RESET

TRANSAMERICA®
FINANCIAL LIFE INSURANCE COMPANY

LONG TERM CARE
ASSOCIATION
SERVICE GROUP REQUEST FORM

Section I: GENERAL INFORMATION

Association Name: _____
(As it should appear on all correspondence)

Nature of Association: _____ Year Established: _____

Street Address: _____

City/State/ZIP: _____

Contact Person: _____ Title: _____

Phone: _____ Fax: _____

Email: _____ Website: _____

Section II: ASSOCIATION (Only Association Members are eligible to apply for insurance. Employees of the Association and employees of Association Members are not eligible to apply for insurance coverage unless they are individual Association Members.)

Return this form with the Association's official Articles of Organization, Bylaws and Membership Eligibility Rules.

Does the Association participate in or negotiate on behalf of members concerning grievances, labor disputes, rates of pay, work hours, or any other terms and conditions of employment? ☐ Yes ☐ No

Number of Association members: _____

How does the Association communicate with its members? _____

In what states are the members located? _____

Membership Listing, Census or Roster available? ☐ Yes ☐ No If Yes, please provide a copy.

Section III: BILLING INFORMATION

☐ Individual Direct Bill ☐ Other

Special Instructions: _____

_____

_____

_____

Section IV: AGENT INFORMATION (Please return a fully detailed Marketing Plan with this form)

Name of Transamerica Long Term Care Regional Sales Director (please print): _____

Agent Name (please print): _____ Agent Number: _____

Agent Address: _____

Phone: _____ Fax: _____ Email Address: _____

Agent Licensing Contact Name: _____ Contact Number: _____

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

Have you completed required long-term care specific training for each state? ☐ Yes ☐ No

How do you plan to solicit members/spouses/family members: (check all that apply)

☐ Direct Mail ☐ Email ☐ HO Call Center ☐ Company Newsletter ☐ Other _____

Has this Organization been offered any kind of LTCI Coverage within the last 5 years? ☐ Yes ☐ No If Yes, add additional page with details.

_____

_____

_____

Section V: ENROLLMENT INFORMATION (Explain more fully in detailed Marketing Plan attached to this form)

Please select the enrollment method(s): ☐ Paper ☐ Electronic

Please select writing agent(s) being used: ☐ Your Agents ☐ Outside Enrollment Co. ☐ Internal Call Center

Are all of the writing agent(s) currently appointed? ☐ Yes ☐ No

Section VI: ASSOCIATION COMMITMENT

1) **It is understood and agreed that by the Association allowing and facilitating active marketing, the Association Members 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 Association. 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 from the requested plans and will be documented in a formal Implementation Memo. 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.**

2) **The Association agrees to allow representatives of Transamerica Financial Life Insurance Company to present a Long Term Care insurance product to its members for the purpose of solicitation and enrollment. The Association will take all agreed upon steps to implement the program. It is understood and agreed that if minimum participation requirements are not met, the premium discount and any underwriting concession will be withdrawn and the program could be closed. The Association hereby agrees to sponsor Transamerica Long Term Care insurance for solicitation to all of its members.**

3) **The information provided to Transamerica concerning the Association is true and complete.**

4) **Transamerica shall have no liability resulting from any of the above Association Commitments or information provided in Section II 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 ASSOCIATION OFFICER:_____ **TITLE:**_____

AUTHORIZED SIGNATURE:_____ **DATE:**_____

Section VII: AGENT/MARKETING COMMENTS OR SPECIAL REQUESTS

1) **I have reviewed the benefit features, premium rates and marketing/enrollment plan with the Association. I understand that the final approved offer may be different from the requested plans.**

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

AGENT SIGNATURE:_____ **DATE:**_____

Section VIII: LTC MARKETING APPROVAL

Name:_____ Date:_____

Signature:_____

SUBMIT FORM TO TRANSAMERICA BUSINESS ADVANTAGE PROGRAM:

Phone: (866) 475-6925 **Fax: (855) 364-1945** **Email: multi-lifesupport@transamerica.com**