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|-----------------|--------------|
| City of Clinton | VF025683 |
| Policyholder | Group Number |

1. Contact Information

| | |
|---|-----------------------------|
| Anita Fransen | (580) 323-7873 |
| Administrative Contact (Daily Administration) | Fax Number |
| (580) 323-7897 | anita.fransen@clintonok.gov |
| Phone Number - Administrative Contact | Email Address |
| Anita Fransen | anita.fransen@clintonok.gov |
| Group Administrator (Plan changes, etc.) | Email Address |
| Anita Fransen | anita.fransen@clintonok.gov |
| Billing Contact (Billing Issues) | Email Address |
| 415 Gary Boulevard | |
| Billing Address | |
| Clinton | OK |
| City: | State |
| | 73601 |
| | Zip |

2. Benefits & Eligibility - As indicated in your proposal.

| | |
|--|---|
| Waiting Periods Subject to the actively at work provision contained in your proposal | New Hires: <u>60</u> <input checked="" type="checkbox"/> Days <input type="checkbox"/> Months <input type="checkbox"/> Years |
| | Do you have any current employees that need to fulfill the waiting period: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |
| | Employees are effective*: <input checked="" type="checkbox"/> 1st day of the insurance month following completion of the eligibility waiting period <input type="checkbox"/> The day following completion of the eligibility waiting period <input type="checkbox"/> Other: _____ |
| | Does any class have a different waiting period: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, Please describe in Special Request Section |
| | Does the waiting period apply to all coverages: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If NO, Please describe in Special Request Section |
| <i>* If medical underwriting is required, an individual's coverage will not take effect until the date the application is approved. The effective date will be delayed for an employee who is not actively at work or for a dependent whose activities are limited due to sickness or injury on the date coverage would otherwise take effect.</i> | |
| Minimum Hours | <u>30</u> (standard is 30 hours per week) |
| Annual Enrollment | Life / AD&D / Accident / Critical Illness / Disability and/or Vision <input checked="" type="checkbox"/> From <u>06/01</u> To <u>06/30</u> ie: (9/1 to 9/30) <input type="checkbox"/> Not Applicable |
| Prior Credit For Rehires | Is there prior employment credit for rehired employees? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If YES, credit will be given for employees rehired within 6 months, unless otherwise approved by The Company. Does the credit for rehires apply to all coverages: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If NO, Please describe in Special Request Section |
| Other | Do you have any Canadian Employees that work in the United States: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Do you intend to cover any US Citizens working outside of the United States: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Do you intend to cover any non-US citizens who work within the United States: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| Basic Dependent Life | Policyholder will contribute: <input checked="" type="checkbox"/> NA <input type="checkbox"/> Other <input type="checkbox"/> 0%; or _____ |
| Spouse Premium | If applicable, calculate spouse premium: <input type="checkbox"/> Based on Employee Date of Birth <input checked="" type="checkbox"/> Based on Spouse Date of Birth |
| Definition of Earnings | <input checked="" type="checkbox"/> As stated in the proposal <input type="checkbox"/> *Other _____ |
| <i>*If "Other" is selected, underwriting approval is required and the proposed rates are subject to change.</i> | |



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3. Group Administration

Certificates Email policy documents and certificates to:

| | | |
|---|---|--|
| <input checked="" type="checkbox"/> Group Administrator | <input type="checkbox"/> Administrative Contact | <input type="checkbox"/> Billing Contact |
| <input type="checkbox"/> Broker | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ |

Disability/Accident Coverage If the employee pays all or a portion of the premium, how is it paid: Pre-Tax Post-Tax Not Applicable

For STD Coverage: Benefits begin after sick leave, vacation, salary, PTO end Benefits begin immediately after the STD elimination period

Do all eligible employees participate in Social Security: Yes No If No, Explain _____

Do all eligible employees participate in Medicare: Yes No If No, Explain _____

Mailing Address for Sick Pay Reports:

Form 5500, Schedule A Does this group have 100 or more eligible employees: Yes No

If YES, what is the benefit plan month, day, and year _____

Information will be sent to the Group Administrator as listed in Section I above, unless otherwise stated below.

4. Billing

Billing Options for groups with:

| | | |
|---------------|--|---|
| 2-149 Lives | <input checked="" type="checkbox"/> List Billed Only | (We will provide an electronic bill with each employee's cost itemized with an option to pay on-line) |
| 150-499 Lives | <input type="checkbox"/> List Billed | (We will provide an electronic bill with each employee's cost itemized with an option to pay on-line) |
| | <input type="checkbox"/> Self Administered, Paper | (You provide to us the number of lives, volume, and premium by coverage, on a monthly basis.) |
| 500+ Lives | <input type="checkbox"/> Self Administered, Paper | (You provide to us the number of lives, volume, and premium by coverage, on a monthly basis.) |

Billing Method Monthly Quarterly

Premium is payable on the first of the month unless mutually agreed upon otherwise and explained in the special requests section of this form

Billing Set Up For List Billing Only

| | | |
|--|---|---|
| <input checked="" type="checkbox"/> Alphabetically You will receive one bill, with one total. Employees will be listed alphabetically. | <input type="checkbox"/> By Account* You receive multiple bills. Employees are separated by accounts. You can pay with multiple checks. | <input type="checkbox"/> By Location* You receive one bill, with subtotals and a grand total. Employees are separated by locations. |
|--|---|---|

*Please indicate billing divisions on the enrollment census. Also include additional billing addresses in the special requests section of this form

Third Party Benefits Administration

Third Party Benefits Administration means the Policyholder chooses or contracts with a vendor to provide services which may include enrollment administration, billing and/or premium collection of the products requested in the Group Application.

If you use a third party benefits administrator, please complete a Policyholder Vendor Authorization and Change Form and submit the signed form along with the completed Group Transmittal and Group Application. Please contact your sales representative to obtain a copy of the form.

5. Special Requests - Attach additional pages if needed.

Coverage Waiting Period: Basic Life/ADD should have no waiting period and should be effective date of hire
Supplemental Life/ADD will have the 60 day waiting period



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6. ERISA (SPD)

Applicant is subject to ERISA? [] Yes [X] No

If this plan is an "employee welfare plan," as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1001, et seq., as amended ("ERISA"), it is subject to certain requirements including those relating to reporting and disclosure and fiduciary responsibility.

You, as the plan Administrator or authorized representative, have selected us as the claims administrator of your plan, and you consent to the delegation of such authority to us.

We cannot be named as the plan administrator and is not responsible for the compliance of your plan with respect to any legal or tax matters, and it cannot offer any legal or tax advice.

ERISA requires the distribution of SPD's for the majority of employee benefit plans. If as plan administrator of your employee benefit plan, you would like us to provide you with the required documents to create your plan's SPD, including certain additional documents such as a Statement of ERISA Rights and Claims Procedure, please indicate "Yes" and provide the following information:

[] Yes [] No If Yes, provide the following: Plan Year Ends Annually On (Month/Day)**

Plan Number assigned to each line of coverage: (will be 3 digits starting with "5")**

Life/AD&D STD LTD AD&D Vision
Vol STD Vol LTD Vol Life Accident
Critical Illness Vol Vision Vol AD&D Vol Accident Vol Critical Illness

Plan Administrator**Required Fields (Address cannot be a P.O. Box)

[] Same as Policyholder [] Other, complete below

Name/Title Phone
Address City State Zip

Agent for Service of Process if different from plan administrator** (Address cannot be a P.O. Box)

Name/Title Phone
Address City State Zip

Plan Trustees (if applicable)** (Address cannot be a P.O. Box)

Name/Title Phone
Address City State Zip

Union Contracts/Collective Bargaining Agreements (if applicable)

*If you are not certain whether your plan is governed by ERISA, please visit the Department of Labor website for more information at: http://www.dol.gov/dol/topic/health-plans/erisa.htm

**Required Fields

7. Broker Authorization for Group Changes

I authorize the Broker of Record, including any subsequently named Broker of Record, to submit policy change requests on our behalf for the policy contracts identified under the Group Policy Number above. I also agree that the policy change requests will not become effective until approved.

8. Signature - This section must be signed.

Gene McCullough

Group Administrator's Signature (or other employee authorized to make plan changes)

6/10/2020

Date

GENE MCCULLOUGH

Typed or Printed Name



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|------------------------------------|
| <i>Additional Special Requests</i> |
| |

New Application Change Group #: VF025683 Federal Tax ID #: 73-6005149

Section 1. POLICYHOLDER INFORMATION: Please Type or Print All Information.

Policyholder (full legal name): City of Clinton

Address (not PO box): 415 Gary Boulevard

City: Clinton State: OK Zip: 73601

Subsidiaries or Affiliates to be covered: Yes; or No (If more than one, indicate on separate sheet and attach to this application)

If Yes: Company Name: _____

Address (not PO box): _____

City: _____ State: _____ Zip: _____

Premium is payable on the first of the insurance month unless mutually agreed upon by the Policyholder and the insurance company.

Section 2. GENERAL INFORMATION:

| Product Choice (Check all that apply) | Policyholder will Contribute: | Requested Effective: | * Replacing Coverage Yes/No |
|---|--|----------------------|-----------------------------|
| <input checked="" type="checkbox"/> Group Term Life <input checked="" type="checkbox"/> AD&D: | <input checked="" type="checkbox"/> 100%; or <input type="checkbox"/> Other: _____ % | <u>07/01/2020</u> | <u>Yes</u> |
| <input checked="" type="checkbox"/> Voluntary Term Life <input checked="" type="checkbox"/> AD&D: | <input checked="" type="checkbox"/> 0%; or <input type="checkbox"/> Other: _____ % | <u>07/01/2020</u> | <u>Yes</u> |

* Enclose a copy of each in force policy to be replaced.

Section 3. POLICYHOLDER STATEMENT:

The Policyholder or authorized representative (Policyholder) applies for a group insurance policy(s) through Dearborn Life Insurance Company.

The Policyholder represents and certifies that:

1. This application must be approved in writing by Dearborn Life Insurance Company. Issuing the insurance policy is evidence of approval. Coverage for insureds under the group policy is effective when the insured applies and is approved for coverage by Dearborn Life Insurance Company. The Policyholder will not collect premium from an insured who requires medical underwriting until Dearborn Life Insurance Company approves the insured's application for coverage; and
2. Dearborn Life Insurance Company will issue a policy only if Dearborn Life Insurance Company decides that the group is an acceptable risk based on Dearborn Life Insurance Company underwriting practices and procedures; otherwise Dearborn Life Insurance Company has no liability except to refund premium. The Policyholder must return to individual insureds any part of the premium paid by those insureds; and
3. The premium rates are contingent, based on the accuracy of insured eligibility data given to Dearborn Life Insurance Company by the Policyholder. Misstatements on an insured's application or failure by the Policyholder or insured to report new medical information before an insured's effective date of coverage may cause a change to the coverage or premium rate as of the policy effective date; and
4. The Policyholder and insureds are subject to all the policy terms and provisions and trust agreements, if applicable. They may be amended from time to time; and
5. If the Policyholder does not collect or pay premiums by the premium due date, the policy will terminate at the end of the policy's grace period; and
6. Even with the purchase of a disability policy, the Policyholder may be required to buy disability coverage under a state disability benefit act or law; and
7. The Policyholder will: a) send Dearborn Life Insurance Company applications of individual insureds prior to the eligibility date; b) give certificates to all insureds; c) report changes in the insured group to Dearborn Life Insurance Company; and d) keep records of insured eligibility.
8. The information given and statements made on this application are complete and correct. Misstatements or omissions of information may affect the validity of any insurance policy issued and cause the denial of an otherwise valid claim.
9. Statements made by the Policyholder are representations and not warranties. No statement made by any insured will be used in any contest unless a copy of the instrument containing the statement is or has been given to the insured or, in case of death or incapacity of the insured, to his beneficiary or personal representative.

This application and the payment of premium are consideration for any master policy and certificates issued. This application is part of any insurance policy issued. The authorized signature on this application is acceptance of the policy terms.

DocuSigned by:

 364CC0008C7E406...

 Authorized Signature

6/10/2020

 Date (Must be signed prior to Effective Date)

GENE MCCULLOUGH, ACTING CITY MANAGER

 Print Name and Provide Title

 Licensed Resident Agent (if required)