GROUP DENTAL/VISION MASTER APPLICATION

Application is hereby made to:

Aflac.

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

Fax (409) 283-6306

City\State\Zip Woodville, TX 75979

Billing Address (If different) ______

Phone (____) ______

City\State\Zip ______

Fax (____) ______

Contact for Administration & Eligibility Leann Monk

Email Address lmonk.cotreas@co.tyler.tx.us

Contact for Billing Maegan Odom

Email Address modom.aud@co.tyler.tx.us

Subsidiaries/Affiliates/Divisions (If applicable) ______

GENERAL INFORMATION

General Eligible Member Requirements

A full-time Eligible Member is a person who works 40 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 3 months of continuous service to be eligible for coverage.

Number of Employees/Members 114 Number of Eligible Members 114

Class of Eligible Members

☑ Regular full-time Members

Requested Policy Effective Date 1/1/21 Plan Year Type ☐ Policy Year ☒ Calendar Year

Initial Rate Guarantee Rates are guaranteed for 1 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. I agree to furnish the information/documentation required to conduct such audits upon Aflac's request.

PLAN SELECTION

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Coverage Requested

☑ DENTAL INSURANCE

Attach a copy of the proposal.

Replacement This Group Dental Policy is ☑ is not ☐ replacing an existing Group Dental Policy. If it is, provide carrier, Schedule of Benefits, and policy number: NGL - National Guardian Life - Argus

☐ 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

Under ERISA (Employee Retirement Income Security Act of 1974), it is required that there be a named fiduciary for each employee benefit plan. It is understood that the undersigned Authorized Representative of the Proposed Policyholder is the named fiduciary for each employee benefit plan. The 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 Woodville, TX (City and State) on 9-13-21 (Date)

Authorized Representative of the Proposed Policyholder

Printed Name Le Ann Monk

Signature [signature]

Title Treasurer

ASSOCIATE'S/AGENT'S STATEMENT

Associate's/Agent's Name Golden (Last name) Juli (First name) (Middle initial)

Associate's/Agent's writing number AFC75 Sit. code 0

I, the undersigned, attest I have fully and completely explained the benefits and limitations of the policy(ies) to the Proposed Policyholder and to the Eligible Members.

Associate's/Agent's Signature Juli Golden (Licensed Associate/Agent) Date ____________________

QN81006.1

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