TRANSAMERICA LIFE INSURANCE COMPANY

(called we, our or us) Home Office: Cedar Rapids, Iowa
Administrative Office: 6300 Bridgepoint Parkway, Building 3, Suite 500, Austin, Texas 78730
FOR INFORMATION, OR TO MAKE A COMPLAINT, CALL 1-866-868-4139
PLEASE READ YOUR CERTIFICATE CAREFULLY

GROUP TERM LIFE INSURANCE CERTIFICATE

This Certificate summarizes the insurance coverage provided under the Group Master Policy identified in the Certificate Schedule. We have issued this Certificate to you (as an employee of the Group Participant identified on the Certificate Schedule) based on information that enabled us to determine that each person insured under this Certificate met all of the eligibility requirements set forth in the Group Master Policy, the Group Participation Agreement and/or your application or enrollment form. Your Group Participant has an agreement through which this insurance is made available. A copy of the Group Master Policy is on file with your Group Participant, and may be examined at any reasonable time during normal business hours.

DEFINITIONS:
Dependent Child means an unmarried child who is: (1) your natural child; (2) your legally adopted child, or a child for whom you have started adoption proceedings; (3) a stepchild who lives with you; or (4) a child for whom you have been appointed legal guardian who lives with you. A dependent child must depend on you for financial support. A dependent child does not include anyone who is personally eligible as an employee under the Group Master Policy. If you and your spouse are both eligible as an employee under the Group Master Policy, your dependent children may be covered as dependent children of either you or your spouse, but not both of you.

Spouse means the person to whom you are legally married, as determined by the laws of the State in which you live. A spouse does not include anyone who is personally eligible as an employee under the Group Master Policy.

WHAT YOU GET: We certify that, as long as the premiums for this insurance are paid as they become due, the persons covered under this Certificate are insured for the coverage summarized in this Certificate, subject to the terms of the Group Master Policy.

WHAT WE WILL PAY: If a person covered under this Certificate dies while insured, we will pay his/her death benefit after we receive due proof of his/her death. If reduction of the death benefit is part of this insurance coverage, the applicable death benefit(s) will be automatically reduced at specified ages, as shown in the Certificate Schedule.

WHO WE WILL PAY:
Employee and Spouse, if shown in the Certificate Schedule: We will pay your death benefit to the beneficiary you named in writing on your application or enrollment form (or on the beneficiary designation form on file with your Group Participant). If you did not name a beneficiary, or if your beneficiary dies before you, we will pay your death benefit to your living relatives in the following order: (1) legal spouse; (2) children, including stepchildren and legally adopted children; (3) parents; or (4) brothers and/or sisters. If none of these relatives are living, we will pay your death benefit to your estate. You may change the beneficiary at any time. The change must be in writing on a form approved by us. The change will not be effective until the date it is recorded. If you are not living on the date the change is recorded, the change will be effective on the date you signed it. However, any benefits paid before the change is recorded will not be subject to it.

Dependent Children, if shown in the Certificate Schedule: We will pay the death benefit to you, the employee. If you are not living, we will pay the death benefit to your spouse. If your spouse is not living (or if you do not have a spouse), we will pay the death benefit to the dependent child's legal guardian, or to the adult(s) whom we determine have assumed custody of the dependent child.

RIGHT TO EXAMINE AND RETURN CERTIFICATE WITHIN 30 DAYS
AT ANY TIME WITHIN 30 DAYS AFTER YOU RECEIVE THIS CERTIFICATE, YOU MAY RETURN IT TO US OR YOUR GROUP PARTICIPANT. WE WILL CANCEL THIS CERTIFICATE AND VOID IT FROM THE BEGINNING. WE WILL REFUND TO YOU ANY PREMIUMS PAID.

THE PREMIUMS PAYABLE UNDER THIS CERTIFICATE ARE VARIABLE AND ARE NOT GUARANTEED AS TO FIXED DOLLAR AMOUNT.

Transamerica Life Insurance Company
Home Office: Cedar Rapids, Iowa

CERTIFICATE SCHEDULE

Group Master Policyholder Name: The Hertz Corporation
Group Master Policy Number: 11344B

Y1F27

Employee Benefit	$10,000
Spouse Benefit	$5,000
Dependent Children Benefit	$2,500

If Dependent Children Coverage:
Dependent Children Coverage begins at 15 days.
Dependent Children Coverage ends when the last insured child reaches age 26 years.
Coverage for age 15 days to 6 months is limited to 10% of the amount selected

*Spouse or equivalent, as defined by governing state law.

Death benefits automatically reduce to the following percentages on the Group Master Policy Anniversary Date that follows the insured's applicable birthday as follows:

Birthday	Death Benefit Payable
65th	65% of pre-age 65 death benefit
70th	50% of pre-age 65 death benefit
75th	25% of pre-age 65 death benefit
80th	The lesser of $5,000 or 25% of pre-age 65 death benefit

Benefits Included

Accidental Death and Dismemberment Rider, Applicable Only to Employees/Members and Spouses (if spouse coverage amount is listed above)
Benefits Stop: on the Employee's/Member's 70th birthday

WHEN INSURANCE STARTS:

Employee: Except as provided in the Deferred Effective Date provision, your insurance starts on the first day of the month that coincides with or next follows: (1) the date you have met the eligibility requirements your Group Participant has indicated in the Group Term Life Participation Agreement (if we do not ask for evidence of insurability); or (2) the date we approve your coverage (if we do ask for evidence of insurability).

Spouse, if shown in the Certificate Schedule: Except as provided in the Deferred Effective Date provision, your spouse's insurance starts on: (1) the date your insurance starts (if we do not ask for evidence of insurability); or (2) the date we approve his/her coverage (if we do ask for evidence of insurability). If you later acquire a spouse, insurance starts on the first day of the month that coincides with or next follows: (a) the date he/she meets the eligibility requirements for a spouse (if we do not ask for evidence of insurability); or (b) the date we approve his/her coverage (if we do ask for evidence of insurability).

Dependent Children, if shown in the Certificate Schedule: Except as provided in the Deferred Effective Date provision, a dependent child's insurance starts on: (1) the date your insurance starts (if we do not ask for evidence of insurability); or (2) the date we approve his/her coverage (if we do ask for evidence of insurability). If you later acquire a dependent child, insurance starts on (a) the date he/she meets the eligibility requirements for a dependent child (if we do not ask for evidence of insurability); or (b) the date we approve his/her coverage (if we do ask for evidence of insurability).

Increases in the Death Benefit: Except as provided in the Deferred Effective Date provision, an increase in the amount of any death benefit starts on the first day of the month that coincides with or next follows: (1) the date of the increase (if we do not ask for evidence of insurability; or (2) the date we approve the increase (if we do ask for evidence of insurability).

DEFERRED EFFECTIVE DATE:

Employee and Employed Spouse, if shown in the Certificate Schedule: If you or your employed spouse are absent from work due to sickness or injury on the date your insurance (or an increase in your death benefit) would start, your insurance (or the increase in your death benefit) will start on the day after you return to work for one full day.

Unemployed Spouse and Dependent Children, if shown in the Certificate Schedule: If your unemployed spouse or a dependent child is: (1) confined to a health care facility; or (2) disabled due to sickness or injury, on the date his/her insurance (or an increase in his/her death benefit) would start, his/her insurance (or the increase in his/her death benefit) will start on the day after he/she is no longer: (a) confined to a health care facility; or (b) disabled due to sickness or injury.

WHEN INSURANCE STOPS:

Employee: Your insurance stops at the earliest of: (1) 31 days after a premium due date, if the premiums for your insurance have not been paid; (2) the first day of the month that follows the date: (a) your employment ends; or (b) your job falls into a class of jobs that is not eligible for insurance under the Group Master Policy; (3) the date the Group Master Policy is amended so that this insurance stops; (4) the date the Group Master Policy stops; (5) the date the Group Participant's participation ends; or (6) the date you ask, in writing, for it to stop.

Spouse, if shown in the Certificate Schedule: Your spouse's insurance stops at the earliest of: (1) 31 days after a premium due date, if the premiums for his/her insurance have not been paid; (2) the date he/she no longer meets the definition of spouse; (3) the date your insurance stops; (4) the date the Group Master Policy is amended so that the spouse's insurance stops; (5) the date the Group Participant's participation is amended so that the spouse's insurance stops; or (6) the date you ask, in writing, for it to stop.

Dependent Children, if shown in the Certificate Schedule: A dependent child's insurance stops at the earliest of: (1) 31 days after a premium due date, if the premiums for the dependent children's insurance have not been paid; (2) the date he/she no longer meets the definition of dependent child; (3) the date your insurance stops; (4) the date the Group Master Policy is amended so that the dependent children's insurance stops; (5) the date the Group Participant's participation is amended so that the dependent children's insurance stops or (6) the date you ask, in writing, for the dependent children's insurance to stop.

CONTINUATION OF COVERAGE DURING TOTAL DISABILITY OPTION: If you become totally disabled while you are insured, you will have the option to continue this insurance by paying the premiums directly to the Group Participant. This option is available for up to six months from the date your total disability begins. However, if the Group Master Policy stops while you are totally disabled, you will have the option to continue this insurance for up to 12 months from the date your total disability begins. Total disability means that, due to sickness or accidental injury, you are not able to perform the material and substantial duties of your regular occupation. After an initial benefit period of twelve (12) months, the you shall be considered totally disabled if you are unable to perform the material and substantial duties of any occupation for which you are suited by means of education, training or experience. Total loss of sight of both eyes, or hearing in both ears, or of use of both hands or both feet, or of one hand and one foot will be considered a total disability.

CONVERSION OPTION:

You have the option to convert all or part of this insurance to permanent insurance if: (1) the Group Master Policy is amended so that any of this insurance stops; or (2) the Group Master Policy under which you are insured terminates; or (3) the Group Participant's participation under the Group Master Policy terminates. This option will be available only if the Group Participant's participation under the Group Master Policy has been in force for five or more years. The face amount(s) of the permanent insurance may not exceed: (a) the applicable death benefit(s) under this Certificate minus the amount of any life insurance that a person covered under this Certificate is eligible for under this same Group Master Policy or another group master policy that is issued or reinstated by us or by any other insurer; or (b) $10,000, whichever is smaller.

You will have the option to convert all or part of this insurance to permanent insurance if any person covered under this Certificate loses eligibility for this insurance for any reason other than the reasons stated in the preceding paragraph. The face amount(s) of the permanent insurance may not exceed the applicable death benefit(s) under this Certificate.

The conversion to permanent insurance will be made, without evidence of insurability, on a form we designate for this purpose. The permanent insurance may not have any disability or supplementary benefits. The premiums for the permanent insurance will be based on our published rates in effect on the date of the conversion. Any Suicide or Right to Contest provision under the permanent insurance will not start anew. Instead, the amount of time that this insurance was in force will be used to offset any time period for Suicide or Right to Contest under the permanent insurance.

If insurance on any person covered under this Certificate is about to stop, your Group Participant will remind you of this option by either giving you a written notice, or mailing a notice to your last known address as provided in its records. If you decide to exercise this option, you will have to tell us in writing at our Administrative Office within 31 days after the applicable insurance stops. This is called the conversion period. We will send you an application to fill out, and let you know what the premiums will be for the permanent insurance. If the reminder notice is not given to you or mailed within 15 days after the conversion period starts, you will have an additional 31 days after the conversion period ends to exercise this option. We will not send you an application, or accept a completed application, if this option is not exercised within the time period allowed. The effective date of the permanent insurance will be the date you applied for the conversion.

If any person covered under this Certificate is eligible to have his/her insurance converted to permanent insurance and he/she dies during the first 31 days after his/her insurance stops, we will pay a benefit equal to the amount that he/she would have been entitled to convert, even if you have not applied for the conversion, and whether or not payment of the first premium has been made. However: (1) for you and your spouse, we will reduce the benefit by the amount of premium necessary to provide insurance to the date of death; and (2) for a dependent child, we will reduce the benefit by the amount of premium necessary to provide insurance to the date of death only if you have no surviving insured dependent children.

RULES FOR FILING A CLAIM: Due proof of death must be submitted to us at our Administrative Office. A beneficiary or personal representative can request a claim form by calling our toll-free telephone number.

MISSTATEMENT OF AGE: If an insured's age was misstated on your application or enrollment form, we will adjust his/her death benefit to the amount that the premiums paid for his/her insurance would buy at his/her correct age.

SUICIDE EXCLUSION: We will not pay a death benefit if an insured dies by suicide, while sane or insane, within two years of the date his/her insurance starts. If you or your spouse die by suicide, we will refund the premiums paid for your insurance (if a dependent child dies by suicide, we will refund the premiums paid for the dependent children's insurance only if you have no surviving insured dependent children). If any death benefit is increased, this suicide exclusion starts anew, but will apply only to the amount of the increase.

RIGHT TO CONTEST: We will not contest this insurance after it has been in force during the lifetime of an insured for two years from the date it starts, except for nonpayment of premiums. If any death benefit is increased, our two-year right to contest starts anew but will apply only to the amount of the increase.

ASSIGNMENT OF THE CERTIFICATE: We are not responsible for the adequacy of any assignment. However, when an assignment is filed with us and recorded by us at our Administrative Office, the owner's rights and those of any revocable beneficiary will be subject to it, subject to legal restrictions.

WHAT THE CONTRACT IS AND HOW YOUR STATEMENTS AFFECT IT: The Group Master Policy, the Participation Agreement, this Certificate, your application or enrollment form and any riders, endorsements and/or amendments form the entire contract of insurance. All statements made by or for an insured will be considered representations and not warranties. We will not use any statement made by or for an insured to contest this insurance unless: (1) that statement is in writing; (2) that statement has been signed by, or on behalf of, the insured; and (3) a copy of that statement has been given to the insured, his/her beneficiary or his/her personal representative.

GROUP PARTICIPANT AS YOUR AGENT: For all purposes related to this insurance, your Group Participant serves as your agent and not as our agent.

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER
(Applicable Only to Employee and Spouse)

TRANSAMERICA LIFE INSURANCE COMPANY has issued this Rider as part of the Certificate to which it is attached (your Certificate). The effective date of this Rider is the later of: (1) the date insurance starts under your Certificate; or (2) the Effective Date shown in the Notification of Certificate Change Endorsement. **PLEASE READ THIS RIDER CAREFULLY.**

DEFINITIONS:

Accidental Bodily Injury means an injury that, directly and independently of all other causes, results solely from a sudden and forceful event that happens solely and directly from unforeseen external and involuntary causes.

Accidental Death means loss of life that, directly and independently of all other causes, results from an accidental bodily injury.

Covered Loss means accidental death or dismemberment that occurs within 365 days of an accidental bodily injury, subject to the What We Will Not Pay provision of this Rider. **Covered Loss** also means: (1) accidental death or dismemberment that occurs within 365 days of an accident that results in unavoidable exposure to the elements; and (2) disappearance, if within 365 days of an accident, your body has not been found after the vehicle in which you were traveling disappeared, made a forced landing, sank or was wrecked.

Dismemberment means an accidental bodily injury that, directly and independently of all other causes, results in the loss of: (1) a hand; (2) a foot; (3) the thumb and the index finger on the same hand; (4) sight; (5) speech; or (6) hearing. **Dismemberment** also means: (1) hemiplegia; (2) paraplegia; and (3) quadriplegia.

- Loss of a hand means actual severance at or above the wrist.
- Loss of a foot means actual severance at or above the ankle.
- Loss of thumb and index finger means actual severance at or above the point at which they are attached to the hand.
- Loss of sight means total and permanent loss of sight.
- Loss of speech means total and permanent loss of speech.
- Loss of hearing means total and permanent loss of hearing.
- Hemiplegia means total and permanent paralysis of both an arm and a leg on the same side of the body.
- Paraplegia means total and permanent paralysis of both legs.
- Quadriplegia means total and permanent paralysis of both arms and both legs.

Doctor means a U.S. licensed medical practitioner, other than a nurse, who is practicing within the scope of his/her license. A doctor does not include yourself or a member of your immediate family. Your immediate family includes your spouse, children and their spouses, parents, grandparents, grandchildren and their spouses, brothers or sisters and their spouses.

You (for purposes of this Rider only) means either the Employee or the Spouse shown in the Certificate Schedule.

WHAT WE WILL PAY: If you suffer a covered loss, we will pay the applicable benefit shown in the Table that follows. If more than one covered loss occurs as a result of the same accidental bodily injury, we will pay for the loss that has the largest benefit. If you have more than one covered loss as a result of more than one accidental bodily injury, we will not include the amount we paid for a previous covered loss when we determine the amount that we will pay for a subsequent covered loss. The benefit we pay for accidental death is in addition to your death benefit under your Certificate.

Covered Loss	Benefit Payable
Accidental Death OR Loss of two or more members ("member" means a hand, foot or sight of an eye)	100% of your death benefit
Quadriplegia	100% of your death benefit
Loss of speech AND loss of hearing in both ears	100% of your death benefit
Paraplegia	75% of your death benefit
Loss of one member OR loss of speech OR loss of hearing in both ears ("member" means a hand, foot or sight of an eye)	50% of your death benefit
Hemiplegia	50% of your death benefit
Loss of hearing of one ear OR loss of thumb and index finger of same hand	25% of your death benefit

WHO WE WILL PAY: We will pay your dismemberment benefit(s) to you, and your accidental death benefit to your beneficiary, as provided in your Certificate.

WHAT WE WILL NOT PAY: We will not pay any benefits if the loss, directly or indirectly, results from any of the following, even if the means or cause of the loss is accidental:

- suicide or intentionally self-inflicted injury, while sane or insane;
- commission of or attempt to commit an assault or felony;
- sickness or mental illness, disease of any kind, or medical or surgical treatment for any sickness, illness or disease;
- injuries received while under the influence of alcohol, a controlled substance or other drugs as defined by the laws of the State where the accident occurs, except as prescribed by a doctor;
- any poison or gas voluntarily taken, administered, absorbed, or inhaled (except in the course of employment);
- flight in any kind of aircraft, except as a fare paying passenger on a regularly scheduled commercial aircraft;
- any bacterial or viral infection;
- declared or undeclared war, or any act of war; and
- taking part in an insurrection.

WHEN THIS RIDER STOPS: This Rider stops on the employee's 70th birthday.

RULES FOR FILING A CLAIM: You must tell us about a claim within 90 days after the date of the covered loss. If you cannot tell us within 90 days, you must tell us as soon after that as is reasonably possible. You must submit claims to us at our Administrative Office. You can get a claim form by calling our toll-free telephone number. If we do not send the claim form within 15 days, you can simply send us written proof of the claim. The proof must describe the covered accident, the nature and extent of the cause for which the claim is being made, and it must be signed by a doctor. This proof must be acceptable to us. Unless you have been legally incapable of filing proof of a claim, we won't accept it if it is filed more than 12 months from the date of the covered accident.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to arrange for you to be examined by a doctor of our choice at our expense as often as is reasonably required while a claim is pending. We also have the right to arrange for an autopsy in case of accidental death, if it is not forbidden by law. You must allow us the opportunity to exercise these rights.

Except as shown in this Rider, the provisions of your Certificate will prevail.

General Counsel and Secretary

President

TRANSAMERICA®
Employee Benefits

Instructions for Submitting a Death Claim Form

CLAIMANT'S STATEMENT:

1) Every question is to be fully and distinctly answered. If space is insufficient for a full and complete answer, additional information may be attached to the Claimant's Statement. Complete answers will assist the Company in taking prompt action on the claim.
2) The beneficiary or claimant is to complete the Claimant's Statement. If one claimant is making claim under two or more policies he is to complete only one Claimant's Statement covering all policies.
3) If there is more than one beneficiary, each beneficiary must complete the Claimant's Statement.
4) If the policy is payable to the Estate or to the Executors or Administrators of the Insured, the Claimant's Statement should be executed by the Executor or Administrator. A certificate of his appointment must be furnished.
5) If the policy is payable to a minor or a mentally incompetent person, the Claimant's Statement is to be executed by the guardian. A certificate of the guardian's appointment is to be furnished; otherwise contact the Company for instructions.
6) If the policy has been assigned absolutely both in form and in fact, the Claimant's Statement is to be completed by the assignee. If collaterally assigned, the Claimant's Statement is to be completed by both the beneficiary and assignee. (Upon approval of claim, payment will be made payable jointly to beneficiary and assignee, unless otherwise directed.)
7) If all or any portion of the proceeds are assigned for funeral expenses, we require 1) an itemized statement of the total funeral expenses and 2) a valid assignment bearing the signatures of all beneficiaries.
8) Under current federal tax laws, each Claimant is required to provide us with a Social Security or tax reporting number and certify that he/she is not subject to backup withholding. You may be subject to backup withholding if (1) you fail to provide us with your Social Security or tax reporting number, pursuant to Internal Revenue Code ("IRC") Section 3406(a)(1)(A); or (2) you were notified that you have underreported interest or dividend income or you were required to but failed to file a return which would have included reportable interest or dividend payments, pursuant to IRC Section 3406(a)(1)(C). If you are subject to these backup withholding rules, we are required to withhold 28% of any reportable interest payments. Indicate whether you are subject to backup withholding on question # 6.

EMPLOYER'S/BUSINESS ENTITY'S STATEMENT:

9) It is necessary that the "Employer's/Business Entity's Statement" portion be completed and signed by an authorized representative of the employer/business entity (Policyholder).
10) The employer/business entity must include verification that premium deductions were being made for coverage when the death occurred, as well as proof of the amount of premiums being deducted.
11) A photocopy of the Insured's Enrollment Form is also required.

CERTIFIED COPY OF DEATH CERTIFICATE:

12) In order to process death claims, you must include a certified copy of the death certificate along with this claim form.

NOTE: The cost, if any, of completing claim papers, is to be borne by the beneficiary or claimant.

If the decedent is not the Policy Owner and premiums have been paid by salary deductions, the Policy Owner must contact the employer to discontinue salary deductions for the decedent's policy.

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company

Administered By: Boon Administrative Services, Inc.
P.O. Box 559017, Austin, TX 78755

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

Description of Personal Representative's Authority or Relationship to Patient/Insured _____

Policy of Contract Number _____

Claimants should retain a copy of this signed document for their records

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company
Administered By: Boon Administrative Services, Inc.
P.O. Box 559017, Austin, TX 78755

Death Claim Form

Decedent's Information				
1. Name in Full	2. Social Security No.	3. Policy No.		
4. Date of Birth	5. Street Address	6. City	7. State	8. Zip Code
9. Employer's Name				
10. Street Address	11. City	12. State	13. Zip Code	
14. Date Last Worked	15. Occupation at Death			
16. Date of Death	17. Place of Death	18. Cause of Death		

19. Name of all physicians or practitioners who attended decedent within five years preceding death: *(attach additional sheet if needed)*

Name	Address	Date of attendance	Diseases or condition

Claimant's Information		
1. Name in Full	2. Social Security No.	3. Date of Birth
4. Daytime Phone Number	5. Evening Phone Number	

6. Are you subject to backup withholding? ☐ Yes ☐ No *(see instruction # 8 for more information on taxes)*
I certify that this is my correct tax reporting number, and that I am not subject to backup withholding.

Signature _____ Date _____

This claimant made claim to the insurance and agrees that by furnishing this form, the Company does not admit that any insurance was in force on the life of the deceased and does not waive any of its rights or defenses.

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

Signature _____ Relationship to deceased _____

Address	City	State	Zip code

The information above is true and correct to the best of my knowledge.

Claimant's Signature _____ Date _____

Employer's/Business Entity's Statement				
1. Decedent's Name in Full	2. Decedent's Age	3. Employee's/Insured Person's Name	4. Employee's/Insured Person's Social Security No.	
5. Name of Company	6. Group Policy No.	7. Employee/Insured Person was ☐ Salaried ☐ Hourly	8. Employee's/ Insured Person's annual salary as per date of loss	
9. Date Insured (employee/insured person)	10. Date Insured (dependent)	11. Date of Hire	12. Last date Employee/Insured person worked	
13. Employee's/Insured Person's status as of last date worked: ☐ Active ☐ Vacation ☐ Leave of Absence ☐ Laid Off ☐ Terminated ☐ Retired If other than Active, Please explain:_____			14. Date employee/insured person returned to work:	
15. Did injury occur on duty ☐ Yes ☐ No	16. If "Yes", give date of injury and details			
17. Amount of Insurance	18. Amount of Claim	19. Was premium paid and insurance in force at time of loss? ☐ Yes ☐ No		

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

Printed Name of Authorized Representative	Signature of Authorized Representative	Official Title

Phone Number _____ Fax Number _____

REQUIRED FRAUD WARNING STATEMENTS

Claimants are required to acknowledge receipt of fraud warnings. Please refer to the fraud warning statement for your state as indicated below. Sign, date, and return with claim documents.

FOR RESIDENTS OF ALASKA or TEXAS: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, or misleading information may be prosecuted under state law.

_____

Claimant's signature Date

FOR RESIDENTS OF ARIZONA: For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

_____

Claimant's signature Date

FOR RESIDENTS OF CALIFORNIA: For your protection California law requires the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

_____

Claimant's signature Date

FOR RESIDENTS OF COLORADO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from the insurance proceeds shall be reported to the Colorado Division of Insurance within the department of regulatory agencies.

_____

Claimant's signature Date

FOR RESIDENTS OF DELAWARE, IDAHO, INDIANA or OKLAHOMA: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

_____

Claimant's signature Date

FOR RESIDENTS OF DISTRICT OF COLUMBIA, LOUISIANA or RHODE ISLAND: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

_____

Claimant's signature Date

FOR RESIDENTS OF FLORIDA: 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.

_____

Claimant's signature Date

FOR RESIDENTS OF HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both

_____

Claimant's signature Date

FOR RESIDENTS OF MAINE, TENNESSEE or VIRGINIA: It is a crime to knowingly provide 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.

_____

Claimant's signature Date

FOR RESIDENTS OF MARYLAND: 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.

_____

Claimant's signature Date

FOR RESIDENTS OF MINNESOTA: A person who files a claim with intent to defraud or help commit a fraud against an insurer is guilty of a crime.

_____

Claimant's signature Date

FOR RESIDENTS OF NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided by RSA 638:20.

_____

Claimant's signature Date

FOR RESIDENTS OF NEW YORK: 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 act, which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____

Claimant's signature Date

FOR RESIDENTS OF PUERTO RICO: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand (5,000) dollars and not more than ten thousand (10,000) dollars, or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances are present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

_____

Claimant's signature Date

FOR RESIDENTS OF ALL OTHER STATES AND TERRITORIES: 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.

_____

Claimant's signature Date

TRANSAMERICA®
Employee Benefits

Transamerica Life Insurance Company

Administered By: Boon Administrative Services, Inc.
P.O. Box 559017, Austin, TX 78755

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

I hereby authorize the use or disclosure of health information about the Insured as described below and revoke any previous restrictions concerning access to such information:

1. Person(s) or group(s) of persons authorized to use and/or disclose the information: Any physician, medical practitioner, hospital, clinic, pharmacy, long-term care facility, nursing home, assisted living facility, home health care entity, medical or medically-related facility, laboratory, and insurance company (including the Company selected above), or other organization, institution or person having records or knowledge of the Insured's health.
2. Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information: the Company noted above, its affiliates, its reinsurers, their agents or other representatives, and business associates.
3. Description of the information that may be used or disclosed: This authorization relates to the release of any medical records necessary to evaluate and determine the Insured's eligibility for benefits, including, but not limited to, those containing diagnoses, treatments, prescription drug information, alcohol or drug abuse information, or information regarding AIDS. Exception: psychotherapy notes require a separate signed authorization.
4. The information will be used or disclosed only for the following purpose(s): The requested information will be used for any claim processing purposes, including but not limited to determining the Insured's benefit eligibility and making benefit determinations.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that the Insured's eligibility for benefits may be affected if I refuse to sign this form. In that case, the Company may not be able to determine if the Insured qualifies for benefits.
- I understand that the Insured has a right to receive the HIPAA Notice of Health Information Privacy Practices that explains the Company's privacy practices (not applicable to life, accident or disability insurance policies).
- I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, to the extent that other law provides the Company with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Company's Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment or health care operations.
- This authorization shall be valid for as long as claims continue under the policy, and I understand I am entitled to a signed copy.
- A copy of this authorization will be considered as valid as the original.
- I acknowledge that I have received a copy of this authorization.

Patient/Insured's Name/Signature _____ Date _____

Patient/Insured's SSN _____ Patient/Insured's Date of Birth _____ Patient/Insured's Phone No. _____

Patient/Insured's Address _____

Personal Representative's (if any) Name/Signature: _____ Personal Representative's Phone No. _____

Personal Representative's (if any) Address _____

Description of Personal Representative's Authority or Relationship to Patient/Insured _____

Policy or Contract Number _____

Claimant should retain a copy of this signed document for their records