

# YOUR FLEXIBLE BENEFITS

## ACCIDENTADVANCE®

### ACCIDENT INSURANCE: BENEFITS FOR UNEXPECTED INJURIES

**AccidentAdvance, underwritten by Transamerica Life Insurance Company, can help protect you and your family in the event of unanticipated medical bills when someone is hurt.**

George enrolls himself, his wife, and his kids in the accident insurance offered at the car dealership where he works, joking that his wife is such a klutz they'll get plenty of use out of it. A few weeks later, he drops a cinder block on his foot while working in his garage, breaking a bone. He ends up with a cast, crutches, and a joke his wife will never let him live down.

#### GET BENEFITS TO SPEND ON WHAT YOU NEED

George's health insurance pays for many of his medical expenses, but he still has copays and a high deductible. He doesn't make commissions for sales on the days he misses work.

Because he has accident insurance, he has help recovering financially without dipping into family savings or using a credit card. Accident insurance benefits are paid directly to the insured, letting George use them where and how they're most needed.

#### FLEXIBILITY TO MEET YOUR NEEDS

George gets specific amounts for his emergency care (including X-rays and physician care received within 96 hours of the accident), for follow-up visits, and for his physical therapy while recovering. He would have received additional help had he needed an ambulance, initial hospitalization, or intensive care. See this brochure for in-depth information about what benefits are paid for specific injuries or procedures.

#### HELP PROTECT YOURSELF AND YOUR FAMILY

George liked the ability to add his wife and kids to his policy. Because kids can be especially accident-prone, a family accident policy provides extra peace of mind. Eligible dependent children can keep their insurance through age 25.

#### HASSLE-FREE ONLINE CLAIMS PROCESS

Our easy-to-navigate website allows you to update your information, keep track of your policies, submit claims, and more from your PC or mobile device.

This is a brief summary of AccidentAdvance accident insurance, underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA.. Forms and form numbers may vary. This insurance may not be available in all jurisdictions. Limitations and exclusion apply. Refer to the policy, certificate, and riders for complete details.

Up-to-date information regarding our compensation practices can be found in the Disclosures section of our website at [tebcs.com](http://tebcs.com).

#### PRODUCT HIGHLIGHTS

- Pays benefits directly to you.
- Family options available.
- Payroll-deducted premiums.



Visit:

[transamericabenefits.com](http://transamericabenefits.com)



Customer Service:

888-763-7474

For Information or to Enroll:  
David Dearie (504) 616-3537

Email: [Dearie@cox.net](mailto:Dearie@cox.net)

## Product Details

		Police Req'd, Open for others 24 Hour		All others 24 Hour		
Module 1	Accident Emergency Treatment	4.00 Units		8.00 Units		
<b>Accident Emergency Treatment Benefit</b> For physician treatment and X-rays in a hospital emergency room or doctor's office within 96 hours of the accident.		\$100		\$200		
<b>Major Diagnostic Examination Benefit</b> For one CT Scan, MRI, or EEG completed within 90 days of the accident.		\$160		\$320		
<b>Dislocation Benefit</b> Payable for joint dislocation reduced under general anesthesia. Dislocation reduced without general anesthesia paid at 25% of the joint's benefit amount. Multiple reduced dislocations are paid at 1 1/2 times the highest benefit amount. No other amount will be paid under this benefit.		<b>Reduction</b>		<b>Reduction</b>		
		<b>Dislocated Joint</b>	<b>Open</b>	<b>Closed</b>	<b>Open</b>	<b>Closed</b>
		Hip	\$3,200	\$1,080	\$6,400	\$2,160
		Knee or Shoulder	\$1,080	\$440	\$2,160	\$880
		Collar Bone	\$1,720	\$320	\$3,440	\$640
		Ankle or Foot (except toes)	\$1,080	\$320	\$2,160	\$640
		Lower Jaw	\$1,080	\$560	\$2,160	\$1,120
		Wrist or Elbow	\$880	\$440	\$1,760	\$880
		Toe or Finger	\$240	\$120	\$480	\$240
<b>Fractures Benefit</b> For repair of a fracture sustained in an accident. A chip fracture is paid at 10% of the fracture's benefit amount. Multiple repaired fractures are paid at 1 1/2 times the highest benefit amount. No other amount will be paid under this benefit.		<b>Reduction</b>		<b>Reduction</b>		
		<b>Fractured Bone</b>	<b>Open</b>	<b>Closed</b>	<b>Open</b>	<b>Closed</b>
		Coccyx	\$560	\$280	\$1,120	\$560
		Hand (except fingers), Foot (except toes/heel), Wrist, Shoulder Blade, Forearm, Ankle, Elbow, Kneecap, Sternum or Lower Jaw	\$1,360	\$680	\$2,720	\$1,360
		Hip	\$4,000	\$1,360	\$8,000	\$2,720
		Leg	\$1,680	\$1,360	\$3,360	\$2,720
		Nose, Heel or Fingers	\$1,360	\$280	\$2,720	\$560
		Ribs	\$2,680	\$280	\$5,360	\$560
		Skull	\$2,160	\$800	\$4,320	\$1,600
		Toes	\$560	\$280	\$1,120	\$560
		Upper Jaw, Upper Arm or Face (except Nose), Collar Bone	\$1,600	\$680	\$3,200	\$1,360
		Vertebrae, Pelvis	\$680	\$680	\$1,360	\$1,360
		Vertebral Processes	\$2,680	\$400	\$5,360	\$800

**For both dislocations and fractures, 1 1/2 times the highest dislocation or fracture benefit amount is paid. No other dislocation or fracture benefit is paid.**

## Product Details

<b>Module 2</b>		<b>Follow-Up Visits and Physical Therapy</b>	<b>5.00 Units</b>	<b>5.00 Units</b>
<b>Accident Follow-Up Treatment Benefit</b>				
Maximum of three (3) follow-up visits per accident. Original treatment must have been within 96 hours of the accident. Treatment must be provided by a physician in their office or in a hospital on an outpatient basis; begin within 30 days of, and be completed within the 6 months following the later of: the accident; discharge from the hospital from a covered confinement; or discharge from an extended care facility.			<b>\$50</b>	<b>\$50</b>
<b>Physical Therapy Benefit</b>				
For treatments by a licensed physical therapist under a physician's advice that begin within 120 days of the accident and are completed within 1 year of the accident, not to exceed 10 treatments per accident.			<b>\$50</b>	<b>\$50</b>
<b>Module 3</b>		<b>Initial Accident Hospitalization</b>	<b>3.50 Units</b>	<b>5.00 Units</b>
<b>Initial Accident Hospitalization Benefit</b>				
Payable once for the first hospital admission due to an accident. Benefit is payable once for the first Intensive Care Unit admission due to an accident. The ICU benefit is paid even if admitted to the hospital initially and then transferred to ICU later during the same hospitalization.			<b>\$1,050</b>	<b>\$1,500</b>
<b>Ambulance Benefit</b> For transportation to the nearest hospital for treatment within 96 hours of the accident by a licensed ambulance service.	Ground Ambulance		<b>\$210</b>	<b>\$300</b>
	Air Ambulance		<b>\$1,050</b>	<b>\$1,500</b>
<b>Additional Riders</b>				
<b>Accidental Death and Dismemberment Rider (Form No. CRADD300)</b>			<b>2.50 Units</b>	<b>5.00 Units</b>
<b>Accidental Death Benefit</b>				
Death must result from and occur within 90 days of the accident. Only one of the following benefits will be paid per insured person per accident and will be reduced by any dismemberment benefits previously paid for the same accident. Child benefit is 50% of the benefit amount.				
<b>Common Carrier Accidental Death</b>				
For death resulting from a covered accident that occurs while riding as a fare-paying passenger on a mode of public transportation			<b>\$75,000</b>	<b>\$150,000</b>
<b>Automobile Accidental Death</b>				
If the insured person was:				
wearing and properly utilizing a seat belt and was seated in a position protected by an air bag system that deployed during the accident, as evidenced by police report.			<b>\$55,000</b>	<b>\$110,000</b>
wearing and properly utilizing a seat belt, as evidence by police report, but an air bag was not present or was not deployed.			<b>\$50,000</b>	<b>\$100,000</b>
not wearing a seat belt.			<b>\$37,500</b>	<b>\$75,000</b>
<i>Benefits are not payable if an insured person was driving without a valid drivers' license</i>				
<b>Other Accidental Death</b>				
Other than those described above.			<b>\$25,000</b>	<b>\$50,000</b>
<b>Transportation of Remains Benefits</b>				
For transporting remains to a mortuary near the insured person's primary residence if death occurs more than 200 miles from primary residence. Child benefit is 50% of the benefit amount.			<b>\$1,000</b>	<b>\$2,000</b>

## Product Details

### Additional Benefits for Accidental Death

If an accidental death benefit is payable, the following benefits will be paid to the survivor. A reduced benefit will be paid to the beneficiary if no eligible survivor. Benefits do not require a spouse or child to be insured under this rider.

<p><b>Surviving Child Educational Benefit</b> Payable for each eligible child ages 17 through 21, who is a full-time student at an accredited college, university, 2-year college, vocational or trade school within 365 days of the accidental death. Payable each year for up to 4 years while the child remains a full-time student.</p>		<b>\$2,000</b>	<b>\$4,000</b>
<p><b>Licensed Day Care Center Benefit</b> Child must be between newborn and 12 years old, attend a licensed day care, which is not an immediate family member, within 90 days from the accidental death date. Day care must be necessary for the survivor to work or obtain training for work.</p>		<b>\$750</b>	<b>\$1,500</b>
<p><b>Career Enrichment Benefit</b> Survivor must be a full-time student at a professional or trade training program from an accredited college, university, 2-year college, vocational, or trade school within 24 months of the accidental death. Training must be for the purpose of obtaining an independent source of income or enriching the survivor's ability to earn a living. This benefit will be paid for up to 4 years while the survivor remains a full-time student. Benefit not available for children.</p>		<b>\$2,000</b>	<b>\$4,000</b>
<p><b>Accidental Dismemberment Benefits</b> Dismemberment must occur within 90 days of the accident. If accidental death benefit is payable after dismemberment benefits have been paid for the same accident, we will deduct the dismemberment benefits paid from the accidental death benefit due. Child benefit is 50% of the benefit amount.</p>	One or more fingers or toes	<b>\$1,250</b>	<b>\$2,500</b>
	One eye, hand, foot, arm or leg	<b>\$5,000</b>	<b>\$10,000</b>
	Two eyes, hands or feet	<b>\$12,500</b>	<b>\$25,000</b>
	Speech <u>or</u> hearing in both ears	<b>\$12,500</b>	<b>\$25,000</b>
	Two arms or two legs	<b>\$12,500</b>	<b>\$25,000</b>
	Speech <u>and</u> hearing in both ears	<b>\$25,000</b>	<b>\$50,000</b>
	Both arms and both legs	<b>\$25,000</b>	<b>\$50,000</b>
<p>Total dismemberment benefits per insured person per accident will not exceed:</p>		<b>\$25,000</b>	<b>\$50,000</b>
<b>Accident Hospital and ICU Income Rider (Form No. CRHICU00)</b>		<b>4.00 Units</b>	<b>8.00 Units</b>
<p><b>Accident Hospital Income Benefit</b> For hospital confinement for treatment of injuries beginning within 30 days of the accident. Benefit is payable for up to 365 days per accident.</p>		<b>\$100</b>	<b>\$200</b>
<p><b>Accident ICU Benefit</b> For ICU confinement while the person is receiving the hospital income benefit. Benefit is payable for up to 15 days per accident.</p>		<b>\$300</b>	<b>\$600</b>

## Product Details

Rates					AccAdv 2018.06.LA.
Accident Insurance	Rate Frequency	Employee	Employee and Child(ren)	Employee and Spouse	Employee, Spouse and Child(ren)
Plan Option I 24 Hour	Monthly	\$12.19	\$15.69	\$19.01	\$23.30
Plan Option II 24 Hour	Monthly	\$22.27	\$28.29	\$34.60	\$42.28

*\*HSA Compatible - Based on its understanding of available guidance, Transamerica Life Insurance Company views the insurance benefits shown in this proposal as compatible with High-Deductible Health Plans and Health Savings Accounts. However, there is no guarantee that the relevant authorities will agree with Transamerica's understanding. Current guidance is not complete and is subject to change. Neither Transamerica nor its agents or representatives provide legal or tax advice. Accordingly, Transamerica encourages its customers to consult with and rely upon independent tax and legal advisors regarding their particular situations, the use of the products presented here with High-Deductible Health Plans and Health Savings Accounts, and the persons/dependents that may be insured under such plans and accounts.*

Issue State: Louisiana  
Rate generation date: July 9, 2018

## Limitations and Exclusions

### Other Insurance with Us

An individual can only have one accident policy or certificate with us. An individual can only have one disability income policy, certificate, or rider with us. If a person already has accident insurance with us, such person is not eligible to apply for this insurance. If a person already has disability income insurance with us, such person is not eligible to apply for the disability income riders.

## Limitations and Exclusions

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We will not pay benefits for losses caused by or as a result of an insured person:

- Driving any taxi for wage, compensation or profit;
- Mountaineering, parachuting or hang gliding;
- Voluntarily taking, administering, absorbing or inhaling poison, gas or fumes;
- Alcoholism or drug addiction;
- Participating in any sport or sporting activity for wage, compensation, profit, or racing any type of vehicle in an organized event;
- Traveling in or descending from any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline (other than a charter airline) on a regularly scheduled passenger trip;
- War, or any act of war, whether declared or undeclared;
- Participating in any activity or event, including the operation of a vehicle, while intoxicated or under the influence according to the laws of the jurisdiction in which the accident occurred;
- Participating in a riot, civil commotion, civil disobedience or unlawful assembly;
- Committing, attempting to commit, or taking part in a felony or assault or engaging in an illegal occupation;
- Intentionally self-inflicting bodily injury or attempting suicide while sane or insane;
- Any loss incurred while on active duty status in the armed forces. If you notify us of such active duty, we will refund any premiums paid for any period for which no insurance is provided as a result of this exception.

### Termination of Insurance

Subject to the Portability Option, insurance on the employee will end on the earliest of:

- the date of his or her death;
- the date he or she ceases to be eligible for insurance;
- the last date for which premium payment has been made to us, subject to the grace period;
- the date he or she terminates employment;
- the date the group master policy terminates;
- the date he or she sends us a written notice to cancel insurance.

The insurance on a dependent will cease on the earliest of:

- the date of the employee's death;
- the date the employee's insurance terminates;
- the last date for which premium payment has been made to us, subject to the grace period;
- the date the dependent no longer meets the definition of dependent;
- the date the certificate is modified so as to exclude dependent insurance;
- the date the employee sends us a written notice to cancel insurance on a dependent.

### Extension of Benefits

Whenever termination of insurance under this section occurs due to termination of employment, such termination will be without prejudice to:

- any hospital confinement which began while insurance was in force; or
- any covered treatment or service for which benefits would be provided and which began while insurance was in force; provided, however that the insured person is and continues to be hospital confined or receiving treatment.

Such Extension of Benefits will continue for up to the earlier of:

- 30 days; or
- the date on which the insured person is no longer hospitalized or receiving treatment.

### Portability Option

If an employee loses eligibility for this insurance for any reason other than nonpayment of premiums, insurance can be continued by paying the premiums directly to us within 31 days after termination. We will bill the employee directly once we receive notification to continue your insurance.

### Termination of the Group Master Policy

The policyholder may end the policy on any premium due date by submitting a 60-day advance written notice. A group will not be continued if it drops below the minimum required participation. The group master policy will be terminated and insurance of all remaining insureds will end, subject to the Portability Option.



**Transamerica Life Insurance Company ("Insurer")**

Home Office: Cedar Rapids, IA  
 Administrative Office: P.O. Box 8063  
 Little Rock, AR 72203-8063

**AccidentAdvance  
 Application**

First Application     Add Dependents – Certificate # \_\_\_\_\_     Increase Coverage – Certificate # \_\_\_\_\_

Group Name	Group Number	Location
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Applicant (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	Date of marriage
Spouse <sup>1</sup> (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of birth	

Date of hire	Avg hours worked per week	Annual salary	Occupation	Employee/Member ID
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Home address	Work phone/ext.
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City	State	Zip code	Home phone
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Child(ren) name	Date of birth	Child(ren) name	Date of birth
_____	_____	_____	_____

Primary Beneficiary: (Last, First, M.I.)	Relationship:
Contingent Beneficiary: (Last, First, M.I.)	Relationship:

*Applicant will be the beneficiary for any spouse and/or child(ren) coverage*

<sup>1</sup> Spouse includes your legally married spouse, common law spouse, civil union partner, or domestic partner, if legally recognized in the governing jurisdiction or as otherwise agreed upon between the policyholder and the Insurer.

Payment Mode:     Weekly     Bi-Weekly     Semi-Monthly     Monthly     Other

I Am Applying For: <input type="checkbox"/> Individual <input type="checkbox"/> Single Parent Family <input type="checkbox"/> Family <input type="checkbox"/> Two-Adult Family	<b>Premium per Payment Mode*</b>
<input type="checkbox"/> Basic Accident Coverage (Applicant Only)	\$
<b>ADDITIONAL RIDERS: (Only available if included in the plan selected by the policyholder)</b>	
<input type="checkbox"/> Applicant Accident Disability Rider    Monthly Benefit*:	\$
<input type="checkbox"/> Applicant Sickness Disability Rider    Monthly Benefit*:	\$
<input type="checkbox"/> Spouse Off-the Job Accident Disability Rider    Monthly Benefit*:	\$
*If increasing coverage, enter the <b>TOTAL</b> Monthly Benefit amount and Premium.	<b>Total Premium</b> \$

**Eligibility Questions**

1. Are you actively at work on a full time basis and able to perform the regular duties of your occupation? If "No", you and your dependents are not eligible for coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. If applying for spouse and/or child(ren) coverage, is any proposed insured currently disabled? If "Yes", List name(s) _____, who will be excluded from coverage, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? If "Yes", List name(s) _____, who will be excluded from coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No

**The following questions should only be answered if the Sickness Disability Rider is included in the plan selected by the policyholder**

4. In the ten years prior to the application date, have you been treated for, been diagnosed as having, or had any indication, sign or symptom of having any heart, brain, lung, circulatory, respiratory, blood, vascular, kidney, liver, digestive, neurological, rheumatoid, or other major organ disorders, blood transfusion, diabetes, drug addiction, alcoholism, cancer or malignancy in any form (except non-melanoma skin cancer)? If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Do you have high blood pressure that is controlled by more than two medications? If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 12 months have you been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any condition in question 4? If "Yes", you are not eligible for coverage under this rider, unless included by special endorsement.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide details of all "Yes" answers to questions 2, 4, 5, and 6. Use additional paper if needed.  
 For High Blood Pressure, please indicate most recent blood pressure reading, name of any medications and dosage.

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

**APPLICANT'S STATEMENTS AND AGREEMENTS:**

**For ID groups only:**

Did you receive an Outline of Coverage describing the insurance for which you are applying?  Yes  No

**I represent** that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached.

**For residents of all states not listed below:**

**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 is a crime and subjects such person to criminal and civil penalties.**

**For residents of DC or LA:**

**I understand that 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.**

**For residents of 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.**

**For residents of NC or 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.**

**For residents of 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.**

**For residents of OK:**

**WARNING: 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.**

**For residents of TN:**

**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.**

**For residents of 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.**

**I understand** that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the Insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled (unless included by special endorsement), on the effective date (according to the Insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office.

**I understand** that completion of this application in no way implies that I will be accepted for insurance coverage.

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

Applicant's Signature \_\_\_\_\_ Spouse's Signature (if applicable) \_\_\_\_\_

**AGENT'S STATEMENTS AND AGREEMENTS:**

**I hereby 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.

Licensed Representative's Name \_\_\_\_\_ Licensed Representative's Signature \_\_\_\_\_ Agent # \_\_\_\_\_



## Transamerica Life Insurance Company

<b>State of Louisiana Employee Payroll Deduction Authorization</b>									
Employee Name			Soc. Sec. No.			Employee No. (for agency use)			
Agency No.		Department/Agency/Section Name							
<p>I hereby authorize my employer to deduct a total of \$ _____, monthly rate, from my salary until further notice and remit same to <b>Transamerica Life Insurance</b>. A TOTAL Semi-Monthly Deduction in the amount of \$ _____ represents one half of the total monthly premium required for the coverage(s) detailed below.</p> <p>The Office of State Uniform Payroll and the employing agency are <b>not</b> representatives or agents of the employee or the vendor. It is the responsibility of the <b>employee</b> to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between <b>the employee and the vendor</b> to ensure that the amount of any payroll deduction is correct and is properly credited to the appropriate policy. Cancellation of a policy must be submitted by the employee in a written request to <b>both</b> the vendor <b>and</b> his/her agency's payroll office. An employee signed SED-4 stopping the deduction may be required before the deduction can be stopped in the LaGov HCM payroll system. Statewide vendor deductions that are not taken due to an employee being on LWOP, not being due any wages, or not being paid enough wages to take the deduction <b>are the employee's responsibility</b> to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee <b>and</b> the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.</p>									
DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS									
PRODUCT NAME	PLAN PART			125 ELIG	MO PREM.	PAYROLL CODE	INELIGIBLE & NON-PART Semi-Mo.	ELIGIBLE PART Semi-Mo.	
	CD	YES	NO						
Cancer	25	P		Y	\$	PA		\$	
Heart	16	P		Y	\$	PC		\$	
<b>SUBTOTALS</b>							<b>Non-Part. - Part.</b>	\$	\$
Universal Life	32		N	N	\$	NR	\$		
Accident	27		N	N	\$	NT	\$		
Cancer-C/V-N/S	80		N	N	\$	NM	\$		
Heart-C/V-N/S	82		N	N	\$	NP	\$		
PP Begin Date				Total Mo. Prem. \$					
Date Authorized				Total Semi-Mo. Ineligible \$					
				Total Semi-Mo. Non-Part. \$					
				Total Semi-Mo. Part. \$					
By: _____						<b>TOTAL SEMI-MONTHLY \$</b>			
Employee Signature									
<b>(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)</b>									
Presentation an deduction authorization processed by:									
_____			Transamerica Life Insurance Representative			Phone		Date	
_____									
Company Address									