# HEART DISEASE, HEART ATTACK & STROKE INSURANCE

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

**Hospital Confinement Benefit (no lifetime maximum)**
You select a daily hospital benefit for each continuous covered hospital confinement due to heart disease, heart attack, or stroke.

| Daily Benefit | $ 100 | $ 150 | $ 200 | $ 250 | $ 300 |
|---|---|---|---|---|---|
| 1st–30th day | $ 100 | $ 150 | $ 200 | $ 250 | $ 300 |
| 31st day and after | $ 200 | $ 300 | $ 400 | $ 500 | $ 600 |

**Government Hospital (no lifetime maximum)**
Pays $175 per day in lieu of all other benefits during the 1st through 30th day of hospital confinement in a government or charity hospital. 30-day maximum per continuous confinement.

**Schedule of Benefits (no lifetime maximums)**

**Surgery Benefit:** Fee for surgery, as scheduled in the policy, up to $2,500 including post-operative attendance.

**Anesthesia Benefit:** Pays charges of up to 25% of the covered surgery benefit, not to exceed $350.

**Drugs and Medicine Benefit:** Pays the hospital charges of up to $25 per day for each day of a covered hospital confinement.

**Attending Physician:** Pays up to $25 per day for visits by an attending physician other than the physician who performed surgery, while you are confined in the hospital. This benefit is payable for one visit per day, for up to the same number of days the Hospital Confinement Benefit is payable.

**Nursing Services Benefit:** Pays up to $50 per day for full-time private-duty nursing services as required by your physician while you are confined in the hospital.

**Physical Therapy Benefit:** Pays up to $40 per day for up to 30 days for services of a registered physical therapist as required.

**Oxygen Benefit:** Pays up to $200 per hospital confinement for oxygen as required.

**Electrocardiogram Benefit:** Pays up to $200 per hospital confinement for electrocardiograms as required.

**Intensive Care Unit Benefit:** Pays up to $150 per day for up to 15 days per period of covered Intensive Care Unit confinement. A period of confinement can include two or more separate periods of ICU confinement if they are separated by fewer than 30 days.

**Ambulatory Surgical Center Benefit:** All benefits payable for hospital services and supplies are applicable to services and supplies furnished in an ambulatory surgical center.

**Ambulance Benefit:** Pays up to $100 per hospital confinement for ambulance services to and from the hospital to which you are admitted for a covered confinement.

**Transportation Benefit:** Includes expenses for round-trip transportation resulting from hospital confinement for prescribed treatment which cannot be obtained locally *(within 50 miles of your residence)*. Pays up to $500 per hospital confinement for transportation by, air, rail, or bus to the nearest hospital. Round-trip mileage allowance of $.50 per mile up to $250 per hospital confinement for use of personal vehicle.

**Heart Transplant Benefit:** Pays up to $100,000 for the permanent implantation of a natural or artificial heart. Including charges for: replacement heart, surgeon's services, assistants and technicians, operating room, recovery room, anesthesia services and supplies, and special equipment and surgical supplies. Benefit is payable in addition to all other benefits once for each covered person.

TRANSAMERICA
WORKSITE MARKETING

*Rider Form Series LPH660. Forms may vary, coverage available where product is approved.*
*Administrative Office: 1400 Centerview Drive, Little Rock, AR. Customer Service: (888) 763-7474*

CHS01C(SLE)-1108

**Coverage Type**

Two-Adult coverage includes the Insured and spouse only. Single-Parent coverage includes the Insured and insured eligible children. Family coverage includes the Insured, spouse and eligible children. Newborn children are automatically covered under the terms of the policy from the moment of birth. Available through age 64 on payroll deduction, ages 18 to 64 on direct billing.

**Limitations and Exclusions**

We may reduce or deny a claim or void the policy if during the first 24 months a material misstatement has been made on the application; or at any time if you make a fraudulent misstatement.

This policy contains a 30-day waiting period. This means that no coverage is provided for any person diagnosed with a heart disease, heart attack, or stroke during the first 30 days of the effective date of such person's coverage *(varies by state)*.

We will not pay benefits for: 1) any charges incurred for treatment of any disease or condition other than heart disease, heart attack, or stroke; 2) any excluded form of heart disease, heart attack, or stroke; 3) any person diagnosed with a heart disease, heart attack, or stroke before the end of the waiting period; 4) any disease or condition caused, complicated, worsened, or affected by or as a result of heart disease, heart attack, or stroke.

"Hospital" does not include an institution or that part of an institution operated as a: 1) convalescent home; convalescent, rest or skilled nursing care facility; or hospice care center; 2) facility primarily affording custodial, rehabilitative, or educational care; or 3) facility for the aged or addicted.

"Surgery" for heart disease, heart attack, and stroke does not include repair of lacerations, puncture wounds, or other traumatic injuries to the heart or blood vessels.

This is a brief summary of coverage. Refer to policy for complete details.

**Renewability**

This heart disease, heart attack, and stroke policy is guaranteed renewable for life. We may only change the premium for your policy after we notify you in advance, and if we change it for all of the policies issued in your class.

**Termination**

Under a Family Policy, coverage on a Spouse will end upon the earlier of death; or valid decree of divorce from you; or written notice to end coverage, effective upon receipt by us. Under a Single Parent Family Policy, or a Family Policy, coverage will end on a dependent child at the earlier of the child's death; or marriage; or attainment of age 19; or attainment of age 25 if a full time student; or written notice to end coverage effective upon receipt by us. Coverage on the Insured will end at the earlier of your death; or failure to pay the Renewal Premium before the Grace Period ends; or written notice to end coverage, effective upon receipt by us. This Policy will terminate if the Insured fails to pay the Renewal Premium before the Grace Period ends.

Terminations due to the Insured's written request may be made later than as specified above when indicated on your written notice.

| Monthly Payroll Rates | $100 | $150 | $200 | $250 | $300 |
|---|---|---|---|---|---|
| Individual | $ 11.60 | $ 13.70 | $ 15.80 | $ 17.90 | $ 20.00 |
| Single Parent Family | $ 12.70 | $ 15.00 | $ 17.30 | $ 19.60 | $ 21.90 |
| Family | $ 20.40 | $ 24.10 | $ 27.80 | $ 31.50 | $ 35.20 |

| Monthly Non-Payroll Rates | $100 | $150 | $200 | $250 | $300 |
|---|---|---|---|---|---|
| Individual | $ 15.00 | $ 17.70 | $ 20.40 | $ 23.10 | $ 25.80 |
| Single Parent Family | $ 16.50 | $ 19.45 | $ 22.40 | $ 25.35 | $ 28.30 |
| Family | $ 26.30 | $ 31.05 | $ 35.80 | $ 40.55 | $ 45.30 |

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

# HeartSelect® Application

☐ First Application ☐ Change Plans -Policy # ☐ Change Daily Benefit - Policy #

Group Name State of Louisiana Group Number Location

| Applicant (Last, First, M.1.) | ☐ Male ☐ Female | Social Security No. | Date of birth | Date of marriage |
|---|---|---|---|---|
| Spouse (Last, First, M.1.) | ☐ Male ☐ Female | Social Security No. | Date of birth | |

| Date of hire | Avg hours worked per week | Occupation | Employee ID |
|---|---|---|---|
| Home address | Email address | | Work phone/ext. |
| City | State | Zip code | Home phone |

| Child(ren) name | Date of birth | Full time student | Child(ren) name | Date of birth | Full time student |
|---|---|---|---|---|---|
| | | ☐Yes ☐No | | | ☐Yes ☐No |
| | | ☐Yes ☐No | | | ☐Yes ☐No |

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

I Am Applying For: Daily Room Benefit: $_____

☐ Individual ☐ Single Parent Family ☐ Family

| Premium per pay period |
|---|
| |

## Eliolbility Questions

1. Is the applicant actively at work on a full time basis and able to perform the regular duties of his/her occupation? ☐ Yes ☐ No
   If "No", you and your dependents are not eligible for coverage.
2. Is any proposed insured covered by any Title XIX program (e.g. Medicaid)? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who will be excluded from coverage.
3. In the past 10 years has any proposed insured been diagnosed, treated, received medical advice, or taken prescribed medication for Stroke, or any disease, disorder, or abnormality of the brain, heart, or circulatory system (arteries, veins, lymph nodes, and vessels)? If "Yes", List narne(s)_____ , who will be excluded from coverage, unless included by special endorsement. (Give details below) ☐ Yes ☐ No
4. In the past 5 years has any proposed insured been diagnosed, treated, received medical advice, or taken prescribed medication for High Blood Pressure or Diabetes (including insulin)? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement- (Give details below)
5. In the past 10 years has any proposed insured had an actual diagnosis of or treatment by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or sexually transmitted disease? ☐ Yes ☐ No
   If "Yes", List name(s)_____ , who will be excluded from coverage, unless included by special endorsement. (Give details below)

Please provide details of all "Yes" answers to questions 3, 4, and 5. 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:

Is the insurance being applied for intended to replace any existing health, accident and sickness, or disability insurance coverage? ☐ Yes ☐ No

If ''Yes'', list name of company _____ ,Policy/certificate # _____ , complete the Replacement form(s) provided by your agent and return with this application.

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

**I understand that any person who knowingly 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.**

**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 my employer waiting period (if applicable); c) I must satisfactorily answer all questions on this form-, d) I must be actively at work on the effective date (according to the insurer's rules); and e) the first months 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.

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

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

Signed in (City/State) _____ This _____ Day of (MonthNear) _____

Applicant's Signature _____

## AGENT'S STATEMENTS AND AGREEMENTS:

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

Licensed Representative's Name David B. Dearie Licensed Representative's Signature _____ Agent # BU0619

*Information regarding your insurability will be treated as confidential. Transamerica Life Insurance Company, or its reinsurers, may, however, make a briefreport 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 ofany information it may have in your file. If you question the accuracy of infon-nation in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. Transamerica Life Insurance Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

# Transamerica Life Insurance Company

## State of Louisiana Employee Payroll Deduction Authorization

| Employee Name | Soc. Sec. No. | Employee No. (for agency use) |
|---|---|---|
| | | |

| Agency No. | Department/Agency/Section Name |
|---|---|
| | |

I hereby authorize my employer to deduct a total of $_____, monthly rate, from my salary until further notice and remit same to **Transamerica Life Insurance .** A TOTAL Semi-Monthly Deduction in the amount of $ _____ represents one half of the total monthly premium required for the coverage(s) detailed below.
The Office of State Uniform Payroll and the employing agency are **not** representatives or agents of the employee or the vendor. It is the responsibility of the **employee** to notify each vendor he/she has a payroll deduction with of address and/or name changes. It is solely the responsibility between **the employee and the vendor** 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 **both** the vendor **and** 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 **are the employee's responsibility** to pay directly to the vendor. Payments made outside of the payroll system are not pre-taxed. By signing this form, both the employee **and** the vendor representative acknowledge that the statements in this section have been read, are understood and are agreed upon.

DEDUCTION DETAIL (Product Names & Codes, 125 Eligible, Premium Amts.) MENU ELECTIONS

| PRODUCT NAME | PLAN PART CD | YES | NO | 125 ELIG | MO PREM. | PAYROLL CODE | INELIGIBLE & NON-PART Semi-Mo. | ELIGIBLE PART Semi-Mo. |
|---|---|---|---|---|---|---|---|---|
| Cancer | 25 | | N | Y | $ | **NA** | $ | |
| Cancer | 25 | P | | Y | $ | **PA** | | $ |
| Heart | 16 | | N | Y | $ | **NC** | $ | |
| Heart | 16 | P | | Y | $ | **PC** | | $ |
| | | | | **SUBTOTALS** | | **Non-Part. - Part.** | $ | $ |
| 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** | $ | |

| | | | |
|---|---|---|---|
| | Total Mo. Prem. | $ | |
| PP Begin Date | Total Semi-Mo. **Ineligible** | $ | |
| | Total Semi-Mo. **Non-Part.** | $ | |
| Date Authorized | Total Semi-Mo. **Part.** | $ | |

By: _____
Employee Signature

**TOTAL SEMI-MONTHLY** $

**(THIS FORM SUPERSEDES AND REPLACES ALL OTHER AUTHORITY FOR DEDUCTIONS FOR THIS VENDOR)**

Presentation an deduction authorization processed by:

_____
Transamerica Life Insurance Representative Phone Date

_____
Company Address

Original: HR Payroll Yellow: Home Office Pink: Customer