## GROUP DENTAL/VISION MASTER APPLICATION Application is hereby made to:

## American Family Life Assurance Company of Columbus 4919 W Laurel Street, Tampa, FL 33607 Toll-Free Phone 1.877.864.0625

Please provide Aflac with the selection of the benefits you wish to make available to your Eligible Members by completing the information below. Eligible Members are your employees or members who are eligible for coverage under the Policy.

PROPOSED POLICYHOLDER					
Legal Name of Group Tyler County Phone (409) 283-3054					
Physical Address 100 W. Bluff Street					
CityIstateIzip Woodville, Tx 75979					
Billing Address (If different) Phone ()					
City\State\Zip_					
Contact for Administration & Eligibility Leann Nonk					
Email Address I Monk, cotrease co. tyler, tx. (1.5					
Contact for Billing 110egan Odom					
Email Address _ modom, and @ co. tyler. tx, us					
Subsidiaries/Affiliates/Divisions (If applicable)					
CENEDAL MUNICIPAL MUNICIPA					
GENERAL INFORMATION  General Eligible Member Requirements					
A full-time Eligible Member is a person who works HD hours or more per week. A Member must be Actively at Work on the date He applies for coverage and on the date His Certificate of Insurance becomes effective. An Eligible Member must complete months of continuous service to					
Nümber of Employees/Members 114 Number of Eligible Members 114					
Class of Eligible Members					
Regular full-time Members					
Requested Policy Effective Date 1112 Plan Year Type Delicy Year Calendar Year					
Initial Rate Guarantee Rates are guaranteed for year(s) from the Group Policy Effective Date.					
Participation Specific participation requirements may apply based on group size and coverage selected. If so, coverage will not be effective until the participation requirements are met. To prevent cancellation of coverage after the Initial Term of the policy, the participation requirements must be maintained continuously while the insurance is in force.					
I understand Aflac may conduct audits to confirm participation requirements are being met now and in the future, Lagree to furnish the information/documentation required to conduct such audits upon Aflac's request.					

Proposed Policyholder agrees to transmit the total premiums under the group policy to Aflac when due. The Proposed Policyholder agrees to accept the terms and provisions of the group policy, including its exhibits, riders, endorsements or amendments, if any. No statements can change the terms of the contract unless attached to the policy and approved by Aflac's President and Secretary.  Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.  Signed and Dated at	Coverage Requested	<del></del>	<del></del>		
Attach a copy of the proposal.  Replacement This Group Dental Policy is wis not replacing an existing Group Dental Policy. If it is, provide carrier, Schedule of Benefits, and policy number:    VISION INSURANCE   Attach a copy of the proposal.   Replacement This Group Vision Policy is is not replacing an existing Group Vision Policy. If it is, provide carrier, Schedule of Benefits, and policy number:    GENERAL AGREEMENT	DENTAL INSURANCE				
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Authorized Robresentative of the Proposed Policyholder  Printed Name  ASSOCIATE'S/AGENT'S STATEMENT  Associate's/Agent's Name  (Last name)  (Last name)  (Middle Initial)  Associate's/Agent's writing number AFC S Sit: code  The undersigned, attest I have fully and completely explained the benefits and limitations of the policy(ies) to the Proposed Policyholder and to the associate's/Agent's Signature  Date	Any person who knowingly presents penalties under state law.	a false statement in an applic	cation for insurance may be	guilty of a criminal offense and sub	ject to
Authorized Robrésentative of the Proposed Policyholder  Printed Name  Associate's/Agent's Name  (Last name)  (Last name)  (Last name)  (Middle initial)  Associate's/Agent's writing number AFC15  Sit. code  The undersigned, attest I have fully and completely explained the benefits and limitations of the policy(ies) to the Proposed Policyholder and to the sessociate's/Agent's Signature  Date	Signed and Dated at _\_\_\_\_\_\_\_\	ville itx	on_9-12	n-21	
ASSOCIATE'S/AGENT'S STATEMENT  Associate's/Agent's Name	<b>.</b>	/ 1		Date	
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