Guaranteed Issue Limited Benefit Medical Insurance Program Options

Take as a stand alone or to complement Major Medical!

Enroll Today!

More information and enrollment can be found on the website https://www.gisconline.com/tlw or call 1-877-817-4803

Plan Options	Freedom Plan	Liberty Plan
TransChoice® Benefits	**Benefit Amount**	**Benefit Amount**
Daily In Hospital Indemnity Benefit—maximum of 30 days per confinement	$300 per day	$750 per day
Outpatient Physician Office Visit Indemnity Benefit—up to 5 visits per calendar year for you and your spouse each, up to 5 visits per calendar year for all children combined	$50 per visit	$75 per visit
Outpatient Diagnostic X-Ray & Laboratory Indemnity Benefit—up to 3 days of testing per calendar year, per covered person	$50 per day	$75 per day
Surgical & Anesthesia Indemnity Benefits—Pays benefit amount shown in the specified plan surgical schedule for the type of surgery performed; pays 20% of the Surgery Benefit for the administration of anesthesia	$1,000 Plan Surgical Schedule	$2,000 Plan Surgical Schedule
Off-The-Job Accidental Injury—100% of expenses up to a maximum specified per covered accident, up to 5 covered accidents per covered person per calendar year (off-the-job only)	$300 Maximum	$500 Maximum
Critical Illness Indemnity Benefit and Subsequent Critical Indemnity Benefit—Up to a lump-sum benefit for the initial diagnosis of a covered critical illness and also an additional lump-sum benefit of the same amount for a subsequent and separate covered critical illness	Up to $10,000	Up to $10,000
Wellness Indemnity Benefit	$25 for physical exams or certain diagnostic tests; one benefit per calendar year per insured, 6 month waiting period	
Group Term Life Insurance Policy with Accidental Death and Dismemberment (AD&D) Rider	Employee: $5,000 Spouse: $2,500 Child(ren) over 6 months: $2,500	
Prescription Drug Indemnity Benefit	$10 per prescription for up to 12 prescriptions per calendar year for you and your spouse each, 12 prescriptions per calendar year for all children combined	
TransChoice® Non-Insurance Benefits		
Employee Discount Card - Offered by New Benefits, Ltd.	This card will provide access to a discount Vision Plan, a Nurses Hotline, Counseling Services and discounts for Hearing Aids	
PPO Network - Offered by Key Benefit Administrators (KBA) Providers can be located at www.multiplan.com	You and your covered dependents will receive contracted discounts from the normal fees charged by network physicians, hospitals, and outpatient x-ray and laboratory provides	
Prescription Drug Discount Card—Offered by Caremark with 55,000 participation providers	You can receive a discount of at least 14% off the retail pharmacy price of brand name drugs and up to 60% for generic drugs.	
Monthly Premium	**Freedom Plan**	**Liberty Plan**
Member Only	$95.00	$148.00
Member + Spouse	$157.00	$259.00
Member + Child(ren)	$150.00	$242.00
Member + Family	$213.00	$354.00

*AD&D coverage is not available for dependent children

**The above rates include an $4 per month billing fee and a $4 administration fee ***Eligible members must also be a member in good standing of CARE

Policy Form Series CP200100 and CC200100 Underwritten by Transamerica Life Insurance Company, Home Office; Cedar Rapids, IA

TransChoice® Limitations and Exclusions:

No benefits will be payable as the result of:

- suicide or any attempt thereof, while sane or insane;
- any intentionally self-inflicted injury or sickness;
- rest care or rehabilitative care an treatment;
- immunization shots and routine examinations such as physical examinations, mammograms, pap smears, immunizations, flexible sigmoidoscopy, prostate-specific antigen tests and blood screenings unless the Wellness Benefit is included;
- routine newborn care, including routine nursery charges;
- the treatment of mental illness; functional or organic nervous disorder, regardless of cause; alcohol abuse; and drug use, unless such drugs were taken on the advice of a physician and taken as prescribed. In such circumstances and with respect to payment of the Daily In-Hospital Indemnity Benefit, benefits will be limited to no more than 10 days in any calendar year;
- participation 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;
- participation in an organized contest of speed, parachuting, parasailing, bungee jumping, or hang gliding;
- air travel, except as a fare-paying passenger on a commercial airline on a regularly scheduled route, or as a passenger for transportation only and not as a pilot or crew member;
- any accident caused by the participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a physician or taken according to the physician's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred);
- any procedure or treatment to change physical characteristics to those of the opposite sex and other treatment related to sex change;
- the reversal of tubal ligation and vasectomies;
- artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or physician's services, unless required by law;
- any loss incurred while on active duty status in the armed forces (if the insured notifies Transamerica of such active duty Transamerica will refund any premiums paid for any period for which no coverage is provided as a result of this exception);
- accidents or sicknesses arising out of and in the course of any occupation for compensation, wage, or profit OR expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
- pre-existing conditions during the first 12 months after the effective date (only applies to the Critical Illness Indemnity Benefit and Subsequent Critical Illness Benefit);
- air or ground ambulance transportation (unless the Ambulance Benefit has been included);
- routine eye examinations or fitting of eye glasses;
- hearing aids or fitting of hearing aids;
- dental examinations or dental care other than expenses resulting from an accident;
- care or treatment of an accident or sickness not specifically provided for in the plan;
- any surgical procedure not specifically listed in the Schedule of Surgical Indemnity Benefits;
- with respect to the Off-the-Job Accidental Injury Benefit only, charges that the covered person is not legally required to pay, or charges which would not have been made if this coverage had not existed; or
- treatment of an accident or sickness made necessary by or arising from war, declared or undeclared, or any act of war.

Transamerica Life Insurance Company Group Term Life and AD&D Rider Limitations and Exclusions:

Group Term Life—We will not pay a death benefit if an insured dies by suicide, while sane or insane, within two years of the date his or her insurance starts. If the insured or his or her spouse dies by suicide, we will refund the premiums paid for the insurance (if a dependent child dies by suicide, we will refund the premiums paid for the dependent children's insurance only if there are 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.

AD&D Rider—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.

ENROLLMENT STEPS

Please complete the following easy steps to enroll in this great new benefit:

To Enroll By Mail:

STEP 1
Complete, Sign and Date Enrollment form. Be sure to include information on all individuals to be covered.

STEP 2
Complete, Sign and Date the Payment Options Form.

STEP 3
Write a Check made payable to GIS for the first month's premium.

STEP 4
Return the following items to: GIS Benefits Center
PO Box 8633
Madison, WI 53708-8633

1. Completed Enrollment Form
2. Completed Payment Option Form
3. Check made payable to GIS for one month's premium

To Enroll Online:

Go to https://www.gisconline.com/tlw
-Credit Card payment is the only option if you enroll online

For Questions:

If you have any questions on the
enrollment process or payment options, please contact
GIS Benefits Center at
1-877-817-4805

If you have any questions on
specific policy benefits, please contact
Transamerica-KBA at
1-866-867-6883

CARE Benefits Program Enrollment Form

Complete form along with Payment Option Form and return to the address at the bottom with a check for the first month's premium

Group Name: TLW Group Number: B00202

Member (Last, First, M.I.)	☐Male ☐Female	Social Security No.	Date of Birth	Date of Marriage***
Spouse** (Last, First, M.I.)	☐Male ☐Female	Social Security No.	Date of Birth	
Home Address		Employer Name		Date of Hire
City	State	Zip Code	Home Phone	

Child(ren) Name	Date of birth	Gender	Student	Child(ren) Name	Date of birth	Gender	Student
		☐M ☐F	☐Yes ☐No			☐M ☐F	☐Yes ☐No
		☐M ☐F	☐Yes ☐No			☐M ☐F	☐Yes ☐No

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

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

Do you choose to enroll in the Limited Medical Indemnity Program ☐Yes ☐No If Yes: ☐Freedom ☐Liberty

I am enrolling in: ☐Member ☐Member Plus Spouse** ☐Member Plus Children ☐Member Plus Family

*Premium includes TransChoice Premium, CARE fee and Billing/Administration Fees

Monthly Premium*
$

Medical Eligibility Question

1. Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? ☐Yes ☐No

If "Yes", list name (s)_____, who will be excluded from coverage

Do you choose to enroll in the Dental Coverage ☐Yes ☐No If Yes: ☐Value ☐Standard ☐Royal

I am enrolling for: ☐Member ☐Member Plus Spouse** ☐Member Plus Children ☐Member Plus Family

*If you are not enrolling in the Medical Program, you must add $1 to your dental Premium for the CARE membership fee.

Monthly Premium
$

Do you choose to enroll in the Eye Care Coverage ☐Yes ☐No

I am enrolling for: ☐Member ☐Member +1 ☐Member + 2 or more

*If you are not enrolling in the Medical Program, you must add $1 to your Eye Care Premium for the CARE membership fee.

Monthly Premium
$

Applicant's Statements and Agreements:

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 whoknowingly 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 insurance act, which is a crime and subjects person to criminal and civil penalties

I also 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 of mMembers; b) I must have satisfied the Association waiting period; c) the Association 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

By signing this I am also enrolling in the CARE association and understand that I must keep this membership in good standing to keep this insurance.

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

Member's Signature _____ Spouse's** Signature (If applicable)_____

Licensed Representative's Name_____ Licensed Representative's Signature _____ Agent #_____

Please send this enrollment form, along with your first month's premium to:

GIS Benefits Center
P.O. Box 8633
Madison, WI 53708-8633

CBPTLOW-09-07

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

Greater Insurance Service Corp. Payment Option Form

Please Complete the Following Information
Please Print
Insured Name:_____ Phone: _____

Address: _____
Street City ST ZIP

Please Select and Check one of the Following Payment Methods

☐ VISA Monthly ☐ MasterCard Monthly

There will be a 4% of premium billing fee for this option.

Instructions for Credit Cards

1. Please complete the following account information and return with a check made payable to Greater Insurance Service for one month's premium
2. Credit cards will be charged around the 20th of the month for the next month's premium (*see example at bottom)

Account # ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____ - ____ ____ ____ ____
Expiration Date: ____/____
Name as it appears on the card: _____

Cardholders Signature: _____

☐ Personal Account Insurance Deduction (P.A.I.D.) Arranged by Greater Insurance Service Corp

Instructions for P.A.I. D.

1.-Please submit voided check (no deposit slips) and a check for one month's premium made payable to GIS.
2.-Premium will be deducted around the 15th of each month for the next month's premium (*see example at bottom)

Please Select the Account Type for Withdrawal
WITHDRAWAL AUTHORIZATION

☐ **Checking Account** ☐ **Savings Account**

Name of Depositor _____
(Print name as shown on Financial Institution Records)

Bank Information _____
(Bank Name, Address and Phone # where account is maintained)

TRANSMIT/ROUTING ABA#_____ ACCT. NO. _____

PRE-AUTHORIZED WITHDRAWAL PAYMENT METHOD

As a convenience to me, I hereby request and authorize Greater Insurance Service Corp. to pay and charge to my account, maintained at the above named financial institution, for the payment of premiums due on policies I currently have or may purchase and desire to include under the P.A.I.D. Agreement. The amounts will be drawn on my account by and payable to the order of Greater Insurance Service Corp. provided there are sufficient funds in said account to pay the same upon presentation. This authorization will remain in effect until revoked by me in writing and until Greater Insurance Service Corp. actually receives such notice. I agree that Greater Insurance Service Corp. shall be fully protected in honoring any withdrawals. I understand that if the withdrawal is presented and not honored for any reason and the amount due is not paid, Greater Insurance Service Corp. assumes no responsibility for a policy lapse or cancellation due to non-payment. This arrangement shall terminate immediately upon the closing of my account with you or upon receipt by you of notice of my bankruptcy. I agree that your treatment of my rights in respect to each such charge shall be the same as if they were signed personally by me. A customer has the right to stop payment of a debit entry by notification to Financial Institution prior to charging account. After account has been charged the customer has the right to have the amount of an erroneous entry immediately credited to their account by Financial Institution up to 15 days following the issuance of statement or 45 days after posting, whichever occurs first.

_____ _____
Date Signature of Depositor

***An example of deductions is as follows: July's premium will be deducted June 20th for Credit Cards or June 15th for PAIDS. If you have any questions, please call our office at 1-800-747-4472.**

Form: GIS Payment 7-08