating Groups & COBRA". On the second screen at the Select Group box, select "City of Dover" from the drop-down list. Be sure to fill out the form in its entirety. After completing the form online, click on "Printable Summary" to print a copy for your records. Please note that completing the spousal coordination of benefits form **DOES NOT** enroll your spouse or discontinue coverage for your spouse. You must complete and submit an enrollment application. If concerns arise regarding your spouse's coverage, Human Resources will request a copy of the Printable Summary mentioned above.

Please take the time to read the information provided so that you are an active participant in this year's Open Enrollment process. If you are not making any changes and wish to continue your current level of coverage, no action is needed, unless you insure a spouse on your plan.

If you are enrolling, changing or canceling coverage during this open enrollment period, please complete the appropriate forms and return them to Human Resources **prior** to the close of Open Enrollment on May 25, 2018. **Changes made during Open Enrollment will become effective on July 1, 2018.**

At the end of open enrollment, employees will receive an email or written notification from Human Resources of all the changes that have been received.

If you have any questions or concerns, please contact a member of the Human Resources Department via phone at (302) 736-7073 or email at humanresources@dover.de.us.

State of Delaware Health Plan Comparison Chart
(Effective July 1, 2018)

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Type	Preferred Provider Organization (PPO)		Preferred Provider Organization (PPO)		Health Maintenance Organization (HMO)		Preferred Provider Organization (PPO)	
Primary Care Provider (PCP) Selection	Recommended		Recommended		Required		Recommended	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Preventive Care/ Screening/Immunization (age, gender and risk parameters may apply)	100% covered, not subject to deductible	70% covered, not subject to deductible	100% covered, not subject to deductible	70% covered after deductible	100% covered	Not covered	100% covered	80% covered after deductible
Deductible (Per plan year)	$500 per individual/ $1,000 per family	$1,000 per individual/ $2,000 per family	$1,500 per individual/ $3,000 per family	$1,500 per individual/ $3,000 per family	N/A	N/A	N/A	$300 per individual/ $600 per family
Health Reimbursement Account (HRA)	N/A	N/A	$1,250 per individual/ $2,500 family	$1,250 per individual/ $2,500 family	N/A	N/A	N/A	N/A
Out-of-Pocket Maximum (including copays and deductibles)	$2,000 per individual/ $4,000 per family	$4,000 per individual/ $8,000 per family	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family	$4,500 per individual/ $9,000 per family	N/A	$4,500 per individual/ $9,000 per family	$7,500 per individual/ $15,000 per family
Prenatal and Postnatal Care	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	100% after $25 initial copay (inpatient room and board copays do apply to hospital deliveries/ birthing centers)	Not covered	100% (inpatient room and board copays do apply to hospital deliveries/birthing centers)	80% covered after deductible
24/7 Nurse Line	Yes, no cost		Yes, no cost		Yes, no cost		Yes, no cost	
Primary Care Visit to treat an injury or illness	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$15 copay per visit	Not covered	$20 copay per visit	80% covered after deductible
Telemedicine (Virtual Doctor Visits)	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$15 copay per visit	Not covered	$20 copay per visit	80% covered after deductible
Urgent Care Visit	100% covered after $25 copay	100% covered after $25 copay	90% covered after deductible	70% covered after deductible	$15 copay per visit	Not covered	$20 copay per visit	80% covered after deductible
Emergency Room	90% covered after deductible	90% covered after deductible	90% covered after deductible	90% covered after deductible	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)	$150 copay per visit (waived if admitted)
Chiropractic Care (Requires medical necessity and excludes preventive/maintenance care)	90% covered after deductible for up to 30 visits per plan year	75% covered after deductible for up to 30 visits per plan year	90% covered after deductible for up to 30 visits per plan year	75% covered after deductible for up to 30 visits per plan year	Lesser of $15 copay or 20% coinsurance (Referrals required through PCP)	Not covered	85% covered for up to 30 visits per plan year	80% covered after deductible for up to 30 visits per plan year

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Physical Therapy **(Requires medical necessity)**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	80% covered for up to 45 visits per illness/injury (Referrals required through PCP)	Not covered	85% covered	80% covered after deductible
Specialist Visit	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$25 copay per visit (Referrals required for certain services through PCP)	Not covered	$30 copay per visit	80% covered after deductible
Lab Work (Blood Work) **Note: Lab Work at a non-preferred non-hospital affiliated lab may not be covered**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	LabCorp and Quest Diagnostics: $10 copay per visit Hospital/Other Lab Facility: $20 copay per visit	Not covered	In-Network Non-Hospital Affiliated Preferred Lab: $10 copay per visit Hospital/Other Lab Facility: $20 copay per visit	80% covered after deductible
Basic Imaging/Radiology **(i.e., X-Ray, Ultrasound)**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit (Referrals required through PCP) Hospital Affiliated Facility: $35 copay per visit (Referrals required through PCP)	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $35 copay per visit	80% covered after deductible
High-Tech Imaging/Radiology **(i.e., MRI, CT Scan)** **Note: Requires a prior authorization**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $50 copay per visit	Not covered	Non-Hospital Affiliated Freestanding Facility (Preferred): $0 copay per visit Hospital Affiliated Facility: $50 copay per visit	80% covered after deductible
Outpatient Surgery	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	Ambulatory Center: $50 copay per visit Hospital Facility: $100 copay per visit	Not covered	Ambulatory Center: $50 copay per visit Hospital Facility: $100 copay per visit	80% covered after deductible
Hospital Admission	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	$100 copay per day with max of $200 per admission	Not covered	$100 copay per day with max of $200 per admission	80% covered after deductible

Plan Options	Highmark Delaware First State Basic Plan		Aetna CDH Gold Plan		Aetna HMO Plan		Highmark Delaware Comprehensive PPO Plan	
Center of Excellence (COE)*: The following services are covered under the State of Delaware Group Health Insurance Program (GHIP). Costs noted are for an inpatient stay. Note: Highmark refers to COE facilities as Blue Distinction Centers and Aetna refers to COE facilities as Institutes of Quality and Institutes of Excellence.								
Plan Feature	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Orthopedic (hip replacement/ knee replacement) **Note: Requires a prior authorization**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	80% covered after deductible
Spine (i.e., Cervical and lumbar fusion, cervical laminectomy, and lumbar laminectomy/ discectomy procedures) **Note: Requires a prior authorization**	90% covered after deductible	70% covered after deductible	90% covered after deductible	70% covered after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: $500 copay per admission	80% covered after deductible
Bariatric **Note: Requires a prior authorization**	COE Facility* (Preferred): 90% covered after deductible Non-COE Facility: 75% covered after deductible	55% covered after deductible	COE Facility* (Preferred): 90% covered after deductible Non-COE Facility: 75% covered after deductible	55% covered after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: 75% covered	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: 75% covered	55% covered after deductible
Transplants (For Highmark plans, does not apply to kidney and bone marrow/stem cell) **Note: Requires a prior authorization**	COE Facility* (Preferred): 90% covered after deductible Non-COE Facility: 70% covered after deductible	70% covered after deductible	COE Facility* (Preferred): 90% covered after deductible Non-COE Facility: 70% covered after deductible	70% covered after deductible	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: Not covered	Not covered	COE Facility* (Preferred): $100 copay per day; $200 copay max per admission Non-COE Facility: 80% covered	80% covered after deductible

*Aetna and Highmark Delaware have designated certain health care facilities within their provider network as Centers of Excellence, or simply COE Facilities. COE Facilities have been identified as delivering high quality services and superior outcomes for specific procedures or conditions. This means improved outcomes and reduced cost, which includes delivering surgery and post-operative care more efficiently and with lower risk of complications and readmissions.

**Members are encouraged to review the Highmark or Aetna plan documents for details regarding coverage.

For more information, including plan documents and listings of eligible Urgent Care Centers, COE Facilities and Non-Hospital Affiliated Freestanding Locations for Lab Work and Imaging/Radiology Services, visit the Statewide Benefits Office (SBO) website at de.gov/statewidebenefits.

Health Premiums
Effective: July 1, 2018
15% Employee Cost Sharing

Plan Name	Coverage Type	Employee Pays per Month	Biweekly Payroll Deduction	City Pays	Total Cost Monthly
Highmark Delaware First State Basic	Employee Only	$ 109.92	$ 54.96	$ 622.92	$ 732.84
	Employee & Child(ren)	$ 166.88	$ 83.44	$ 945.70	$ 1,112.58
	Employee & Spouse	$ 227.00	$ 113.50	$ 1,286.32	$ 1,513.32
	Family	$ 283.66	$ 141.83	$ 1,607.38	$ 1,891.04
Highmark Delaware Comprehensive PPO	Employee Only	$ 125.44	$ 62.72	$ 710.82	$ 836.26
	Employee & Child(ren)	$ 193.10	$ 96.55	$ 1,094.25	$ 1,287.34
	Employee & Spouse	$ 259.86	$ 129.93	$ 1,472.57	$ 1,732.42
	Family	$ 324.76	$ 162.38	$ 1,840.33	$ 2,165.08
Aetna HMO	Employee Only	$ 114.74	$ 57.37	$ 650.20	$ 764.94
	Employee & Child(ren)	$ 175.30	$ 87.65	$ 993.46	$ 1,168.76
	Employee & Spouse	$ 241.46	$ 120.73	$ 1,368.36	$ 1,609.82
	Family	$ 301.20	$ 150.60	$ 1,706.82	$ 2,008.02
Aetna CDH Gold	Employee Only	$ 113.74	$ 56.88	$ 644.61	$ 758.36
	Employee & Child(ren)	$ 173.58	$ 86.79	$ 983.65	$ 1,157.24
	Employee & Spouse	$ 235.44	$ 117.72	$ 1,334.12	$ 1,569.54
	Family	$ 298.98	$ 149.49	$ 1,694.26	$ 1,993.24

Health Premiums
Effective: July 1, 2018
20% Employee Cost Sharing

Plan Name	Coverage Type	Employee Pays per Month	Biweekly Payroll Deduction	City Pays	Total Cost Monthly
Highmark Delaware First State Basic	Employee Only	$146.56	$ 73.28	$ 586.28	$ 732.84
	Employee & Child(ren)	$222.52	$ 111.26	$ 890.06	$ 1,112.58
	Employee & Spouse	$302.66	$ 151.33	$ 1,210.66	$ 1,513.32
	Family	$378.20	$ 189.10	$ 1,512.84	$ 1,891.04
Highmark Delaware Comprehensive PPO	Employee Only	$167.24	$ 83.62	$ 669.02	$ 836.26
	Employee & Child(ren)	$257.46	$ 128.73	$ 1,029.88	$ 1,287.34
	Employee & Spouse	$346.48	$ 173.24	$ 1,385.94	$ 1,732.42
	Family	$433.02	$ 216.51	$ 1,732.06	$ 2,165.08
Aetna HMO	Employee Only	$152.98	$ 76.49	$ 611.96	$ 764.94
	Employee & Child(ren)	$233.74	$ 116.87	$ 935.02	$ 1,168.76
	Employee & Spouse	$321.96	$ 160.98	$ 1,287.86	$ 1,609.82
	Family	$401.60	$ 200.80	$ 1,606.42	$ 2,008.02
Aetna CDH Gold	Employee Only	$151.68	$ 75.84	$ 606.68	$ 758.36
	Employee & Child(ren)	$231.44	$ 115.72	$ 925.80	$ 1,157.24
	Employee & Spouse	$313.90	$ 156.95	$ 1,255.64	$ 1,569.54
	Family	$398.64	$ 199.32	$ 1,594.60	$ 1,993.24

20% Employee Cost Sharing

AFSCME Union Employees hired on or after May 20, 2015

DOE Union Employees hired on or after December 22, 2015

FOP Union Employees hired on or after October 9, 2015

IBEW Union Employees hired on or after July 1, 2014

12.6.2011

STATE OF DELAWARE — OFFICE OF MANAGEMENT AND BUDGET — STATEWIDE BENEFITS OFFICE

AETNA — Enrollment/Change Request Form

A. REASON FOR APPLICATION

☐ New coverage
☐ Change coverage
☐ Information change
☐ Waive coverage
Date of event checked: _____

ADD DEPENDENTS DUE TO:
☐ Marriage/Civil Union ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship
Date of event checked: _____

TERM DEPENDENTS DUE TO:
☐ Divorce ☐ Death
☐ Over age ☐ Other
☐ No longer dependent
Date of event checked: _____

REINSTATE COVERAGE DUE TO:
☐ Administrative error
☐ Other
Date of event checked: _____

B. PERSONAL INFORMATION

☐ Male ☐ Female	Social Security Number	**Employer**	Employer Group Number:

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & child (ren) ☐ Family

CHOOSE ONE: ☐ Aetna HMO ☐ Aetna CDH Gold ☐ Aetna HMO COBRA ☐ Aetna CDH Gold COBRA

D. ELIGIBLE DEPENDENTS TO BE C OVERED / PRIMARY CARE PHYSICIAN SELECTION

If you select Aetna HMO complete all of the below information. If you Select Aetna CDH Gold you do not need to provide Primary Care Physician information.

If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

Name of Your Primary Care Physician	Physician's ID Number	Is this your current physician? ☐YES ☐NO

☐Add ☐Change ☐Remove	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Spouse's Social Security Number	Spouse's Primary Care Physician	Physician's ID Number	Spouse's current physician? ☐Y ☐N
☐Add ☐Change ☐Remove	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N
☐Add ☐Change ☐Remove	Dependent's First Name ☐ Fulltime student ☐Male ☐ Handicapped ☐Female	M.I.	Last Name (if different), Jr., Sr.	Birth Date / /	Dependent's Social Security Number	Dependent's Primary Care Physician	Physician's ID Number	Dependent's current physician? ☐Y ☐N

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐I am ☐My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below: If covering a spouse you must go online at www.ben.omb.delaware.gov/documents/cob and complete a Coordination of Benefits form.	Name and Location of Other Insurance Company

F. CONDITIONS OF ENROLLMENT – Applicant Acknowledgments and Agreements

On behalf of myself and dependents listed, I agree to or with the following: 1) I acknowledge that by enrolling in the following plans, coverage is underwritten or administered by the following entities (collectively referred to as "Aetna"):

- HMO
- HMO COBRA
- CDH Gold Plan
- CDH Gold COBRA

2) I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage. 3) I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers") to give Aetna or its agent information concerning the medical history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health, substance abuse and HIV/AIDS. I further authorize Aetna to use such information and to disclose such information to affiliates, providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents and I have obtained their consent to those terms. I understand that this authorization is provided under state law and that it is not an "authorization" within the meaning of the federal Health Insurance Portability and Accountability Act. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that I am entitled to receive a copy of this authorization upon request and that a copy is as valid as the original. 4) The plan documents (Schedule of Benefits, Group Agreement, Certificate of Coverage, Group Policy, Group Insurance Certificate) will determine the rights and responsibilities or other description of the plan. 5) I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

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

I ELECT to participate in the State Plan and do agree to the above terms.

Signature: _____ Date: _____

I elect **NOT** to participate in the State Plan.

Signature: _____ Date: _____

HIGHMARK® Delaware

STATE OF DELAWARE APPLICATION FOR COVERAGE

FOR STATE OF DELAWARE USE ONLY

Name	Phone	Date	Group Number	Contact	Dept./Agency

A. REASON FOR APPLICATION (CHECK ALL THAT APPLY). PLEASE PRINT LEGIBLY.

☐ New coverage
☐ Change coverage
☐ Information change
☐ Refuse coverage *(see Section E)*

ADD DEPENDENTS DUE TO:
☐ Marriage/Civil Union ☐ Non-voluntary coverage loss
☐ Birth ☐ Other
☐ Adoption/Guardianship
Date of event checked:

CANCEL DEPENDENTS DUE TO:
☐ Divorce/Dissolution ☐ Death
☐ Over age ☐ Other
☐ No longer dependent
Date of event checked:

REINSTATE COVERAGE DUE TO:
☐ Rehire ☐ Administrative error
☐ Return from leave ☐ Other
☐ Return from layoff
Date of event checked:

B. PERSONAL INFORMATION

☐ Male ☐ Retiree ☐ Non-employee
☐ Female ☐ Surviving spouse

Date of Hire/Retirement (month, day, year)	Social Security Number	Agency or School District

Last Name	First Name	M.I.	Date of Birth (month, day, year)	Home Phone (include area code)	Business Phone (include area code)

Street Address	City	State	Zip Code

C. HEALTH CARE COVERAGE CHOICES

COVERAGE IS FOR: ☐ Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family
PLEASE MAKE ONE HEALTHCARE COVERAGE CHOICE: ☐ First State Basic ☐ Comprehensive PPO
☐ Special Medicfill ☐ Special Medicfill without prescription
☐ **I AM 65 OR OLDER.** ☐ **MY SPOUSE IS 65 OR OVER; I AM A FULLTIME EMPLOYEE.**

MEDICARE INFORMATION:
Applicant's Medicare #: ______________________
Part A Effective Date: ______________________
Part B Effective Date: ______________________

D. ELIGIBLE DEPENDENTS TO BE COVERED

If more space is needed to list dependents, please use a separate sheet of paper and attach it to this application.

☐ Add ☐ Cancel	Spouse's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Spouse's Social Security Number	
☐ Add ☐ Cancel	Dependent's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Dependent's Social Security Number	☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female
☐ Add ☐ Cancel	Dependent's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Dependent's Social Security Number	☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female
☐ Add ☐ Cancel	Dependent's First Name	M.I.	Last Name (if different), Jr., Sr.	Birth Date (month, day, year)	Dependent's Social Security Number	☐ Fulltime student ☐ Male ☐ Handicapped ☐ Female

ENR-196 (R3-17)

E. OTHER COVERAGE INFORMATION

Anyone covered by other health insurance? ☐ I am ☐ My spouse ☐ My dependent child(ren)	If YES, and the coverage is through an employer, list name of employer below:	Name and Location of Other Insurance Company	Transferring your coverage from another Highmark DE contract? ☐ Y ☐ N

F. TERMS OF AGREEMENT

I understand that: 1) Rights to service are subject to acceptance of this application and to the terms and conditions specified in the present contract and any future contract between my employer, association and Highmark Blue Cross Blue Shield Delaware (Highmark DE). 2) I certify that all representations and information supplied by me are true. My coverage shall be void if any or part of this application is false or incomplete. 3) I authorize my employer, as my agent, if applicable to collect the premiums by payroll deduction or otherwise, for remittance to Highmark DE, with the understanding that payment will not be complete until actually received. 4) I, on behalf of myself and my covered dependents, authorize any physician, hospital or any other health care provider to release information available to them concerning any diagnosis, treatment or other health care services they render to me or my covered dependents to Highmark DE or its designee for purposes reasonably related to this contract. 5) I, on behalf of myself and my covered dependents, authorize Highmark DE to release appropriate demographic information, diagnostic and medical conditions to other persons, entities or organizations for audits, claims processing, coordination of benefits, disease management programs, member satisfaction surveys, other party liability, utilization review, case management, quality improvement and assurance and other reasonably related purposes for the administration of this contract or as required by law. 6) If covering a spouse, you must go online at and complete a Coordination of Benefits form.

I elect not to participate in the State Health Insurance Program. Signature:	I have read and do agree to the above terms. Signature:	Date

HIGHMARK. Delaware

An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Insurance or benefit/claims administration may be provided by Highmark, Highmark Choice Company, Highmark Coverage Advantage, Highmark Health Insurance Company, First Priority Life Insurance Company, First Priority Health, Highmark Benefits Group, Highmark Select Resources, Highmark Senior Solutions Company or Highmark Senior Health Company, all of which are independent licensees of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

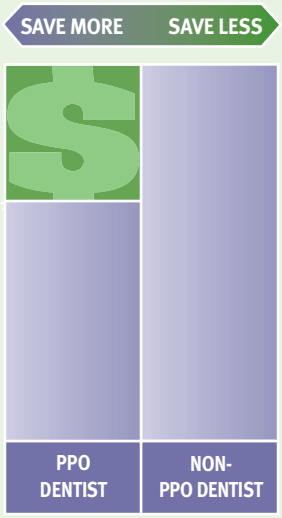
ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

Delta Dental PPO℠ – Easy, Friendly, Accessible

We'll do **whatever it takes and then some.**

Save with a PPO dentist

YOUR COSTS



AMOUNT YOU **SAVE**

AMOUNT YOU **PAY**

Illustration showing sample enrollee share of cost for information purposes only. Actual dentist fees and contract allowances will vary by region, procedure and group contract.

We're pleased to be your partner in maintaining great oral health. The Delta Dental PPO† plan makes it easy for you to find a dentist and control your costs when you visit a network dentist. Here are some of the great things you'll need to know about enrolling with Delta Dental:

- **Save with a PPO dentist.** Our PPO network dentists accept reduced fees for covered services, so you'll usually pay the least when you visit a PPO network dentist. Non-Delta Dental dentists may balance bill you the difference between the contracted fee and their usual fee.
- **Large dentist network.** Since Delta Dental offers access to some of the largest dentist networks in the U.S.,‡ chances are there's a wide choice of PPO dentists near your home or office. Use your desktop or mobile device to search for a dentist at deltadentalins.com.
- **Visit the dentist of your choice.** Want to visit a non-Delta Dental dentist? No problem. You can visit any licensed dentist, but your costs are usually lowest with a PPO dentist.
- **Log in to Online Services.** Check benefits, eligibility and claims status, view or print an ID card and use our "Fee Finder" tool to check average costs in your area. You can also change your Profile preference to go paperless. Use your mobile device to access many of these tools on the go; show the dental office your ID card information instead of carrying a printed card.

Visit the *SmileWay*® Wellness section of our site for dental health articles, videos, quizzes and a risk assessment tool. You can also subscribe to our free dental health e-newsletter.

† In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.
‡ Netminder Dental Network Trend Report, March 2013.

DELTA DENTAL®

A REGISTERED MARK OF DELTA DENTAL PLANS ASSOCIATION

Socialize with us: deltadentalins.com/enrollees

HL_PPO_2col #72828 (rev. 7/13)

Plan Benefit Highlights for: City of Dover

Group No: 15426 – Low Plan

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month that dependent turns age 19 or to age 23 if dependent is full-time student		
Deductibles	$50 per person / $150 per family each plan year		
Deductibles waived for D & P?	Yes		
Maximums	$1,000 per person each plan year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Benefits None	Major Benefits N/A	Prosthodontics N/A

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals)	0 %	0 %
Periodontics (gum treatment)	0 %	0 %
Oral Surgery	0 %	0 %
Major Services Crowns, inlays, onlays and cast restorations	0 %	0 %
Prosthodontics Bridges and dentures	0 %	0 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental of Delaware
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Plan Benefit Highlights for: City of Dover

Group No: 15426 – High Plan

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse and eligible dependent children to the end of the month that dependent turns age 19 or to age 23 if dependent is full-time student		
Deductibles	$50 per person / $150 per family each plan year		
Deductibles waived for D & P?	Yes		
Maximums	$1,250 per person each plan year		
D & P counts toward maximum?	Yes		
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings and simple tooth extractions	80 %	80 %
Endodontics (root canals) Covered Under Major Services	50 %	50 %
Periodontics (gum treatment) Covered Under Major Services	50 %	50 %
Oral Surgery Covered Under Major Services	50 %	50 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and 90th percentile for non-Delta Dental dentists.

Delta Dental of Delaware
One Delta Drive
Mechanicsburg, PA 17055

Customer Service
800-932-0783

Claims Address
P.O. Box 2105
Mechanicsburg, PA 17055-6999

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

We're online wherever you are: Your computer or on the go!

Quick, convenient and secure

Visit us online for up-to-date account information, tips on using your plan, help finding a dentist, oral health information and more.

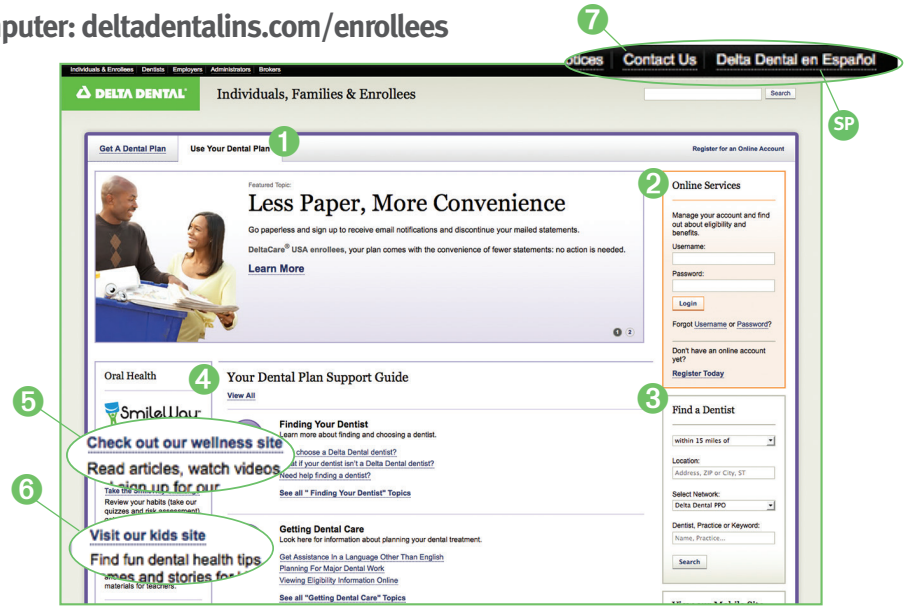
Mobile? We are, too.

Our streamlined mobile website provides the on-the-go services you need most (see page 2).

Speak Spanish? So do we.

Visit Delta Dental en Español at **es.deltadentalins.com** or from our home page (see **SP** in graphic to the right).

At your computer: deltadentalins.com/enrollees



1. Select the **Use Your Dental Plan** tab.
2. Log into **Online Services** (or sign up by selecting **Register Today**) to check benefits, eligibility and claims status, opt for paperless statements, view or print an ID card, check average dental costs in your area and more.
3. The **Find a Dentist** feature helps you locate a Delta Dental dentist in your area. Search by features that matter to you like location, specialty and languages spoken (see page 2).
4. **Your Dental Plan Support Guide** provides advice on plan-related topics like learning how your plan works, tips for saving money on dental treatments and help navigating our website.
5. At our **SmileWay® Wellness site**, take one of our interactive quizzes, access dental health articles and videos and sign up for *Grin!*, our fun dental health e-newsletter.
6. **MySmileKids®** offers stories, games and tips to make oral health routines kid-friendly.
7. Have a question? Our **Customer Support** link makes it easy to contact our team.

SP Access our site in Spanish.

DELTA DENTAL®

Socialize with us: deltadentalins.com/enrollees

ABOUT DELTA DENTAL

DeltaCare® USA
800-422-4234

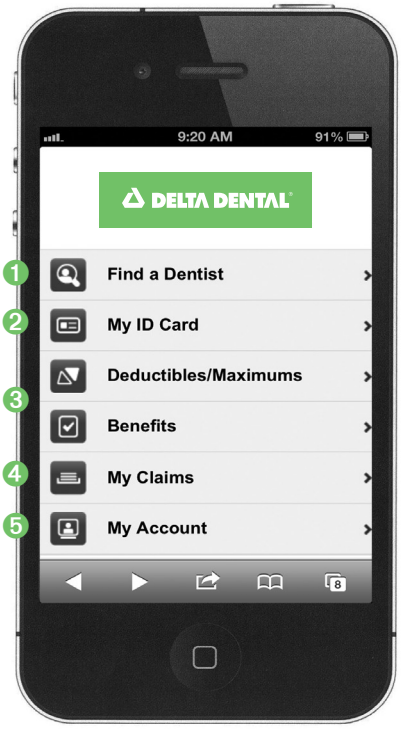
Delta Dental PPO℠ and Delta Dental Premier®
Delta Dental of California
800-765-6003

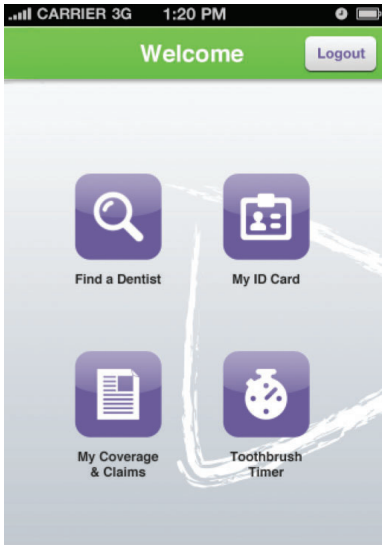
Delta Dental of Delaware, Inc.
Delta Dental of the District of Columbia
Delta Dental of New York, Inc.
Delta Dental of Pennsylvania (and Maryland)
Delta Dental of West Virginia, Inc.
800-932-0783

Delta Dental Insurance Company (Alabama, Florida, Georgia, Louisiana, Mississippi, Montana, Nevada, Texas, Utah)
800-521-2651

Our Delta Dental enterprise includes these companies in these states: Delta Dental of California – CA • Delta Dental of Pennsylvania – PA & MD • Delta Dental of West Virginia – WV • Delta Dental of Delaware – DE • Delta Dental of the District of Columbia – DC • Delta Dental of New York – NY • Delta Dental Insurance Company – AL, FL, GA, LA, MS, MT, NV, TX, UT.

These enterprise companies are members, or affiliates of members, of the Delta Dental Plans Association, a network of 39 Delta Dental companies that together provide dental coverage to more than 60 million people in the U.S. The website deltadentalins.com is the home of the Delta Dental companies listed above. For other Delta Dental companies, visit the Delta Dental Plans Association website at deltadental.com.





On your smartphone: deltadentalins.com mobile site

It's easy to get the information you need when you're on the go. Bookmark or add a shortcut to our mobile site so you can return in just one tap.

1. **Find a dentist:**
   Our mobile site uses your phone's location services to find dentists close to you (see below for more details).

PPO and Premier enrollees,* log in to:

2. View your ID card — and show it to your dentist.
3. Check benefits, eligibility, deductibles and maximums. Search by keyword or procedure code.
4. Check claims status and history.
5. Go paperless. Under "My Account" choose "Receive Statements Online."

Free Delta Dental app

Download our convenient smartphone app from the App Store or Google Play to quickly access your account on the go. It's simple to:

- Find a dentist: Search by address, current location, dentist name and more.
- View your ID card — show it to your dentist or quickly email a copy.
- Check benefits, eligibility, deductibles and maximums.
- Check claims status and history, or email a claim for your records.
- Use the toothbrush timer — its fun music makes it easy to brush the recommended two minutes.

Find your Delta Dental dentist

Delta Dental has the largest dentist network in the nation. And our online dentist directory makes it easy to locate a dentist who's right for you, with convenient search criteria, like:

- **Network(s) served:** PPO, Premier or DeltaCare USA
- **Location:** Search by address, landmark or ZIP code to find a dentist by your office or home.
- **Language:** From Spanish to Mandarin, we've got you covered.
- **Specialty**: You need braces? We have orthodontists and other specialists, too.

Once you've chosen a dentist, click the office address to view a map and driving directions.

*Benefits, eligibility and claims information are not currently optimized for enrollees in DeltaCare USA plans, but can still be accessed from your smartphone.

DELTA DENTAL®

deltadentalins.com/enrollees

EF30 #77389 (rev. 3/14)

Enrollee Notices Flyer

- **CA Tissue and Organ Donations:** This notice informs subscribers of the societal benefits of organ donations and the methods they can use to become organ and/or tissue donors. California regulations require every health plans to provide this information on enrollment and annually.

- **New York Domestic Violence:** New York provides victims of domestic violence the right to keep their health status, location, and provider private from the policyholder if the subscriber is the person who is violent. This notice describes how Delta Dental protects domestic violence victims and is relevant regardless of state of residence.

- **Non-Covered Services:** Non-covered services are defined as those dental services for which there is no benefit under any circumstances, including services that are never covered above a specific age limit (e.g., sealants). This notice describes that situation.

- **Spousal Equivalents:** Spouses and spousal equivalents are equally covered under a Delta Dental policy. A spouse or spousal equivalent is a partner of the primary enrollee as defined by the laws of the state where the contract is written, the laws of the state where the primary enrollee resides, or as may be additionally recognized by the group contract holder.

General Information Notices:

- **Health Education Program:** For DeltaVision enrollees, we have prepared an additional notice related to after hours, emergency care services, eye protection and eye safety.

For questions concerning the notices, please contact us at **866-530-9675.** You may also write to us at:

Delta Dental of California
PO Box 997330
Sacramento, CA 95899-7330

Enrollee Notices Flyer

Federal and state laws require enrollees to be notified on a periodic basis about enrollee rights and privacy practices. These notices address a variety of potential enrollee questions, including: Delta Dental privacy practices, regarding health and financial information, coverage rights, such as covered services, spousal equivalents, language assistance, how to file a grievance (complaint), and COBRA and ACA rights should an enrollee lose health care coverage.

Delta Dental notices are briefly described below. To access the full text of each of Delta Dental notices, please visit our website at http://www.deltadentalins.com/about/legal/index-enrollee.html. Or, call Customer Service at **866-530-9675** to receive a paper copy of the notices appropriate for your plan and state.

Federal Notices:

- **HIPAA Notice of Privacy Practices (NPP**): Federal regulations insurance plans to share information about the company's privacy practices. This is called a 'Notice of Privacy Practices (NPP)" and should be read when individual first becomes an enrollee and every three years thereafter. Delta Dental last updated this notice in 2013 to address changes in Federal law and regulation, also known as the Omnibus Rule.

- **Gramm-Leach-Bliley (GLB):** Financial institutions and insurance companies must describe their information-collection and information-sharing practices, regarding demographic and financial information. California requires a state specific notice called the California Financial Privacy Notice, which is described below.

- **COBRA Notice:** Enrollees who lose health care coverage may be able to continue their group coverage through COBRA or obtain dental coverage through the Health Care Exchange Marketplace. This notice describes these rights

State Notices:

- **Language Assistance Notice and Survey:** Delta Dental provides phone interpretation to callers who do not speak English. In California, Delta Dental will also provide, on request, translated copy of certain vital documents in either Spanish or Chinese. In Maryland and Washington DC, enrollees may receive grievance materials in Spanish or Chinese.

- **CA Financial Privacy Notice:** This notice to Californians describes Delta Dental's demographic and financial information-collection and information-sharing practices. It is similar to the Gramm-Leah-Bliley (GLB) notice described above.

- **CA Grievance Process:** This notice describes Delta Dental's procedure for processing and resolving enrollee grievances and gives the address and phone number to make a complaint. Californians are encouraged to read this notice when they first enroll and annually thereafter.

Monthly Premiums

Effective: July 1, 2018

Plan Name	Coverage Type	Employee Pays per Month
Delta Dental High Plan	Employee Only	$ 40.35
	Employee & One Dependent	$ 75.70
	Family	$ 119.65
Delta Dental Low Plan	Employee Only	$ 27.24
	Employee & One Dependent	$ 52.33
	Family	$ 98.07

Premiums for dental coverage are deducted from second paycheck of the month.

Enrollment/ Change Form

DELTA DENTAL

One Delta Drive, Mechanicsburg, PA 17055
(800) 932-0783
TTY/TDD (888) 373-3582
deltadentalins.com

Please check the applicable box or boxes.

☐ **New enrollment** ☐ **Address change**
☐ **COBRA** ☐ **Change of dependents**
☐ **Coverage change** ☐ **Termination**
☐ **Name change** ☐ **Decline Coverage**

Please check the applicable box or boxes.

■ **Delta Dental PPO Plus Premier**
☐ **High Plan**
☐ **Low Plan**

Please check the Delta Dental plan that administers your dental benefits.

☐ Delta Dental of Pennsylvania
☐ Delta Dental of New York
☐ Delta Dental Insurance Company
■ Delta Dental of Delaware
☐ Delta Dental of West Virginia

Primary Enrollee Social Security Number	Last Name	First Name	MI	Date of Birth	Gender ☐ Male ☐ Female

Alternate Identification Number *(if applicable)*

Address (Is this a change of address? ☐ Yes ☐ No) Street City State Zip Code

Group Number	Sublocation	Group Name
15426		CITY OF DOVER

Change of Coverage

New Coverage: Former Coverage:

Name Change

From: To:

Dependent Change

Please check one of the boxes: ☐ Add dependent(s) listed below ☐ Delete dependent(s) listed below

Do you or your dependents have other dental coverage?

☐ Yes ☐ No *If yes, please complete the following:*

Carrier Name and Address: _____

Group Number: _____

Last name (if different)	First Name	MI	Gender	Date of Birth	Social Security Number
Spouse			M F		
Children			M F		
			M F		
			M F		
			M F		
			M F		

Date of Hire:	Effective Date:	Primary Enrollee Signature

Any person who knowingly and with intent to defraud any insurance company or any 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. Enrollees whose company is headquartered in the state of New York and who commit a fraudulent insurance crime shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

VBA Vision makes using your benefits simple and easy.

Step 1

Go to **www.vbaplans.com**, log in to your account then click on “Am I Eligible.”

Step 2

If you are eligible, click on “Find A Doctor” at the top of the page. From there you can fill in your zip code and find a doctor close to you.

Step 3

Go to your appointment and let your doctor know that you have a VBA Vision plan. During your appointment, your doctor will give you an exam, order your materials, make sure your lenses are made correctly, and dispense your prescription.

Step 4

Relax—we’ve got you covered! VBA Vision will pay your doctor for covered exams, lenses, and frames.

If your doctor is not within the VBA network, requesting reimbursement is simple.

To request reimbursement for services provided by an out-of-network provider, go to **www.vbaplans.com**, download and complete a reimbursement form, attach all receipts and mail or fax to the address below.

This sheet is for information only and does not guarantee benefits.

300 Weyman Road, Suite 400
Pittsburgh, PA 15236
1-800-432-4966
Fax: 412-881-4898
www.vbaplans.com

vba

Plan Rules - Regular

Plan Rules - Regular

Group: 087 - DOVER CITY OF

General Plan Rules *

What is Covered ?

EITHER (1) EYEGLASS EXAM WITH LENSES & FRAME **OR (2)** ALLOWANCE TOWARD CONTACT EXAM & CONTACT LENS MATERIALS

Plan Specifics

Plan Type:	LAST DATE OF SERVICE
Student Age Limit:	25
Child Age Limit:	19

Exam Copay	Lens/Frame Copays
None	$10.00[2]

Plan Benefit Frequency

	Exam	Lens	Frame	Contacts
Child	12 months	12 months	24 months	**- OR -** $90 every 12 months [1]
Adult	24 months	24 months	24 months	**- OR -** $90 every 24 months [1]

[1] Elective contact lens can only be selected in lieu of all other benefits. When selected, your plan will provide a **total allowance of up to $90 toward the cost of the routine eye exam, contact fitting fees and contacts** (if all purchased at the same time and same provider). Any additional cost over the $90 will be the member's responsibility.
Member may be asked to pay the contact fitting fee out of pocket, at some locations.

[2] Exam copay is not paid if the member elects contact lenses and chooses to order contact lenses the day of the exam. Material copays do not apply to contact lenses.

* Contact lens policies and pricing varies by provider. Be sure to check both before receiving services. Your coverage does not provide both glasses and contact lenses in the same eligibility period.

* Coupons or advertised specials cannot be used in conjunction with your vision coverage.

Plan Rules - Regular

Plan Rules - Regular

Group: 087 - DOVER CITY OF

In Network Covered Services*

Vision Exam(for Glasses):	Covered	
Single Vision Lens:	Covered	
Lined Multifocals:	Covered	
Lenticular:	Covered	
Frame	Covered [1]	
Scratch Coating(1 Year):	Covered	More
Polycarbonate:	Covered	More
Blended Bifocals:	Covered	More
Medical Contacts:[6]	Covered w/ Authorization	More
Elective Contact Lens Allowance:	$90 [2]	

In Network Lens Options **

Option Name		VBA Discount Pricing	
Digital / Elite Progressives:	Cost Contained	**Starting at** $ 100	More
Premium Progressives:	Cost Contained	**Starting at** $ 80	More
VBA Absolute Progressives:	Cost Contained	**Starting at** $ 65	More
Standard Progressives:	Cost Contained	**Starting at** $ 45	More
Mid or High Index:	Cost Contained	**Price Varies**	More
Standard Photochromic:	Cost Contained	**Starting at** $ 18	More
Vantage™ Photochromic:	Cost Contained	**Starting at** $ 131	More
DriveWear® Photochromic:	Cost Contained	**Starting at** $ 111	More
XTRActive™ Photochromic:	Cost Contained	**Starting at** $ 93	More
Polarized:	Cost Contained	**Starting at** $ 56	More
UV 400:	Cost Contained	$ 12	More
Aspheric:	Cost Contained	**Price Varies**	More
Digital Surfacing:	Cost Contained	$ 48	More
Tints (Solid or Gradient):	Cost Contained	$ 11	More
Scratch Resistant:	Cost Contained	**1 Year Warranty is FREE**	More
Anti-Reflective, 1 Yr:	Cost Contained	$ 40	More
Anti-Reflective, 2 Yr:	Cost Contained	$ 49	More
Anti-Reflective, Premium:	Cost Contained	$ 69 or $ 85	More
Color Coating:	Cost Contained	$ 23	More
Mirror:	Cost Contained	$ 35	More
Edge Treatments:	Cost Contained	$ 10	More
Rimless Mounting:	Cost Contained	**Starting at** $ 8	More

Trivex®:	Cost Contained	**Starting at** $ 50	More
Computer or Near Variable:	Cost Contained	$ 40	More

Out of Network Reimbursements

Exam:	$30
Single Vision Lens:	$25
Bifocal:	$40
Trifocal:	$60
Lenticular:	$80
Contacts:	$90 [2]
Medical Contacts:	$200 [3]
Frames:	$30
Progressive:	$60

1 up to group's wholesale allowance

2 Elective contact lens can only be selected in lieu of all other benefits. When selected, your plan will provide a **total allowance of up to $90 toward the cost of the routine eye exam, contact fitting fees and contacts** (if all purchased at the same time and same provider). Any additional cost over the $90 will be the member's responsibility.
Member may be asked to pay the contact fitting fee out of pocket, at some locations.

3 authorization of medical condition required

4 price does not include base charge for material (if applicable)

6 Medical contacts can only be selected in lieu of all other benefits.

† includes UV coating on the backside of the lenses

* Member may select only one pair of the covered lens options listed below.

** Benefits may vary where prohibited by state law.

*** Certain plans may specify that no more than 50% of the above benefit may be used per eye.

Expert Solutions.
Exceptional Service.

Monthly Premiums as of July 1, 2018

**Premiums for vision coverage are deducted from the first paycheck of the month.*

Employee Only	$0.00
Employee & Child(ren)	$4.09
Employee & Spouse	$3.97
Family	$8.21

VISION BENEFITS OF AMERICA **City of Dover**

ENROLLMENT FORM **VBA # 087**

COVERAGE EFFECTIVE DATE _____/_____/_____

INSTRUCTIONS FOR EMPLOYEE:

1. COMPLETE SECTION BELOW AND SIGN.
2. RETURN COMPLETED FORM TO YOUR BENEFITS OFFICE.

EMPLOYEE SOCIAL SECURITY NUMBER _____

EMPLOYEE NAME _____ BIRTHDATE ____|_____|_____

ADDRESS _____

CITY _____ STATE_____ZIP CODE _____-_____

PLEASE LIST ALL FAMILY MEMBERS TO BE COVERED:

	FIRST NAME	**MIDDLE INITIAL**	**LAST NAME**	**BIRTHDATE**
SPOUSE				
CHILD				
CHILD				
CHILD				
CHILD				

STUDENT INFORMATION (COMPLETE FOR DEPENDENTS WHO ARE ENROLLED **AS FULL-TIME COLLEGE STUDENTS**.)

STUDENTS NAME	NAME OF SCHOOL OR UNIVERSITY	

ANY HANDICAPPED CHILD COVERED ON MEDICAL?

CHILD NAME		

EMPLOYEE SIGNATURE _____ DATE _____/_____/_____

☐ Decline Coverage

2018 Open Enrollment

Fred Wilson
AFLAC Insurance Agent
Phone: (302) 858-8719
frederick_wilsoniii@us.aflac.com

Now More Than Ever

Aflac®

INDIVIDUAL POLICIES

1-in-8
people seek medical attention for an injury each year.[1]

Short-Term Disability

Provides you with a source of income if you're disabled due to an accident or illness.

In Idaho, Short-Term Disability policy A57600IDR. In Oklahoma, Short-Term Disability policies A57600OK and A57600LBOK. In Idaho and Oklahoma, Life policies ICC1368100 through ICC1368400.

$17,553
was the average facility price for a hospital stay in 2013[2]

Hospital Confinement Indemnity

Eases the financial burden of hospital stays due to an accident or illness by providing cash benefit.

In Idaho, Hospital Confinement Indemnity policies A49100ID—A49400ID, A4910HID. In Oklahoma, Hospital Confinement Indemnity policies A49100OK—A49400OK, and A4910HOK. In Idaho, Dental policies A82100RID—A82400RID. In Oklahoma Dental, policies A82100ROK—A82400ROK. In Idaho, Vision policy VSN100ID. In Oklahoma, Vision policy VSN100OKR.

1-in-2
The lifetime risk of U.S. men for developing cancer. For women the risk is a little more than one-in-three.[3]

Accident

Reduces the financial impact of an accident by providing cash benefits.

Cancer/Specified-Disease

Helps with the costs of cancer treatment.

Critical Illness (Specified Health Event)

Helps with the costs of treatment if you experience a covered health event, such as a heart attack, stroke, or paralysis.

Aflac Plus Rider

Pays a lump sum benefit amount along with additional benefits when you are diagnosed with a covered health event.

Contact Fred Wilson by May 20th to discuss obtaining the Aflac products of your choice!

AFLAC CANCELLATION NOTICE

Date: _____

I, _____, do hereby request cancellation
(print name of insured)

of my _____ Policy _____.
(type of policy) (policy number)

I, _____, do hereby request cancellation
(print name of insured)

of only my _____ rider on my
(type of rider)

_____ policy, Policy No. _____.
(type of policy) (policy number)

Please make this cancellation effective _____.
(date)

Insured's signature: _____

Insured's SSN: _____

Associate/Agent: _____
(name and writing number)

American Family Life Assurance Company of Columbus (Aflac)
Worldwide Headquarters • 1932 Wynnton Road • Columbus, Georgia 31999
1.800.992.3522 telephone • 1.800.448.8922 fax • aflac.com

City of Dover
Summary of Voluntary Life Benefits
Policy #670530

Voluntary Group Term Life Insurance

What would your family do without your income? Voluntary Term Life Insurance is an affordable and sensible way to provide your family with the additional financial protection they may need if an untimely death should occur. The face amount of the policy can help to pay for mortgage/rent, credit card debt, loans, utilities, health care costs, child care expenses, and final expenses

- **Available Coverage:**
  - **Employee:** up to 5 times your annual salary to a maximum of $500,000
  - **Spouse:** up to 100% of employee amount to a maximum of $500,000
  - **Child(ren):** up to $10,000 (not to exceed 100% of the employee amount).
- **Guarantee Issue Coverage is available!**
- **Accelerated Benefit Amount:** 50% to $750,000
- **Suicide Exclusion:** 24 months
- **Life Benefit Reduction Formula:** Life Benefit reduces to 50% of original amount at age 70

Group Life Standard Plan Features Include:

- Portability and Conversion
- Waiver of Premium
- *Life Planning Financial and Legal Resources*

A Closer Look at Guarantee Issue Coverage

Guarantee Issue Amounts:

- **Employee:** $150,000
- **Spouse:** $25,000
- **Child(ren):** $10,000

How GI Works:

- **If you or your eligible dependents *are currently enrolled* in coverage:** now is your chance to increase you life coverage up to the GI amounts above ***without answering any medical questions***. Any life insurance coverage over the guaranteed amount(s) will be subject to medical questions.
- **If you or your eligible dependents *do not elect coverage during this enrollment*:** you may apply for coverage during a future annual enrollment and will be required to answer health questions for ***any*** amount of coverage.
- **If you are newly eligible:** in order to lock in your guarantee issue coverage during future enrollments, you must apply for coverage within 31 days of your eligibility period. If you apply for coverage after 31 days, or if you choose coverage over the amount you are guaranteed, you will need to complete a medical questionnaire.

See opposite side for sample bi-weekly premium amounts.

Bi-Weekly Premium Illustrations

Employee Voluntary Life (rates will increase with age)											
	15-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$0.35	$0.40	$0.55	$0.91	$1.58	$2.64	$4.62	$4.86	$8.58	$14.86	$23.80
$20,000	$0.70	$0.79	$1.11	$1.82	$3.16	$5.29	$9.23	$9.71	$17.17	$29.72	$47.59
$30,000	$1.05	$1.19	$1.66	$2.73	$4.74	$7.93	$13.85	$14.57	$25.75	$44.58	$71.39
$40,000	$1.40	$1.59	$2.22	$3.64	$6.31	$10.58	$18.46	$19.42	$34.34	$59.45	$95.19
$50,000	$1.75	$1.98	$2.77	$4.55	$7.89	$13.22	$23.08	$24.28	$42.92	$74.31	$118.98
$60,000	$2.10	$2.38	$3.32	$5.46	$9.47	$15.87	$27.69	$29.13	$51.51	$89.17	$142.78
$70,000	$2.46	$2.78	$3.88	$6.36	$11.05	$18.51	$32.31	$33.99	$60.09	$104.03	$166.58
$80,000	$2.81	$3.18	$4.43	$7.27	$12.63	$21.16	$36.92	$38.84	$68.68	$118.89	$190.38
$90,000	$3.16	$3.57	$4.98	$8.18	$14.21	$23.80	$41.54	$43.70	$77.26	$133.75	$214.17
$100,000	$3.51	$3.97	$5.54	$9.09	$15.78	$26.45	$46.15	$48.55	$85.85	$148.62	$237.97
$110,000	$3.86	$4.37	$6.09	$10.00	$17.36	$29.09	$50.77	$53.41	$94.43	$163.48	$261.77
$120,000	$4.21	$4.76	$6.65	$10.91	$18.94	$31.74	$55.38	$58.26	$103.02	$178.34	$285.56
$130,000	$4.56	$5.16	$7.20	$11.82	$20.52	$34.38	$60.00	$63.12	$111.60	$193.20	$309.36
$140,000	$4.91	$5.56	$7.75	$12.73	$22.10	$37.02	$64.62	$67.98	$120.18	$208.06	$333.16
$150,000	$5.26	$5.95	$8.31	$13.64	$23.68	$39.67	$69.23	$72.83	$128.77	$222.92	$356.95
$160,000	$5.61	$6.35	$8.86	$14.55	$25.26	$42.31	$73.85	$77.69	$137.35	$237.78	$380.75
$170,000	$5.96	$6.75	$9.42	$15.46	$26.83	$44.96	$78.46	$82.54	$145.94	$252.65	$404.55
$180,000	$6.31	$7.14	$9.97	$16.37	$28.41	$47.60	$83.08	$87.40	$154.52	$267.51	$428.34
$190,000	$6.66	$7.54	$10.52	$17.28	$29.99	$50.25	$87.69	$92.25	$163.11	$282.37	$452.14
$200,000	$7.02	$7.94	$11.08	$18.18	$31.57	$52.89	$92.31	$97.11	$171.69	$297.23	$475.94

Spouse Voluntary Life (rates will increase with age)											
	15-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	$0.18	$0.20	$0.28	$0.45	$0.79	$1.32	$2.31	$2.43	$4.29	$7.43	$11.90
$10,000	$0.35	$0.40	$0.55	$0.91	$1.58	$2.64	$4.62	$4.86	$8.58	$14.86	$23.80
$15,000	$0.53	$0.60	$0.83	$1.36	$2.37	$3.97	$6.92	$7.28	$12.88	$22.29	$35.70
$20,000	$0.70	$0.79	$1.11	$1.82	$3.16	$5.29	$9.23	$9.71	$17.17	$29.72	$47.59
$25,000	$0.88	$0.99	$1.38	$2.27	$3.95	$6.61	$11.54	$12.14	$21.46	$37.15	$59.49

Child	
	Life
$2,000	$0.04
$4,000	$0.07
$6,000	$0.11
$8,000	$0.15
$10,000	$0.18

One rate regardless of # of children

Note: for illustration only; actual costs may vary slightly due to rounding.
Life cost for employee and spouse coverage will increase as insured individual ages.

GROUP INSURANCE ENROLLMENT FORM
Unum Life Insurance Company of America
2211 Congress Street, Portland, ME 04122

Please print legibly and complete this form in its entirety. Blank fields will cause significant delays in processing.

Policyholder Name | **Policy No.** | **Division No.**

Employee Social Security Number | **Gender** M ☐ F ☐ | **Date of Birth** (mm/dd/yyyy) | **Hours Worked Per Week**

Employee First Name | **M.I.** | **Last Name**

Employee Street Address | **City** | **State** | **Zip Code**

Original Date of Hire | **Annual Salary** $ | **Occupation**

☐ Exempt ☐ Non-Exempt

☐ **Date entered into an eligible class** ***(ex: part time to full time)*** **or**
☐ **Rehire Date or**
☐ **Date of promotion to an eligible class**

Spouse First Name (if coverage is selected) | **Spouse Date of Birth** (mm/dd/yyyy)

COVERAGE ELECTIONS: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life/AD&D ☐ Yes ☐ No **Dependent Life** ☐ Yes ☐ No **LTD** ☐ Yes ☐ No **STD** ☐ Yes ☐ No

AMOUNT OF COVERAGE SELECTED FOR:

LIFE/AD&D You: $, , Spouse: $, , Child: $,

Note: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting and will become effective on the first of the month coincident with or next following the date Unum approves your Evidence of Insurability form. If you **DO NOT APPLY FOR** coverage for you or your dependent (s) during your or their initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage. You may complete and electronically submit an Evidence of Insurability form—please see your Plan Administrator.

Beneficiary Information:

Name (last name, first, middle initial):	**Relation to You:**	**Benefit %:**
If the beneficiary(ies) named above are not living, then pay:		

Request for Signature and Certification: I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature | *Date* | *Work Phone* | *Home Phone*

RETAIN A COPY OF THIS FORM FOR YOUR RECORDS AND SEND A COPY TO YOUR EMPLOYER

TRANSAMERICA®
Employee Benefits

Universal Life Insurance

PROVIDES A BENEFIT TO A LOVED ONE IN THE EVENT OF A FATAL OCCURRENCE

This is your opportunity to apply for additional insurance to supplement your core benefits. These insurance policies can help protect your financial future. Enroll today!

Universal Life rates are projected to stay the same throughout the life of your policy.

Other insurance plans (such as term life) increase in price on a regular basis.

- Guaranteed insurance benefits among the highest in the industry
- Benefit Flexibility – select what fits your budget
- Cash Value Accumulation account enables policy flexibility
- Portability – Keep the plan if you leave your employer with no change in the rate
- Ability to purchase insurance on dependents
- Includes Accidental Death and Dismemberment, which doubles your insurance in the event of an accidental death*

Guaranteed Acceptance

No Medical Questions during Your Open Enrollment Period!

Employee - $150,000

Spouse - $15,000

Child - $25,000

***See flip side for other important information!**

Example Rates:

Age	Non-Tobacco			Tobacco		
	Weekly Expense	Benefit Amount	Projected Cash Value @ Age 65*	Weekly Expense	Benefit Amount	Projected Cash Value @ Age 65*
30	$6.00	51,460	$8,421	$6.00	$35,788	$8,285
40	$6.00	$35,649	$5,031	$6.00	$23,481	$4,583
50	$6.00	$22,435	$2,247	$6.00	$14,270	$1,859

- You may apply for up to $500,000 (up to 5 times your annual salary)
- If you apply for benefits greater than 5 times your annual salary, your benefit will be reduced to match what you are eligible for.
- If you are applying for :
    - Over $150,000 for yourself OR
    - Over $15,000 for your spouse

  You will need to complete a medical questionnaire. Please contact the representative below.
- Accidental Death and Dismemberment is available to employees under age 70.

If you have questions about your enrollment, need help with the application or pricing or are applying for more that the guaranteed issue amounts for you or your spouse, please contact

Jan Marie Dysart

Brown and Brown of PA

800-724-6369, ext 115

jmarie@bbofpa.com

TransElite HFA - Universal Life Insurance

With Riders: TI, WML, ADD

Non-Tobacco

Death Benefit Option: A

TRANSAMERICA
Employee Benefits

Issue Age	$15,000 Face Amount			$25,000 Face Amount			$35,000 Face Amount			Issue Age
	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	
16	N/A†			N/A†			N/A†			16
17	N/A†			N/A†			N/A†			17
18	N/A†			N/A†			N/A†			18
19	N/A†			N/A†			N/A†			19
20	N/A†			N/A†			N/A†			20
21	N/A†			N/A†			N/A†			21
22	N/A†			N/A†			N/A†			22
23	N/A†			N/A†			N/A†			23
24	N/A†			N/A†			N/A†			24
25	N/A†			N/A†			N/A†			25
26	N/A†			N/A†			N/A†			26
27	N/A†			N/A†			N/A†			27
28	N/A†			N/A†			N/A†			28
29	N/A†			N/A†			N/A†			29
30	N/A†			N/A†			8.16	0	5,726	30
31	N/A†			N/A†			8.59	0		31
32	N/A†			N/A†			8.86	110		32
33	N/A†			N/A†			9.15	246		33
34	N/A†			N/A†			9.45	372		34
35	N/A†			N/A†			9.77	495	5,397	35
36	N/A†			N/A†			10.11	607		36
37	N/A†			N/A†			10.47	725		37
38	N/A†			N/A†			10.93	815		38
39	N/A†			8.11	368		11.36	939		39
40	N/A†			8.41	445	3,521	11.78	1,017	4,932	40
41	N/A†			8.85	513		12.39	1,090		41
42	N/A†			9.20	590		12.88	1,177		42
43	N/A†			9.63	648		13.49	1,243		43
44	N/A†			10.01	707		14.02	1,297		44
45	N/A†			10.41	751	3,092	14.57	1,338	4,330	45
46	N/A†			10.89	776		15.25	1,358		46
47	N/A†			11.42	807		15.99	1,381		47
48	N/A†			12.03	843		16.84	1,412		48
49	N/A†			12.63	842		17.68	1,392		49
50	8.02	308	1,501	13.37	840	2,502	18.72	1,371	3,504	50
51	8.43	318		14.06	833		19.68	1,344		51
52	8.87	328		14.80	825		20.72	1,316		52
53	9.33	300		15.54	744		21.77	1,193		53
54	9.83	333		16.38	777		22.93	1,219		54
55	10.32	348	1,101	17.21	782	1,841	24.10	1,212	2,577	55
56	10.91	257		18.19	604		25.47	950		56
57	11.59	126		19.32	365		27.06	604		57
58	12.39	27		20.65	175		28.91	323		58
59	13.29	0		22.15	0		31.01	56		59
60	14.25	0	190	23.75	0	318	33.25	0	444	60
61	15.37	0		25.62	0		35.87	0		61
62	16.66	0		27.77	0		38.88	0		62
63	18.00	0		30.00	0		42.00	0		63
64	19.55	0		32.59	0		45.62	0		64
65	21.31			35.52			49.73			65
66	22.76			37.94			53.11			66
67	24.40			40.67			56.94			67
68	26.09			43.48			60.88			68
69	27.83			46.39			64.94			69
70	29.73			49.55			69.38			70
71	32.37			53.95			75.54			71
72	35.22			58.71			82.19			72
73	38.28			63.81			89.34			73
74	41.56			69.27			96.98			74
75	45.15			75.25			105.36			75
76	48.90			81.50			114.11			76
77	52.97			88.28			123.60			77
78	57.30			95.50			133.70			78
79	61.94			103.24			144.54			79
80	66.85			111.42			156.00			80

† Face Amount is insufficient to require the minimum planned premium.

Solve for Target Premium – A100

* Guaranteed values are based on the minimum interest rate of 3.00% and maximum fees and charges. Non-Guaranteed values are based on a current illustrated interest rate of 5.25% and current fees and charges and are not guaranteed. Values are affected by the actual interest rates credited and cost of insurance rates charged. WML and WMD not included in Issue Ages 56+. Issue Ages 66+ do not include the ADD Rider. TI, LBR, EXT, RES not included in Issue Ages 76+. The Child Term Rider may be added for additional premium of $1.15 BiWeekly26 per $10,000.

A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

4/11/2016

Underwritten by Transamerica Life Insurance Company, Home Office: Cedar Rapids, IA

Issue State: DE Ver: 2.0.0.2406

TransElite HFA - Universal Life Insurance

With Riders: TI, WML, ADD

Tobacco

Death Benefit Option: A

TRANSAMERICA Employee Benefits

Issue Age	$15,000 Face Amount			$25,000 Face Amount			$35,000 Face Amount			Issue Age
	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	
16	N/A†			N/A†			N/A†			16
17	N/A†			N/A†			N/A†			17
18	N/A†			N/A†			N/A†			18
19	N/A†			N/A†			8.16	0		19
20	N/A†			N/A†			8.38	0	8,754	20
21	N/A†			N/A†			8.79	0		21
22	N/A†			N/A†			9.04	0		22
23	N/A†			N/A†			9.30	0		23
24	N/A†			N/A†			9.59	0		24
25	N/A†			N/A†			9.86	0	8,431	25
26	N/A†			N/A†			10.17	0		26
27	N/A†			N/A†			10.57	0		27
28	N/A†			N/A†			10.91	0		28
29	N/A†			8.10	0		11.35	0		29
30	N/A†			8.38	0	5,779	11.73	0	8,073	30
31	N/A†			8.78	0		12.29	0		31
32	N/A†			9.09	0		12.73	0		32
33	N/A†			9.48	0		13.27	0		33
34	N/A†			9.83	0		13.76	0		34
35	N/A†			10.20	0	5,405	14.28	0	7,569	35
36	N/A†			10.65	0		14.91	120		36
37	N/A†			11.13	0		15.59	316		37
38	N/A†			11.63	0		16.28	461		38
39	N/A†			12.22	131		17.10	623		39
40	N/A†			12.77	240	4,875	17.88	759	6,820	40
41	8.01	0		13.36	350		18.71	896		41
42	8.41	0		14.02	448		19.62	992		42
43	8.84	0		14.74	532		20.64	1,100		43
44	9.28	20		15.47	586		21.65	1,144		44
45	9.75	76	2,487	16.25	646	4,151	22.75	1,212	5,811	45
46	10.26	129		17.10	693		23.94	1,256		46
47	10.80	177		18.00	737		25.20	1,297		47
48	11.35	205		18.93	759		26.50	1,307		48
49	11.94	233		19.91	768		27.88	1,304		49
50	12.61	240	1,950	21.02	748	3,253	29.43	1,256	4,555	50
51	13.31	239		22.18	710		31.05	1,184		51
52	14.03	220		23.39	657		32.75	1,092		52
53	14.80	201		24.66	589		34.53	981		53
54	15.61	241		26.03	639		36.44	1,031		54
55	16.45	275	1,364	27.43	669	2,277	38.40	1,060	3,187	55
56	17.41	190		29.02	501		40.62	808		56
57	18.48	65		30.80	265		43.13	468		57
58	19.72	0		32.87	113		46.02	238		58
59	21.12	0		35.20	0		49.27	32		59
60	22.60	0	370	37.66	0	616	52.73	0	864	60
61	24.02	0		40.04	0		56.06	0		61
62	25.58	0		42.63	0		59.69	0		62
63	27.31	0		45.52	0		63.73	0		63
64	29.14	0		48.57	0		67.99	0		64
65	31.04			51.73			72.42			65
66	33.80			56.33			78.87			66
67	36.07			60.12			84.17			67
68	38.50			64.16			89.83			68
69	40.92			68.22			95.50			69
70	43.46			72.44			101.41			70
71	46.95			78.25			109.55			71
72	50.64			84.41			118.17			72
73	54.55			90.92			127.29			73
74	58.62			97.70			136.78			74
75	63.00			105.00			147.00			75
76	67.59			112.66			157.73			76
77	72.45			120.76			169.06			77
78	77.63			129.38			181.14			78
79	83.07			138.45			193.83			79
80	88.61			147.69			206.76			80

† Face Amount is insufficient to require the minimum planned premium.

Solve for Target Premium – A100

* Guaranteed values are based on the minimum interest rate of 3.00% and maximum fees and charges. Non-Guaranteed values are based on a current illustrated interest rate of 5.25% and current fees and charges and are not guaranteed. Values are affected by the actual interest rates credited and cost of insurance rates charged. WML and WMD not included in Issue Ages 56+. Issue Ages 66+ do not include the ADD Rider. TI, LBR, EXT, RES not included in Issue Ages 76+. The Child Term Rider may be added for additional premium of $1.15 BiWeekly26 per $10,000.

A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

4/11/2016

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

Issue State: DE Ver: 3.0.0.2406

TransElite HFA - Universal Life Insurance

With Riders: TI, WML, ADD

Non-Tobacco

Death Benefit Option: A

TRANSAMERICA Employee Benefits

Issue Age	$50,000 Face Amount			$60,000 Face Amount			$75,000 Face Amount			Issue Age
	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	
16	8.03	0		9.63	0		12.04	0		16
17	8.21	0		9.85	0		12.31	0		17
18	8.40	0		10.08	0		12.60	0		18
19	8.58	0		10.29	0		12.87	0		19
20	8.77	0	8,823	10.53	0	10,606	13.16	0	13,245	20
21	9.20	0		11.04	0		13.80	0		21
22	9.43	0		11.32	0		14.15	0		22
23	9.66	0		11.59	0		14.49	0		23
24	9.89	0		11.88	0		14.85	0		24
25	10.16	0	8,554	12.19	0	10,258	15.24	283	12,840	25
26	10.42	0		12.51	12		15.64	539		26
27	10.71	0		12.85	243		16.07	799		27
28	11.01	85		13.21	462		16.51	1,027		28
29	11.32	260		13.58	649		16.98	1,258		29
30	11.65	428	8,158	13.98	847	9,793	17.48	1,478	12,251	30
31	12.27	625		14.73	1,072		18.41	1,746		31
32	12.66	806		15.19	1,258		18.99	1,954		32
33	13.07	967		15.69	1,452		19.61	2,181		33
34	13.50	1,120		16.20	1,610		20.26	2,371		34
35	13.97	1,284	7,742	16.76	1,784	9,268	20.95	2,560	11,594	35
36	14.44	1,405		17.33	1,927		21.66	2,712		36
37	14.96	1,538		17.95	2,079		22.44	2,892		37
38	15.62	1,642		18.75	2,195		23.44	3,022		38
39	16.24	1,804		19.48	2,358		24.36	3,223		39
40	16.83	1,882	7,055	20.19	2,445	8,453	25.24	3,309	10,575	40
41	17.70	1,956		21.24	2,533		26.55	3,394		41
42	18.41	2,067		22.08	2,642		27.61	3,528		42
43	19.27	2,122		23.12	2,709		28.91	3,600		43
44	20.03	2,183		24.03	2,766		30.04	3,652		44
45	20.82	2,221	6,190	24.98	2,805	7,423	31.23	3,692	9,287	45
46	21.79	2,229		26.15	2,811		32.69	3,682		46
47	22.84	2,238		27.41	2,812		34.26	3,670		47
48	24.06	2,261		28.88	2,832		36.10	3,685		48
49	25.26	2,218		30.32	2,774		37.90	3,597		49
50	26.74	2,166	5,002	32.09	2,700	6,007	40.11	3,494	7,505	50
51	28.12	2,112		33.75	2,627		42.18	3,394		51
52	29.60	2,053		35.52	2,546		44.40	3,285		52
53	31.09	1,858		37.32	2,309		46.65	2,978		53
54	32.77	1,888		39.32	2,330		49.15	2,997		54
55	34.43	1,861	3,683	41.32	2,291	4,419	51.65	2,939	5,524	55
56	36.38	1,469		43.66	1,816		54.58	2,337		56
57	38.65	958		46.39	1,198		57.98	1,552		57
58	41.30	545		49.57	695		61.96	917		58
59	44.30	151		53.17	216		66.46	310		59
60	47.51	0	636	57.01	0	764	71.27	0	956	60
61	51.24	0		61.49	0		76.86	0		61
62	55.54	0		66.65	0		83.32	0		62
63	60.01	0		72.01	0		90.01	0		63
64	65.18	0		78.22	0		97.77	0		64
65	71.04			85.26			106.57			65
66	75.88			91.06			113.82			66
67	81.34			97.61			122.01			67
68	86.97			104.37			130.46			68
69	92.78			111.34			139.17			69
70	99.11			118.94			148.68			70
71	107.92			129.50			161.88			71
72	117.42			140.91			176.13			72
73	127.63			153.16			191.45			73
74	138.54			166.26			207.82			74
75	150.51			180.61			225.77			75
76	163.01			195.61			244.52			76
77	176.57			211.88			264.85			77
78	191.00			229.20			286.50			78
79	206.49			247.79			309.73			79
80	222.86			267.43			334.29			80

Solve for Target Premium -- A100

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A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

4/11/2016

Underwritten by Transamerica Life Insurance Company, Home Office: Cedar Rapids, IA

Issue State: DE Ver: 3.0.0.2406

TransElite HFA - Universal Life Insurance

With Riders: TI, WML, ADD

Tobacco

Death Benefit Option: A

TRANSAMERICA
Employee Benefits

Issue Age	$50,000 Face Amount			$60,000 Face Amount			$75,000 Face Amount			Issue Age
	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	
16	10.73	0		12.87	0		16.09	0		16
17	11.02	0		13.23	0		16.54	0		17
18	11.34	0		13.61	0		17.02	0		18
19	11.65	0		13.98	0		17.48	0		19
20	11.97	0	12,480	14.36	0	14,955	17.96	0	18,758	20
21	12.56	0		15.08	0		18.85	0		21
22	12.91	0		15.49	0		19.37	0		22
23	13.28	0		15.94	0		19.93	0		23
24	13.69	0		16.44	0		20.54	0		24
25	14.08	0	12,039	16.90	0	14,470	21.13	0	18,097	25
26	14.52	0		17.43	0		21.79	0		26
27	15.11	0		18.13	0		22.67	0		27
28	15.59	0		18.70	0		23.38	0		28
29	16.21	0		19.45	0		24.32	0		29
30	16.76	0	11,544	20.11	0	13,853	25.14	0	17,338	30
31	17.56	0		21.07	0		26.34	18		31
32	18.18	0		21.82	4		27.28	423		32
33	18.96	7		22.75	318		28.44	795		33
34	19.66	271		23.60	637		29.50	1,170		34
35	20.41	549	10,840	24.49	940	13,005	30.62	1,536	16,266	35
36	21.29	743		25.56	1,177		31.95	1,807		36
37	22.27	997		26.73	1,451		33.41	2,138		37
38	23.26	1,175		27.91	1,653		34.90	2,378		38
39	24.44	1,385		29.33	1,894		36.66	2,650		39
40	25.55	1,554	9,757	30.66	2,078	11,709	38.32	2,857	14,625	40
41	26.72	1,705		32.07	2,251		40.09	3,070		41
42	28.04	1,834		33.65	2,393		42.06	3,226		42
43	29.48	1,948		35.38	2,516		44.22	3,365		43
44	30.93	1,990		37.12	2,556		46.40	3,403		44
45	32.51	2,071	8,313	39.01	2,633	9,968	48.77	3,492	12,469	45
46	34.21	2,106		41.05	2,669		51.32	3,522		46
47	36.00	2,139		43.20	2,699		54.01	3,547		47
48	37.86	2,136		45.44	2,690		56.80	3,516		48
49	39.83	2,109		47.79	2,639		59.74	3,443		49
50	42.04	2,018	6,509	50.45	2,524	7,808	63.06	3,285	9,762	50
51	44.36	1,895		53.23	2,369		66.54	3,080		51
52	46.79	1,745		56.15	2,182		70.18	2,833		52
53	49.33	1,571		59.19	1,959		73.99	2,547		53
54	52.06	1,624		62.47	2,018		78.09	2,611		54
55	54.86	1,648	4,555	65.83	2,038	5,465	82.29	2,626	6,832	55
56	58.03	1,270		69.64	1,580		87.06	2,046		56
57	61.62	770		73.94	972		92.42	1,274		57
58	65.75	429		78.90	554		98.62	743		58
59	70.39	119		84.48	179		105.60	266		59
60	75.33	0	1,235	90.40	0	1,483	113.00	0	1,853	60
61	80.09	0		96.11	0		120.14	0		61
62	85.26	0		102.32	0		127.90	0		62
63	91.05	0		109.26	0		136.57	0		63
64	97.14	0		116.57	0		145.71	0		64
65	103.47			124.16			155.20			65
66	112.67			135.20			169.01			66
67	120.24			144.29			180.36			67
68	128.34			154.00			192.50			68
69	136.43			163.72			204.65			69
70	144.88			173.86			217.32			70
71	156.50			187.80			234.75			71
72	168.82			202.58			253.23			72
73	181.85			218.22			272.77			73
74	195.40			234.48			293.10			74
75	210.01			252.01			315.01			75
76	225.32			270.39			337.98			76
77	241.52			289.82			362.28			77
78	258.77			310.52			388.15			78
79	276.89			332.28			415.35			79
80	295.38			354.45			443.07			80

Solve for Target Premium – A100

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4/11/2016

Underwritten by Transamerica Life Insurance Company, Home Office: Cedar Rapids, IA

Issue State: DE Ver: 3.0.0.2406

TransElite HFA - Universal Life Insurance

With Riders: TI, WML, ADD

Non-Tobacco

Death Benefit Option: A

TRANSAMERICA
Employee Benefits

Issue Age	$100,000 Face Amount			$125,000 Face Amount			$150,000 Face Amount			Issue Age
	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	
16	16.05	0		20.07	0		24.08	0		16
17	16.42	0		20.52	0		24.63	0		17
18	16.80	0		21.00	0		25.20	0		18
19	17.16	0		21.45	0		25.74	0		19
20	17.55	0	17,693	21.94	0	22,115	26.33	448	26,586	20
21	18.40	0		23.00	189		27.60	722		21
22	18.86	66		23.58	692		28.30	1,294		22
23	19.32	410		24.15	1,065		28.98	1,743		23
24	19.80	722		24.75	1,448		29.70	2,173		24
25	20.32	1,063	17,109	25.40	1,853	21,395	30.48	2,643	25,681	25
26	20.85	1,358		26.06	2,197		31.27	3,027		26
27	21.42	1,683		26.78	2,586		32.13	3,470		27
28	22.02	1,987		27.53	2,957		33.03	3,890		28
29	22.64	2,256		28.30	3,246		33.96	4,252		29
30	23.31	2,520	16,330	29.14	3,571	20,422	34.97	4,629	24,527	30
31	24.55	2,852		30.69	3,966		36.83	5,079		31
32	25.32	3,117		31.65	4,265		37.98	5,428		32
33	26.15	3,387		32.69	4,594		39.23	5,793		33
34	27.01	3,609		33.76	4,846		40.52	6,104		34
35	27.93	3,836	15,447	34.92	5,137	19,336	41.90	6,413	23,189	35
36	28.89	4,037		36.11	5,356		43.33	6,669		36
37	29.93	4,257		37.41	5,605		44.89	6,959		37
38	31.25	4,396		39.06	5,770		46.87	7,139		38
39	32.47	4,633		40.60	6,063		48.72	7,487		39
40	33.65	4,736	14,097	42.07	6,172	17,631	50.49	7,609	21,165	40
41	35.40	4,837		44.25	6,280		53.10	7,723		41
42	36.81	4,988		46.02	6,462		55.22	7,927		42
43	38.54	5,062		48.18	6,540		57.82	8,014		43
44	40.06	5,129		50.07	6,601		60.08	8,070		44
45	41.64	5,163	12,385	52.05	6,630	15,478	62.46	8,097	18,571	45
46	43.59	5,132		54.48	6,578		65.38	8,028		46
47	45.69	5,104		57.12	6,541		68.54	7,969		47
48	48.13	5,106		60.17	6,527		72.20	7,948		48
49	50.53	4,976		63.17	6,355		75.80	7,731		49
50	53.48	4,825	10,011	66.85	6,154	12,514	80.22	7,479	15,014	50
51	56.25	4,680		70.31	5,958		84.37	7,239		51
52	59.21	4,520		74.01	5,750		88.81	6,981		52
53	62.20	4,093		77.75	5,209		93.30	6,324		53
54	65.54	4,108		81.92	5,217		98.31	6,327		54
55	68.86	4,016	7,366	86.08	5,095	9,208	103.30	6,176	11,053	55
56	72.78	3,204		90.97	4,069		109.16	4,932		56
57	77.32	2,148		96.65	2,743		115.98	3,337		57
58	82.61	1,287		103.27	1,659		123.92	2,030		58
59	88.61	467		110.77	627		132.92	784		59
60	95.02	0	1,274	118.78	0	1,593	142.54	0	1,912	60
61	102.48	0		128.10	0		153.73	0		61
62	111.09	0		138.86	0		166.64	0		62
63	120.02	0		150.03	0		180.03	0		63
64	130.36	0		162.96	0		195.55	0		64
65	142.09			177.62			213.14			65
66	151.77			189.71			227.65			66
67	162.68			203.35			244.02			67
68	173.94			217.44			260.92			68
69	185.56			231.95			278.34			69
70	198.23			247.80			297.35			70
71	215.84			269.80			323.76			71
72	234.85			293.56			352.27			72
73	255.27			319.08			382.90			73
74	277.09			346.37			415.64			74
75	301.03			376.29			451.55			75
76	326.03			407.53			489.04			76
77	353.14			441.42			529.70			77
78	382.00			477.50			573.00			78
79	412.98			516.23			619.47			79
80	445.72			557.15			668.58			80

Solve for Target Premium – A100

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4/11/2016

Underwritten by Transamerica Life Insurance Company, Home Office: Cedar Rapids, IA

Issue State: DE Ver: 3.0.0.2406

TransElite HFA - Universal Life Insurance

With Riders: TI, WML, ADD

Tobacco

Death Benefit Option: A

TRANSAMERICA
Employee Benefits

Issue Age	$100,000 Face Amount			$125,000 Face Amount			$150,000 Face Amount			Issue Age
	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	BiWeekly26 Premium	Guaranteed Cash Value at Age 65*	Current Cash Value at Age 65*	
16	21.46	0		26.82	0		32.19	0		16
17	22.05	0		27.56	0		33.07	0		17
18	22.69	0		28.37	0		34.04	0		18
19	23.31	0		29.14	0		34.97	0		19
20	23.94	0	25,012	29.93	0	31,291	35.92	0	37,545	20
21	25.13	0		31.42	0		37.70	0		21
22	25.83	0		32.29	0		38.75	0		22
23	26.57	0		33.22	0		39.86	0		23
24	27.39	0		34.25	0		41.09	0		24
25	28.17	0	24,117	35.22	0	30,175	42.26	0	36,195	25
26	29.05	0		36.32	0		43.58	0		26
27	30.22	0		37.78	0		45.33	0		27
28	31.18	0		38.97	0		46.76	0		28
29	32.43	0		40.54	34		48.65	426		29
30	33.53	195	23,144	41.91	687	28,910	50.29	1,188	34,689	30
31	35.12	602		43.90	1,178		52.68	1,770		31
32	36.37	1,122		45.47	1,821		54.56	2,520		32
33	37.92	1,582		47.41	2,384		56.89	3,179		33
34	39.33	2,061		49.17	2,959		59.00	3,850		34
35	40.82	2,516	21,681	51.03	3,503	27,107	61.24	4,498	32,542	35
36	42.59	2,844		53.25	3,908		63.90	4,958		36
37	44.55	3,272		55.69	4,419		66.83	5,554		37
38	46.53	3,569		58.16	4,761		69.79	5,952		38
39	48.88	3,905		61.10	5,170		73.32	6,430		39
40	51.10	4,170	19,508	63.87	5,479	24,383	76.65	6,798	29,273	40
41	53.45	4,419		66.82	5,784		80.18	7,139		41
42	56.08	4,612		70.10	6,008		84.12	7,395		42
43	58.96	4,777		73.70	6,198		88.44	7,610		43
44	61.87	4,819		77.34	6,227		92.81	7,644		44
45	65.02	4,909	16,621	81.28	6,330	20,778	97.54	7,755	24,939	45
46	68.42	4,932		85.53	6,345		102.64	7,762		46
47	72.01	4,949		90.01	6,347		108.02	7,756		47
48	75.73	4,893		94.67	6,270		113.60	7,644		48
49	79.66	4,784		99.57	6,118		119.49	7,459		49
50	84.08	4,555	13,018	105.11	5,828	16,277	126.13	7,098	19,533	50
51	88.72	4,267		110.90	5,451		133.08	6,636		51
52	93.58	3,923		116.97	5,009		140.37	6,099		52
53	98.66	3,527		123.33	4,509		147.99	5,487		53
54	104.12	3,596		130.15	4,582		156.18	5,569		54
55	109.72	3,603	9,108	137.16	4,585	11,389	164.58	5,560	13,663	55
56	116.08	2,818		145.09	3,588		174.12	4,363		56
57	123.23	1,777		154.04	2,280		184.85	2,785		57
58	131.49	1,057		164.37	1,372		197.24	1,687		58
59	140.79	409		175.99	554		211.19	698		59
60	150.66	0	2,470	188.34	0	3,090	226.00	0	3,706	60
61	160.19	0		200.23	0		240.28	0		61
62	170.53	0		213.17	0		255.80	0		62
63	182.10	0		227.62	0		273.15	0		63
64	194.28	0		242.85	0		291.42	0		64
65	206.94			258.67			310.41			65
66	225.35			281.68			338.02			66
67	240.48			300.60			360.72			67
68	256.68			320.84			385.01			68
69	272.87			341.09			409.31			69
70	289.76			362.21			434.65			70
71	313.00			391.26			469.50			71
72	337.64			422.05			506.47			72
73	363.70			454.62			545.55			73
74	390.80			488.51			586.20			74
75	420.02			525.03			630.03			75
76	450.65			563.31			675.98			76
77	483.04			603.80			724.56			77
78	517.54			646.92			776.31			78
79	553.79			692.25			830.70			79
80	590.76			738.45			886.14			80

Solve for Target Premium – A100

* Guaranteed values are based on the minimum interest rate of 3.00% and maximum fees and charges. Non-Guaranteed values are based on a current illustrated interest rate of 5.25% and current fees and charges and are not guaranteed. Values are affected by the actual interest rates credited and cost of insurance rates charged. WML and WMD not included in Issue Ages 56+. Issue Ages 66+ do not include the ADD Rider. TI, LBR, EXT, RES not included in Issue Ages 76+. The Child Term Rider may be added for additional premium of $1.15 BiWeekly26 per $10,000.

A detailed illustration will be provided on delivery of a contract or earlier if requested. This is a quotation, not a contract.

4/11/2016

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

Issue State: DE Ver: 3.0.0.2406

HFA **TransElite HFA – Universal Life Insurance:** HFA policies have flexible premiums and an accumulation value to provide the greatest death benefit amount per premium dollar and are ideal for those who want a higher death benefit, but are not interested in a high cash value accumulation. The premium is expected to provide coverage to the later of age 80 or 10 years, with no cash value expected at the coverage period's end. HFA policies have a minimum guaranteed interest rate and a maximum guaranteed cost of insurance. The premium is expected to sustain the policy to the later of age 80, or 10 years - however, skipped or reduced premium payments, changes in the non-guaranteed interest rate or charges, or acquiring a policy loan, a partial surrender, or a face amount increase could require additional payments. Coverage may be extended to age 100 and could require additional payments.

TI **Accelerated Death Benefit for Terminal Illness Rider (Form CRLTI100):** Lets the insured "tap into" life insurance in the event of a future terminal illness diagnosis and still provides a benefit for the beneficiary.

WML **Waiver of Monthly Deductions Due to Layoff or Strike Rider (Form CRLWL100):** Protects life insurance from lapsing for up to six months if the insured (employee only) is involuntarily laid off.

ADD **Accidental Death and Dismemberment Rider (Form CRLAD100):** Provides an additional death benefit if the insured employee or spouse dies as the result of an accidental bodily injury. A specified percentage (25% to 100%) of the accidental death benefit, is payable for specific dismemberments caused by a covered accidental bodily injury. As an added benefit under the rider, where permitted, we will pay 3% of the AD&D death benefit-up to $3,500-for qualified elder care, surviving spouse job training, surviving child education, and surviving child care. The AD&D benefit amount is the same as the face amount of the base Certificate, up to a maximum AD&D coverage amount of $150,000. (This benefit is in addition to any life insurance death benefit.)

TRANSAMERICA®

TransElite℠ universal life insurance, underwritten by Transamerica Life Insurance Company

Child Rate Sheet

Monthly Premium for $25,000 Child/Grandchild Coverage

AGE	Policy Monthly	Policy Bi-Weeky Premium
0	$13.00	$6.00
1	$13.00	$6.00
2	$13.00	$6.00
3	$13.00	$6.00
4	$13.00	$6.00
5	$13.00	$6.00
6	$13.00	$6.00
7	$13.00	$6.00
8	$13.00	$6.00
9	$13.00	$6.00
10	$13.00	$6.00
11	$13.26	$6.12
12	$13.69	$6.32
13	$14.29	$6.60
14	$14.74	$6.80
15	$15.36	$7.09
16	$15.64	$7.22
17	$15.92	$7.35
18	$16.22	$7.49
19	$16.52	$7.62
20	$16.85	$7.78
21	$17.18	$7.93
22	$17.55	$8.10
23	$17.93	$8.28
24	$18.33	$8.46
25	$18.75	$8.65
26	$19.21	$8.87

Policy includes Accelerated Death Benefit for Terminal Illness Rider.
WPL - Waiver of Monthly Deduction for Layoff or Strike Rider
CCR - Critical Care Condition Rider
WMD - Waiver of Month Deductions for Total Disability Rider

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

TransElite Universal Life Application

☐ First Application ☐ Add Dependents – Contract # _____ ☐ Increase Coverage – Contract # _____

Group Name | Group Number | Location

Applicant Information
required for all coverage

Name *(Last, First, M.I.)*	☐ Male ☐ Female	Social Security No.	Date of birth	Cell or home phone
Home address		City	State	Zip code
Email address	Do you agree to receive correspondence about your coverage electronically? ☐ Yes ☐ No		Tobacco user in the last year? ☐ No ☐ Yes *Answer if rates are tobacco distinct.*	
Date of hire / Weekly hours worked	Annual salary	Occupation	Applicant ID	Work phone/ext.

Protection against unintended lapse: I understand I have the right to designate at least one person other than myself to receive notice of lapse or termination of this coverage for nonpayment of premium. I understand notice will not be given until thirty days after premium is due and unpaid.
☐ I elect **NOT** to designate any person to receive such notice.

Secondary Addressee Name	Home Address	City	State	Zip code

Dependent Information
if applying for dependent coverage

Name *(Last, First, M.I.)*	Gender	Relationship to applicant	Date of birth	Social Security No.	Tobacco user in the last year? *Answer for Spouse or Civil Union/Domestic Partner**
	☐ M ☐ F				☐ No ☐ Yes
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				
	☐ M ☐ F				

Beneficiary

Name *(Last, First, M.I.)*	Address	Relationship	Phone #	Social Security No.
Primary				
Contingent				

Applicant will be the beneficiary for any dependent coverage

Benefit Selections

Premium Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Universal Life

☐ **TransElite Universal Life** Option: ☐ A (level) ☐ B (increasing)	Universal Life Face Amount	Automatic Increase Option Rider	Premium
☐ Applicant	$	☐ Yes ☐ No	$
☐ Spouse or Civil Union/Domestic Partner	$	☐ Yes ☐ No	$
☐ Children	$		$
*Attach Child Term Rider to ☐ Applicant ☐ Spouse or Civil Union/Domestic Partner			$

Term Rider* Face Amount	Premium
$	$
$	$
$	$
	$

Dependents can be covered under UL or Term Rider, but not both

Total Premium $

Life Insurance Owner (if different than Applicant)	Address	Relationship	Social Security No.

**The terms "Civil Union" or "Domestic Partner" are not recognized in all states.*

Eligibility Questions

1. *Employer Groups:* Are you actively at work on a full-time basis and able to perform the duties of your occupation? *Member Groups:* Are you a member in good standing and able to perform the normal activities of someone of like age? If "no", you and your dependents are not eligible for coverage.	☐ No ☐ Yes
2. If applying for dependent coverage, is any proposed insured currently disabled? If "yes", list names _____, who are not eligible for coverage.	☐ No ☐ Yes

If you answer "no" to question #1, no coverage will be issued. Anyone named as being ineligible on question 2 will be automatically excluded from coverage.*
**Residents of MD and NH cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions Part 1: Please answer the following questions to the best of your knowledge and belief.	
3. In the past six months, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any accident or sickness, except for normal pregnancy? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes
4. In the past five years, has any proposed insured had an actual diagnosis or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ***(Residents of CA: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.)*** ***(Residents of FL:*** In the past five years, has any proposed insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded – You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

Evidence of Insurability Questions Part 2: Please answer the following questions to the best of your knowledge and belief.	
5. Indicate Height and Weight: Applicant	/
Spouse or Civil Union/Domestic Partner	/
6. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession for any heart (including heart attack), circulatory, vascular (including stroke), blood, brain, digestive, kidney, liver, lung, musculoskeletal, respiratory, rheumatoid, neurological, pancreas, reproductive, or other major organ disorders, cancer or malignancy in any form (except non-melanoma skin cancer), diabetes, Optic Neuritis, blood transfusion, chronic fatigue syndrome, fibromyalgia, high blood pressure requiring more than two medications to control, or been treated or counseled in the past two years for alcohol or drug abuse? ***(Residents of FL:*** *diagnosed or treated by a licensed physician)* ***(Residents of ME:*** *exclude HIV related diseases)* If "yes", list names _____, who do not qualify for coverage.	☐ No ☐ Yes

Anyone named as not qualifying for coverage will have coverage reduced to the Guaranteed Issue amount, or, if Guaranteed Issue is not available, will be excluded from coverage.*
**Residents of MD cannot be automatically excluded - You must sign an endorsement form acknowledging these exclusions before coverage can be issued.*

For further consideration for anyone who fails to qualify for coverage above, provide details of all "yes" answers to questions 2, 3, 4, & 6.
*(**Residents of FL:** Do NOT provide details regarding "yes" answers to question 4)*
Anyone found to be acceptable will be added to your coverage via an endorsement.

Question #	Name	Please list: Illness, Injury, Condition, Medication, Date of last Treatment, Date Condition Diagnosed, Duration, Result, Current Health Status, Prognosis, Name & Address of Doctor or Hospital. For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

Life Replacement

Residents of AL, AK, AZ, CO, HI, IA, LA, MD, ME, MS, MT, NC, NE, NH, NJ, NM, OH, OR, RI, SC, SD, TX, UT, VA, VT, WI, or WV:
Answer question L1. If "yes", complete a life replacement form for your state and return with this application.

Residents of AR: Answer questions L1 and L2. If "yes" to question L2, complete a life replacement form for your state and return with this application.

Residents of all other states: Answer question L2. If "yes", complete a life replacement form for your state and return with this application.

L1. Do you currently have any other existing life insurance policies or contracts? ☐ No ☐ Yes

L2. Is the insurance being applied for intended to replace or change any existing life insurance coverage? ☐ No ☐ Yes (provide details)

Which product(s)	Name of existing insurance company	Policy/certificate #

Universal Life and Whole Life Illustration Acknowledgement

I certify that a life insurance illustration showing non-guaranteed values was not used during the sale of the insurance coverage I am applying for on this application. I understand that if my application is approved, an illustration conforming to the policy/certificate as issued will be delivered to me no later than when I receive my policy/certificate. I understand that any non-guaranteed elements contained in any illustration are subject to change and could be either higher or lower and that they are not guaranteed. I will review the illustration, sign the acknowledgment, and will return a copy of the signed illustration to the Insurer.

Life Accelerated Death Benefit Disclosure Acknowledgement

If applying for an Accelerated Death Benefit Rider, did you receive the applicable Disclosure, if required in your state?
ADB for Chronic Condition Rider ☐ Yes ☐ No ADB for Critical Condition Rider ☐ Yes ☐ No ADB for Terminal Condition Rider ☐ Yes ☐ No

Applicant Statement and Agreement

I have read or had read to me the completed application. **I represent** ***(Residents of MN and VA: I certify)*** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief. **I 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.

AL, DC, LA, & RI: **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.**

CA: I understand that any false statement made with actual intent to deceive or which materially affects either the acceptance of the risk or the hazard assumed could bar the right to receive benefits under the policy to which this application is attached.

FL: **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.**

KS: **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.**

KY: **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.**

MA, NC & OR: **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.**

MD: **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.**

NJ: **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.**

OK: **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.**

TN & WA: **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.**

VA: **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.**

VT: **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.**

***ME* 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.**

I understand that completion of this application in no way implies that I will be accepted for insurance coverage. **I understand** that coverage will take effect only if this application is approved by the Insurer and the first month's premium has been received by the Insurer, provided that I meet any eligibility or coverage effective date requirements listed in the policy/certificate to which this application is attached.

Signed in (City/State) _____ Date: _____

Signatures _____ _____

Applicant Adult Dependents (where required)

Licensed Agent/Representative Statement and Agreement

I certify that I have accurately recorded on this application all of the information supplied by the applicant. The applicant has read or had read to him/her the completed application.

I certify that this insurance does not replace or change any existing life insurance coverage, except as noted under Life Replacement.

(For applications written in North Carolina – *To the best of your knowledge, does any applicant currently have any other existing life insurance policies or contracts?* ☐ *No* ☐ *Yes If yes, be sure the applicant completes a life replacement form for your state and return with this application.*

(For applications written in Utah – I certify *that I am not aware of any existing life insurance coverage, except as noted under Life Replacement.)*

I certify that a life insurance illustration **was not** used in connection with this application (but a company-provided rate sheet may have been used and no non-guaranteed values were shown to the applicant)

I certify that I have provided any applicable outline of coverage and life accelerated death benefit disclosure forms.

Name _____ Signature _____ Agent # _____ License # _____

Authorization to Release Information

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 Insurer, or its reinsurers, any such information.

***Residents of MN**: This authorization excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. Emergency medical personnel includes individuals employed to provide pre-hospital emergency services; licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards (including security guards at the Minnesota security hospital) who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency or while an injured person is being transported to receive medical care and who would qualify for immunity under the good Samaritan Law.*

I hereby authorize Transamerica Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to the Medical Information Bureau*. **I understand** the information obtained by use of this Authorization will be used by Insurer to determine eligibility for insurance. Any information obtained will not be released by Insurer 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, or any person authorized by me, 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 24 months from the date shown below. *(**Residents of MN: I agree** that this Authorization shall be valid as long as any proposed insured is continually insured with Transamerica Life Insurance Company.)* I understand that I may revoke this authorization at any time by sending written notice to Transamerica Life Insurance Company.

Signed in (City/State) _____ Date: _____ Signatures _____ _____
Applicant Adult Dependents

*Information regarding your insurability will be treated as confidential. The Insurer, 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. 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734, telephone number 866-692-6901 (TTY 866-346-3642 for hearing impaired). Insurer, 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.