TRANSAMERICA®
FINANCIAL LIFE INSURANCE COMPANY

RESET

LONG TERM CARE
WORKSITE
SERVICE GROUP REQUEST FORM

Section I: GENERAL INFORMATION

Employer/Worksite Name: _____
(As it should appear on all correspondence)

Industry or Nature of Worksite: _____ Year Established: _____

Street Address: _____

City/State/Zip: _____

Employer Contact Person: _____ Title: _____

Phone: _____ Fax: _____

Email: _____ Website: http:// _____

Section II: WORKSITE INFORMATION (Attach Census/See Section VI for details)

Total Number of Employees _____

Minimum number of hours worked in a week to be considered Full-Time & able to receive Company paid benefits _____

If less than 30 - supporting documentation required (< 20 not allowed)

Is the offer of LTCi to employees intended to be an ERISA Plan? ☐ Yes ☐ No

Has this Worksite been offered any kind of Individual or Group LTCi Coverage within the last 5 years? ☐ Yes ☐ No

If yes, please provide details for the following: Company Offered, Year Offered, Number of Employees who purchased product, Benefit Plan Purchased

_____

_____

_____

Does this Worksite have a 401(k) plan in place? ☐ Yes ☐ No If yes, provide % of employees participating in the plan: _____

Proposed Open Enrollment Dates: Start Date: _____ End Date: _____

Where policies should be mailed: ☐ Agent ☐ Employee ☐ Other _____

Please select the billing method(s)? ☐ Individual Direct Bill
☐ List Bill/Payroll Deduction **(If selected, complete billing addendum)**

Section III: WORKSITE TYPE (If multiple worksites types being used complete all details)

Worksite Plan Options:

EX - Executive Advantage Program

- **The employer pays 100% of premium for a single benefit plan for all employees or for all employees in a defined class**
- **Employer must fund a minimum benefit pool of $50,000**
- **Step Rated Benefit Increase Option available (must be indicated in the benefits section below)**
- **No buy ups are allowed**
- **Minimum class size of 5 employees**

ES - Corporate Advantage Program

- **Employer must pay for a minimum pool of benefits equal to $50,000**
- **Core benefit must be the same for all members of any defined class**
- **Step Rated Benefit Increase Option is NOT available**
- **Minimum class size of 5 employees**
- **Buy ups are allowed**

EV - Employee Advantage Program

- **Available for either all or a defined class(es) of employees**
- **Employer funding a minimum benefit pool of less than $50,000**
- **Step Rated Benefit Increase Option available (must be indicated in the benefits section below)**

Defined class(es) must follow generally accepted, well defined groupings. (i.e. job titles, income grouping, management/non-management, etc.)

Each defined class must be clearly identified on the census

Number of Defined Classes: ☐ 1 ☐ 2 ☐ 3 ☐ Other_____

Please indicate in the boxes below, the proposed minimum and maximum benefit package(s). Provide the Daily Benefit Amount, Max Benefit Pool and Elimination Period desired. Example: $50 DB/ $36,500/ 90 day EP

Maximum and minimum plan cannot exceed a 5 times spread for all classes (e.g. Min Plan $80 DB/2 yrs BP = 80 x 365 x 2 = $58,400, therefore, the Max plan cannot exceed $292,000)

	Class Description	Plan Type (EX, ES, EV)	Proposed Minimum Plan	Proposed Maximum Plan	# in Class	Employer Funding (Y/N)
Class 1						
Class 2						
Class 3						
Class 4						
Class 5						

If Employer Funding is Y, additional information is required in the Billing Addendum

Indicate the type of underwriting requested: **Employee** ☐ SI ☐ AA ☐ Full ☐ MGI* **Spouse** ☐ AA ☐ Full
(* **Home Office approval required prior to submission**)

Section IV: AGENT INFORMATION

Agent/Enroller Name (please print):_____ LTC Agent Number:_____

Agent Address:_____

Phone:_____ Fax:_____ Email Address:_____

Agent Licensing Contact Name:_____ Contact Number:_____

During the enrollment, who should Transamerica communicate with regarding outstanding items?

☐ Agent ☐ GA ☐ Other _____

Marketing Organization:_____ GA Name:_____ GA Contact Email:_____

Transamerica LTC Regional SD Name:_____ Email Address:_____

TEB Regional VP Name (if applicable):_____ Email (if applicable): _____

Section V: MARKETING PLAN

Is the enrollment being done in conjunction with any other benefit enrollment? ☐ Yes ☐ No

If yes, what other products are being offered during this enrollment period?

☐ Life ☐ Health ☐ Disability ☐ 401(k) ☐ Other _____

Are there multiple states you plan to market? ☐ Yes ☐ No If Yes, list the States_____

Will the employer allow employee education? ☐ Yes ☐ No

If yes, will the employer allow (check all that apply): ☐ Prior to Enrollment ☐ During Enrollment

Which education methods will be used (check all that apply): ☐ Direct Mail ☐ Email ☐ Company newsletter ☐ Web Based Education

Meetings: ☐ Mandatory ☐ Voluntary

Will the employer allow enrollment during company time? ☐ Mandatory ☐ Voluntary ☐ None

Please attach a copy of the marketing plan details.

Section VI: CENSUS INFORMATION

Minimum Census information to be included with this Service Group Request Form: (Must be in Electronic Media Format)

Last Name, First Name **or** Employee ID*	Salary	Hire Date	Date of Birth	Gender
Classification (Full-Time, Part-Time)	Job Title	Resident State	Marital Status**	Last 4 of SSN***

*** If Employer Funding, full name is required**
**** If captured, provide the information**
***** Required for electronic enrollment only**

Section VII: ENROLLMENT INFORMATION

Please select the enrollment method(s)?

☐ Paper ☐ Electronic (Typically not available for worksite cases of less than **25** lives)

Please select what if any enrollment support that will be used or is needed?

☐ National Sales Desk ☐ Enrollers Hired by Home Office ☐ Enrollers Hired by Writing Agent

Section VIII: RE-ENROLLMENT INFORMATION

If the initial enrollment participation requirement is met, re-enrollment will be available for future enrollees.

Re-Enrollment Options:

Annual Re-Enrollment

- Employees must have been continuously employed on a full-time basis for at least 6 months with the sponsoring employer at time of application
- The original underwriting level will not necessarily be offered with this option
- Full Underwriting may also be available at any time to applicants, who do not meet the MGI, SI, and AA criteria or who wish to apply outside of the approved Annual Re-enrollment period
- Re-Enrollment Service Group Request form and census must be submitted to the Home Office for review 90 days prior to proposed OEP

New Hire Rule (Available for new hires only)

- New employees that become eligible can apply for coverage using the same underwriting (MGI, SI or AA)
- New employee must apply within 30 days after they have reached 6 months of continuous employment with sponsoring employer. Application must be submitted within 15 days of the 30 day window
- Once the 30 day period has passed, the employee will be subject to Full Underwriting
- Home Office reserves the right to request a census annually for Worksites that select this option

Full Underwriting

- Full Underwriting is available to new and current employees subject to the Employer's enrollment policies and Home Office agreement.

If a re-enrollment option is not selected, it will default to Full Underwriting.

Please select the re-enrollment type requested: ☐ Annual Re-enrollment ☐ New Hire Rule ☐ Full Underwriting ☐ None

Section IX: EMPLOYER/ORGANIZATION COMMITMENT

It is understood and agreed that by the Employer/Organization allowing and facilitating active marketing, applicants may be eligible for a premium discount, to be determined by Transamerica, on currently available Long Term Care insurance premium rates. The available benefit features and premium rates that may be offered have been reviewed and approved by the employer. The purpose of this document is to obtain a final insurance proposal from Transamerica. It is understood and agreed that Transamerica's actual insurance offering may be different than the requested plans and will be documented in a formal Implementation Memo. Once Transamerica has made an offer, if the Employer/Organization requests any changes that alter the parameters, demographics, characteristics or risks, Transamerica reserves the right to change or adjust the offer in its sole discretion. Transamerica reserves the right, without limitation or liability, to (i) change or discontinue any marketing concept, underwriting program or premium discount; (ii) amend, discontinue, or stop selling any Policy; (iii) change any Policy premium rate; (iv) change the conditions or terms under which any Policy is offered; and/or (v) reject any application for a Policy.

The undersigned Employer/Organization agrees to allow representatives of Transamerica and/or its affiliates to present a Long Term Care insurance product to its employees for the purpose of solicitation and enrollment. The Employer/Organization agrees to take all steps necessary to successfully implement the Long Term Care insurance program, including use of any provided census information. If Executive Advantage or Corporate Advantage, the Employer/Organization agrees to pay the required premium for a period of no less than three years.

It is understood and agreed that Modified Guaranteed Issue, Simplified Issue and Abbreviated Application are subject to minimum participation requirements and that if minimum participation requirements are not met, all applications will be subject to Full-Underwriting standards.

The Employer/Organization shall be solely responsible for establishing and maintaining any employee welfare benefit plan that includes Long Term Care and shall be responsible for compliance with all laws that may be applicable to such employee welfare benefit plan, including but not limited to any provisions of the Employee Retirement Income Security Act of 1974, as amended, Age Discrimination in Employment Act, Patient Protection and Affordable Care Act, and Title VII of the Civil Rights Act of 1964 that may be applicable to the Program. The Employer/Organization shall provide Transamerica with copies of all plan documents, including any amendments, with respect to any such employee welfare benefit plan that includes Long Term Care, and Transamerica shall not be bound by or have any obligations under those plan documents except to the extent set forth in any Long Term Care policies issued by Transamerica.

The information provided to Transamerica concerning the Employer/Organization is true and complete. Transamerica shall have no liability resulting from any of the above Employer/Organization Commitments or any information provided to Transamerica that is incorrect. Transamerica shall hold all personal, non-public information (including financial, health and medical information) regarding applicants for policies (collectively, "Non-Public Information") in confidence and shall only use Non-Public Information in accordance with applicable federal and state laws addressing the privacy of personal, Non-Public Information.

NAME OF AUTHORIZED EMPLOYER/ORGANIZATION OFFICER:_____

TITLE:_____

AUTHORIZED SIGNATURE:_____

DATE:_____

Section X: AGENT/MARKETING COMMENTS OR SPECIAL REQUESTS

I have reviewed the benefit features, premium rates and marketing/enrollment plan with the organization. I understand that the coverage offered by Transamerica may be different from the plans requested by the employer or agent.

I understand that failure to achieve minimum participation requirements may result in the withdrawal of any premium discount for this organization and full underwriting may be applied to all applications received.

AGENT SIGNATURE:_____ **DATE:**_____

SUBMIT FORM TO TRANSAMERICA BUSINESS ADVANTAGE PROGRAM:

Phone: 866-475-6925 **Fax: 855-364-1945** **Email: Multi-LifeSupport@transamerica.com**

BILLING ADDENDUM

Billing Contact Name:_____ Title:_____

Billing Address:_____

Billing City/State/Zip:_____

Billing Phone:_____ Billing Fax:_____

Billing Email Address:_____ Website: http://_____

Payroll Deduction Frequency: ☐ Weekly ☐ Bi-Weekly (26) ☐ Semi-Monthly (24) ☐ Monthly
☐ Other _____
(Please specify frequency and/or number of deductions – identify any months deductions will not occur, if applicable)

Payroll Billing Schedule: ☐ Yes ☐ No If Yes, please attach a copy

Group Remittance Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually ☐ Other (Please specify)_____

Billing Sequence: ☐ Alphabetical ☐ Policy Number ☐ Social Security Number ☐ Employee Identification Number

Billing Format preferred: ☐ Paper ☐ Other (minimum of 100 policyholders)

Who should receive bill? ☐ Group ☐ Third Party Administrator (Will require TPA contract and **Proof of TPA Licensing be submitted with this form**.)

If TPA list Name:_____ TPA Contact:_____

TPA Address:_____

TPA Phone Number:_____ TPA Fax Number:_____

Employer is paying: ☐ All Premium ☐ Percent of Premium _____% ☐ Flat Amount _____ ☐ None
☐ Set Benefit Plan (**if selected outline below**)

If Employer funding, will Employer pay for future premium increases such as Deferred Benefit Increase Option or Step Rated Benefit Increase Option?
☐ Yes ☐ No (Employee will be responsible for future increases by payroll deduction)

	Class Description	Benefit Package Employer Funding **Required: Daily Benefit, Max Benefit Pool, Elimination Period & Riders if applicable (Example: $50 DB/ $36,500/ 90 day EP)**
Class 1		☐ All Premium ☐ Percent of Premium _____% ☐ Flat Amount _____ ☐ None ☐ Benefit Package - _____ DB/ _____ Max Pool/ _____ EP
Class 2		☐ All Premium ☐ Percent of Premium _____% ☐ Flat Amount _____ ☐ None ☐ Benefit Package - _____ DB/ _____ Max Pool/ _____ EP
Class 3		☐ All Premium ☐ Percent of Premium _____% ☐ Flat Amount _____ ☐ None ☐ Benefit Package - _____ DB/ _____ Max Pool/ _____ EP
Class 4		☐ All Premium ☐ Percent of Premium _____% ☐ Flat Amount _____ ☐ None ☐ Benefit Package - _____ DB/ _____ Max Pool/ _____ EP
Class 5		☐ All Premium ☐ Percent of Premium _____% ☐ Flat Amount _____ ☐ None ☐ Benefit Package - _____ DB/ _____ Max Pool/ _____ EP

ALL THIRD PARTY BILLING REQUIRES HOME OFFICE APPROVAL & REQUIRED TPA FORM(S) COMPLETED.

LIST BILL/PAYROLL DEDUCTION INSTRUCTIONS:
Five Applicants are Required and No Premium Collected at Time of Application.
Transamerica Home Office will coordinate Payroll Deduction Schedule with Employer.
Transamerica Home Office will determine the Effective Date for Payroll Deduction/List Bill.

NOTICE FOR PAYROLL DEDUCTIONS: If the employer advances the first premium, and any employee applicant terminates before the premium is deducted from the employee's salary, Transamerica will reimburse the initial premium payment to the employer.

PERSON RESPONSIBLE FOR BILLING

SIGNATURE:_____ **DATE:**_____