

**CONTRACT ROUTING FORM**

1. Complete the information below BEFORE printing and completing items 2 through 7. Items in red are required.

Department: County Manager's Office  
Department contract file name (use effective date): Aflac\_HR\_20240701  
Project Code: Click here to enter text.  
Contract type: Agreement  
Contracted Services/Goods: Aflac Insurance (Various coverage plans)  
Contract Component: undefined  
Change Order Number/Addendum Number: Click here to enter text.  
Vendor Name: Aflac  
Effective Date: 7/1/2024  
Approved by: County Manager  
Ending Date: Click here to enter a date.  
Total Amount: Varies

2. Department Head or his/her designee has read the contract in its entirety.  
By: Courtney Jones (Department Head signature required)

3. County Attorney has reviewed and approved the contract   
County Attorney has reviewed and rejects the contract  Reason: \_\_\_\_\_

This is an automatic renewal and does not require approval from the County Attorney: Yes  No

If this box is checked the County Attorney's Office has reviewed the contract but has not made needed changes to protect the County because the contract is a sole source contract and the services required by the County are not available from another vendor.

4. Technical/MIS Advisor has reviewed the contract if applicable. Yes  No

5. Vendor has signed the contract. Yes  No

6. A budget amendment is necessary before approval. Yes  No   
If budget amendment is necessary, please attach to this form.

7. Approval

- Requires approval by the BOC - contracts over \$100,000.00. Follow Board submission guidelines.
- Requires approval by the Manager – contracts \$100,000 or less.

8. Submit to Clerk.

**Clerk's Office Only**

Finance Officer has signed the contract  
 The Finance Officer is not required to sign the contract



## AFLAC ENROLLMENT & ADMINISTRATION GUIDE GROUP ONBOARDING

American Family Life Assurance Company of Columbus  
American Family Life Assurance Company of New York  
Continental American Insurance Company  
Continental American Life Insurance Company (CA DBA)  
("Collectively, Aflac")  
Version 20231031

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## WELCOME TO AFLAC

At Aflac, we focus on your experience.

For more than 60 years, we have promised to do right by our customers – and keep that promise with honest, straightforward conversations about your goals and needs.

We will use everyday words that make sometimes complex products and services accessible and understandable. We will be professional and compassionate.

Our Onboarding Team will guide you through the Aflac Program and partner with you to ease the implementation and make administration simple. We look forward to exceeding your expectations.

Thank you for choosing Aflac.

## PURPOSE

This Guide is an overview of the standards and best practices for implementing Your Aflac Group insurance program. The Guide outlines Your and Aflac's obligations and is the framework to implement the Aflac Group program.<sup>1</sup>

To help ensure a successful onboarding and administration experience, please review the **obligations and agreements** and complete the acknowledgement **here**.

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<sup>1</sup> If there are differences between this guide and the application for insurance or the insurance master policy or certificate, the policy forms will always govern. This Guide does not apply to Aflac's Premier Life Absence and Disability Services (PLADS) or Aflac Benefit Solutions Network Dental and Vision products.

## ONBOARDING OVERVIEW

The Aflac Implementation Manager is your single point of contact to deliver a seamless onboarding experience to you and your team. Over the next few weeks, you will partner closely with your Implementation Manager and key stakeholders to ensure expectations are clear and aligned.



There are various phases during implementation, with our first goal being a clear and easy setup of our plans for enrollment. However, our goal in implementation reaches far beyond the enrollment phase as we strive to provide a billing and administrative experience that meets your needs and promotes long term satisfaction of the Aflac benefits being a part of your program.

Following successful implementation, you will transition into our Service and Administration phase and be introduced to your Aflac Client Solutions team.

Throughout this process, we promise to keep you informed and engaged. We look forward to partnering with you and delivering on our promise!

### Electronic Enrollment Timeline

Each implementation starts with a timeline to set clear expectations for the activities need to make your program a success. The timeline below outlines general timing and responsibilities for each interested party and is based on your electronic enrollment method. Each implementation is unique, and timelines will vary based on client and vendor availability.

Phase	Activity	Responsibility	Timeframe
	Notification of Sale	Client	Client Dependent
	Implementation Assignment	Aflac	3 days from sale notification to Aflac HQ
<b>Pre-Enrollment</b>	Welcome Call / Data Collection	Aflac / Client	5-10 days from sale notification
	Signed Master Application	Aflac/Client	5 days from Welcome Call/Data Collection
	Platform Build Requirements	Aflac/Vendor	5 days from Welcome Call/Data Collection
	Technical Call	Aflac/Client/Vendor	3 days from Platform Build Requirements (as needed)
	File (EDI) Specifications	Aflac/Vendor	1 day after Technical Call (as needed)
	Custom Marketing Materials	Aflac	15 days from request date (as needed)
	Enrollment Site Review	Aflac/Vendor	Minimum 15 days prior to Open Enrollment
	Billing & Admin Call	Aflac / Client	5 days before Enrollment End (at the latest)
	Enrollment Site Approval	Aflac/Vendor	Minimum 5 days before Open Enrollment
	<b>Enrollment</b>	Enrollment Start	Client
Test (EDI) File		Vendor	5 days into Open Enrollment Start (as needed)
Enrollment End		Client	Client Dependent
<b>Policy Issuance</b>	Production (EDI) File	Vendor	10 days from Enrollment End
	Certificate Issuance	Aflac	Up to 15 days after Production (EDI) File
	Coverage Effective Date	Client/Aflac	Client Dependent
<b>Service &amp; Admin</b>	Payroll Deductions	Client	Within the Coverage Effective Date month
	Service Team Transition	Aflac / Client	20 days after Coverage Effective Date
	Premium Payment	Client	40 days after Coverage Effective Date

## OBLIGATIONS AND AGREEMENTS

As the plan administrator your agreement to the obligations outlined in this section is required. Please read carefully and let your Implementation Manager know if there are questions or concerns.

### *Enrollment Partners*

#### **1. You select your partners for enrollment.**

This may include administrative and/or technology platforms. Make sure that all Your partners agree to these enrollment guidelines. You are responsible for ensuring timely and accurate enrollment data is sent to Aflac, including any qualified life event status changes. Aflac will not take any status changes from an individual. If Your partner also collects and remits premium, You remain responsible for the actions of Your partner. If Aflac sponsors the enrollment partner, then an additional agreement may be required.

### *Master Application*

#### **2. You will sign and return all master applications prior to enrollment.**

Aflac will provide Master Application(s) that are specific to Your situs state and products offered. The Master Application will include Your legal name, city, state, eligibility waiting period, Aflac products, effective date of the product offering, and the general agreement to transmit premiums and accept the terms and provisions of the group policy.

### *Aflac Enrollment and Eligibility Guidelines*

#### **3. You understand and agree to adhere to these Enrollment and Eligibility Guidelines and will only allow enrollment of the Aflac plans to eligible employees.**

The following are standard Aflac enrollment and eligibility guidelines.

- The Effective Date for Aflac coverage is required to be the 1<sup>st</sup> of the month following the eligibility waiting period (as determined by You) and following the day coverage is elected.
- Enrollment may be made available for new hires, newly eligible employees, during open enrollment, or with a qualifying life event. Enrollment may not take place mid-year unless the aforementioned is true.
- Employees must participate in the plan(s) for Spouse and/or Child coverage be elected. Dependent only coverage is not available.
- Temporary or seasonal employees are not eligible.

*Build Requirements - Electronic Enrollment Only*

- 4. You are responsible and agree to ensure a proper build of the Aflac plans on Your electronic platform in accordance with the Build Requirements, with special regard given to the Compliance and Regulatory Language and the configuration of the enrollment rates.**

Aflac will provide to You and Your enrollment technology vendor Aflac Build Requirements and/or a Vendor Playbook. These documents provide guidelines for building Aflac products on Your platform for the purpose of enrollment. The Build Requirements include but are not limited to:

- Enrollment Eligibility Guidelines
- Eligibility Questions / Statements, if applicable
- Health Questions, if applicable
- Compliance and Regulatory Language
- Product Brochures
- Rates and rating rules

*Enrollment Forms - Paper Enrollment Only*

- 5. You, Your vendor, or Your Aflac representative will submit completed enrollment forms as scanned images in PDF format. Images must be legible, must include all pages of the enrollment form provided, and include a completed Transmittal Form (cover page).**

Aflac will provide PDF copies of paper enrollment forms that are specific to Your situs state and products offered. In accordance with State Department of Insurance and Aflac regulations, these enrollment forms should not be changed or edited without written consent from Aflac.

Enrollment Forms should be reviewed annually to ensure accuracy.

*Rates*

- 6. You are responsible for the validation of the rates enrolled and to ensure they align with the premium rates provided.**

Aflac will provide a detailed rate table for enrollment for each of the Aflac plans offered. Premiums may be based on age, tobacco status, dependents enrolled, or other factors.

*Product Brochures – Electronic or Paper Enrollment*

- 7. You are responsible and agree to make the product brochures available for employees to reference at the time of their enrollment.**

Aflac will provide product brochures that outline the benefits, limitations and exclusions for the products being enrolled.



*Enrollment Site Testing - Electronic Enrollment*

- 8. You are solely responsible for the accurate presentation of the Aflac Compliance and Regulatory Language and rates on the enrollment platform as provided in the Build Requirements.**

Aflac will have the right, but not the obligation, to conduct reviews of the enrollment platform to confirm a compliant and accurate build of the Aflac products.

*File Format and Submission - Electronic Enrollment or Employer-Paid Census*

- 9. You are responsible for ensuring secure, timely and accurate enrollment data is sent to Aflac, in accordance with the Aflac-provided File Specifications including any terminated coverage or qualified life event status changes.**

Aflac will provide File Specifications that include the file format and data requirements for the development of EDI File Transmission of enrollment elections. Aflac will create and/or grant You or Your enrollment technology vendor access to Aflac's Secure File Transfer Protocol (SFTP) for the submission of EDI Files.

Aflac may require a Test EDI File for validation of the file format and data structure prior to accepting a Production EDI File used for certificate issuance.

*Premium*

- 10. You or Your administrator agrees to collect and send premium payments to Aflac or Aflac's delegate and comply with laws related to payment and payroll deduction. Premiums collected and/or remitted by a third-party administrator or bill pay facilitator may require additional agreements.**

*Other Obligations and Agreements*

- 11. Act as the "Record Keeper."**

As Record Keeper You are responsible for:

- a. Collecting, maintaining, and retaining all the elements of enrollment for each individual covered by each plan. This includes employee level coverage, dependent information and when applicable, beneficiary information. This also includes keeping track of additions or deletions of coverage.
- b. Providing Aflac enrollment information. Information requested may include enrollment forms, beneficiary information, and/or information requested for a regulatory exam or legal action, underwriting or compliance audit, or fraud investigation. You agree to provide these documents in a reasonable period, within two business days.

- c. Maintaining records, policies and procedures, data logs and other documentation directly related to this Agreement in a manner that will allow review for ten years after coverage ends.

**12. Information to Employees.** Deliver all Aflac information to all eligible individuals.

Information includes enrollment forms, product brochures, certificates of insurances, notices, disclosures, disclaimers, and any other information given by Aflac for enrollment.

**13. Administrator.** You agree, when applicable, to act as a Cafeteria or ERISA Plan Administrator, and maintain a Business Associate Agreement with Your enrollment vendor, where applicable.

**14. Compliance.** Ensure compliance with applicable data security, privacy, payroll, and accessibility laws.

Aflac will have the right, but not the obligation, to conduct compliance reviews and audits of Your and/or Your vendors' systems, books, records, policies, procedures, internal practices, and/or data logs to verify compliance with this Guide and any related federal or state laws.

You agree to perform the above enrollment obligations on behalf of all eligible individuals. You agree to indemnify and hold Aflac harmless against loss, claim or action, including costs, penalties, and reasonable attorney fees, arising from Your failure to comply with this Guide.

Any person who knowingly and with intent to defraud, submits enrollment data or documentation to Aflac containing materially false information or who knowingly conceals or fails to disclose material information for the purpose of misleading Aflac commits a fraudulent insurance act.

Failure to implement and maintain compliance with this Guide may result in Aflac withdrawing its offering, changing its offering, or terminating its coverages.

**Acknowledged and Agreed:**

I have received a copy of these Enrollment Requirements and agree to follow them.

Legal Name of Group: \_\_\_\_\_

Printed Name of Authorized Representative: Dan LaMontagne

Signature of Authorized Representative: \_\_\_\_\_

Email: dan.lamontagne@chathamcountync.gov

Title: Dan LaMontagne, County Manager

Date: 4/8/2024

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Roy Lynch  
Roy Lynch, Finance Officer

## PREMIUM ADMINISTRATION

Your Implementation Manager will partner with you to find the most right administration model for your Aflac Program.

Your or Your designated facilitator is solely responsible for making payroll deductions, collecting premium, managing premium, reimbursing certificate holders as applicable, and managing any associated tax filings or withholdings.

### *Self-Bill with Summary Remittance*

Once per month, You or Your designated facilitator will self-initiate a premium payment to Aflac that includes premiums collected from the prior month. Aflac will monitor expected premium versus received premium and may partner with You to reconcile Aflac's administration system versus Your eligibility information.

#### **You agree to the following:**

1. Your enrollment technology will be the sole platform relied on for eligibility, active enrollment, and premiums to be collected.
2. You will make updates within the enrollment technology platform, including employee Terminations, coverage Cancellations, and other changes to enrollment (within Aflac's eligibility guidelines) that impact premiums.
3. Your or Your designated facilitator is responsible for collecting and remitting premium for all active certificate holders.
4. Your or Your designated facilitator is responsible for managing premium credits and refunding premiums to certificate holders when applicable.

### *Self-Bill with Detailed Remittance*

Once per month, You or Your designated facilitator will self-initiate a premium payment to Aflac that includes premiums collected from the prior month.

With each payment, You or Your designated facilitator will submit Payment Details breaking down the total monthly payment per certificate holder. The Payment Details may be submitted in .xlsx or .csv format and must be submitted securely through the [Aflac Group Remittance Portal](#).

#### **You agree to the following:**

1. Your enrollment technology will be the sole platform relied on for eligibility, active enrollment, and premiums to be collected.
2. You will make timely updates within the enrollment technology platform, including employee Terminations, coverage Cancellations, and other changes to enrollment (within Aflac's eligibility guidelines) that impact premiums.
3. You or Your designated facilitator are responsible for collecting and remitting premium for all active certificate holders.
4. You or Your designated facilitator will accept premium refunds and issue them to the certificate holders when applicable.
5. Your Payment Details will match the monthly payment amount.

## PAYMENT INSTRUCTIONS

### *Premium Payments*

Premiums are due by the 10<sup>th</sup> of the month following the deduction.

#### **Mailed Premium Payments:**

Aflac-CAIC  
PO Box 641629  
Pittsburgh, PA 15264-1629

#### **ACH Instructions:**

**Bank Name:** PNC Bank  
**Bank Address:** 500 First Ave, Pittsburgh PA 15219  
**Bank Routing #:** 043000096  
**Name on Account:** Continental American Insurance Company  
**Account Type:** Checking  
**Account #:** 1092208224

Addenda Record or Reference Field should include Group Name and Group #.

### *Premium Payments - New York Only*

Premiums are due by the 10<sup>th</sup> of the month following deduction.

#### **Mailed Premium Payments:**

Aflac-CAIC  
PO Box 641629  
Pittsburgh, PA 15264-1629

#### **ACH Instructions:**

**Bank Name:** PNC Bank  
**Bank Address:** 500 First Ave, Pittsburgh PA 15219  
**Bank Routing #:** 043000096  
**Name on Account:** American Family Life Assurance Company of New York  
**Account Type:** Checking  
**Account #:** 1092208208

Addenda Record or Reference Field should include Group Name and Group #.

## COMPENSATION DISCLOSURE

### *Producer and Third-Party Compensation Disclosure*

Aflac enters into arrangements concerning the sale, servicing, administration, and/or renewal of Aflac Group insurance products with licensed insurance producers (i.e., agents and brokers) and third parties, such as third-party administrators, consultants, payment facilitators, enrollers, and/or technology companies.

Producers are authorized by their license to confer with insurance purchasers about the benefits, terms, and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell, solicit, and negotiate insurance; and to provide other services to purchasers of insurance.

Compensation may include base commissions and supplemental compensation such as fees, awards, overrides, bonuses, contingent commissions, loans, gifts, prizes, and any other form of valuable consideration. Compensation may be based on the type of products sold, the volume of business produced, the profitability of insurance contracts produced, and/or whether a third-party administrator, consultant, payment facilitator, enroller(s), and/or technology company is required.

### *Base Commissions*

Base commissions are built into Your premium rate. Base commissions are paid as a percentage of premium or a fixed dollar amount and may be paid based on volume of business and other factors and may change at renewal. Base commissions are paid to the "broker of record" as long as You remain with Aflac and with Your broker.

### *Supplemental Compensation*

Supplemental compensation is generally available to any producer who meets qualifying criteria. Supplemental compensation may be based on one or more of the following: (1) the number of policies or coverages sold by the producer; (2) the amount of premium or fees generated by the producer; (3) the persistency ratio of policies sold by the producer; (4) the number of new customers generated by the producer; (5) premium growth by the producer; (6) additional services provided by the producer; and/or (7) a fixed percentage or sliding scale of premium. The costs of supplemental compensation is not directly included in premium but is considered overhead costs.

### *Third-Party Compensation*

Compensation may be paid directly to third parties for services. Compensation may be paid as a flat fee or on a per-employee basis. Examples include payments made to enrollment/technology platforms used to enroll insureds in coverage.

### *Additional Information*

You may obtain additional information about compensation directly from Your insurance professional.

**GROUP MASTER APPLICATION**

Application to:



**CONTINENTAL AMERICAN INSURANCE COMPANY**

P.O. Box 427, Columbia, SC 29202

By CHATHAM COUNTY Government  
Full Legal Name of Proposed Policyholder

Of Pittsboro, NC  
City and State in which the Master Policy will be Issued (situs state)

Including (if applicable) \_\_\_\_\_  
(Any Subsidiaries/Affiliates/Divisions)

**REPRESENTATIONS ARE MADE AS FOLLOWS:**

**General Employee Requirements**

A full-time Employee is one who works 19 hours or more per week. An Employee must be Actively at Work on the date he applies for coverage and on the date his Certificate of Insurance becomes effective. An Employee must complete 1 months of continuous service to be eligible for coverage.

Number of eligible Employees: **629**

The minimum number of enrolled Employees necessary to keep the Group Policy in force\*: **25 Payors**

\*See separate Hospital Indemnity requirement below

HEALTH COVERAGES: If this coverage will replace any existing Aflac individual policy, please be aware that it may be in the insureds' best interest to maintain their individual guaranteed-renewable policy with Aflac via direct bill. Insureds may contact Aflac for an explanation of their options for both continuation or cancellation of any existing coverage.

ERISA Plan:  Yes  No If yes, identify the Plan Number: \_\_\_\_\_ If no, is the plan a governmental or church plan?  Yes  No

**COVERAGE REQUESTED**

**GROUP ACCIDENT** Series **70000**  24 Hour  
Application Reason:  New Policy  Change to Existing Policy # \_\_\_\_\_  
 Other \_\_\_\_\_

**Class of Eligible Employees:**

- Regular full-time Employees at least age 18
- Spouses of eligible Employees at least age 18

**Plan:**

**Optional Features:**  Initial Accident Treatment Category (Base Plan)  High  
 Hospitalization Category  High  
 After Care Category  High  
 Life Change Events Category  High  
 Wellness Rider  High-LT  
 Accidental Death Rider  
 Organized Athletic Activity Rider

The requested Effective Date is **7/1/2024**.

Rates are guaranteed for **2** year(s) from the Group Policy Effective Date.

**Premium Contributions:** Percentage to be paid by Employee **100%**

Percentage to be paid by Employer **0%**

Will this Group Accident Policy replace any existing Group Accident Policy? Yes  No

If yes, provide carrier and policy number: \_\_\_\_\_

**GROUP CRITICAL ILLNESS** Series **22000**  
Application Reason:  New Policy  Change to Existing Policy # \_\_\_\_\_  
 Other \_\_\_\_\_

**Class of Eligible Employees:**

- Regular full-time Employees at least age 18
  - Spouses of eligible Employees at least age 18
- Optional Features:** With Cancer:  yes Non-Invasive Cancer Benefit:  yes  
 Skin Cancer Benefit:  yes With Health Screening Benefit:  yes  
 Waiver of Premium:  yes  Additional Benefits Rider  
 Childhood Conditions Rider  Progressive Diseases Rider  Specified Disease Rider

The requested Effective Date is 7/1/2024.

Rates are guaranteed for 2 year(s) from the Group Policy Effective Date.

**Premium Contributions:** Percentage to be paid by Employee 100%  
 Percentage to be paid by Employer 0%

Will this Group Critical Illness Policy replace any existing Group Critical Illness Policy? Yes  No

If yes, provide carrier and policy number: \_\_\_\_\_.

- GROUP HOSPITAL INDEMNITY Series 80000 Plan** \_\_\_\_\_
- Application Reason:  New Policy  Change to Existing Policy # \_\_\_\_\_  
 Other \_\_\_\_\_

**Class of Eligible Employees:**

- Regular full-time Employees at least age 18
- Spouses of eligible Employees at least age 18

**Optional Features:**

Hospitalization (Base Plan) (check one)  Mid  
 Health Screening Benefit (check one: Mid  
 Dependent Child Rider  Dependent Spouse Rider

The requested Effective Date is 7/1/2024.

The minimum number of enrolled Employees necessary to keep the Group Hospital Indemnity Policy in force: 25

**Payors**

Rates are guaranteed for 2 year(s) from the Group Policy Effective Date.

**Premium Contributions:** Percentage to be paid by Employee 100%  
 Percentage to be paid by Employer 0%

Will this Group Hospital Indemnity Policy replace any existing Group Hospital Indemnity Policy? Yes  No

If yes, provide carrier and policy number: \_\_\_\_\_.

- GROUP DISABILITY INCOME (Employee Only) Series 50000 Class B**
- Application Reason:  New Policy  Change to Existing Policy # \_\_\_\_\_  
 Other \_\_\_\_\_

**Class of Eligible Employees:**

- Regular full-time Employees under age 75

Class:  B

**Optional Features:**  Non-Occupational

Elimination Period: 7/7 Benefit Period: 3-Month

Percentage of Income Replacement: 60 %

The percentage of income replacement may vary for state-sponsored disability programs for Employees who reside in: California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island

The requested Effective Date is 7/1/2024.

Rates are guaranteed for 1 year(s) from the Group Policy Effective Date.

**Premium Contributions:** Percentage to be paid by Employee 100%  
 Percentage to be paid by Employer 0%

Will this Group Disability Income Policy replace any existing Group Disability Income Policy? Yes  No

If yes, provide carrier and policy number: \_\_\_\_\_.

Agent's certification: To the best of my knowledge, I certify this policy will not replace or change any existing life insurance policy(ies).

### GENERAL AGREEMENT

**By signing this Application, you, as the Applicant's authorized representative, understand and agree to the following:**

Application is for the group insurance plans indicated above on the basis of the information contained in this Application, the enrollment data, and available experience. CAIC's group underwriting rules will be used to determine whether the Applicant, if accepted, will be issued a Group Policy.

The Application in its entirety, and any other required information, is subject to CAIC's approval before insurance can become effective. Insurance will become effective on the effective date shown above unless CAIC sends written notice of a different effective date. CAIC may issue separate Group Policies if more than one coverage is requested.

The Applicant acknowledges that it has selected the coverage specified in the application based upon written information provided by CAIC. All material terms of coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to the coverages provided under a Group Policy available to CAIC for inspection, at CAIC's expense, at the Applicant's office, during regular business hours, upon advance written request. This paragraph survives termination of the Group Policy(ies).

#### **Applicant Agrees That:**

- Premium rate quotes were based on data submitted to CAIC. Final premium rates will be determined by the actual composition of the group. Initial premium is due on or before the effective date of the Group Policy.
- Payment of premium after receipt of a Group Policy is acceptance of the terms of a Group Policy.
- No agent or producer may change or waive any of the provisions of this Application or of any of plan(s) of insurance. No one except an officer of CAIC may make or modify the contract, and no waiver is valid unless it is in writing and signed by an officer of CAIC and the Applicant.
- If the representations contained in this Application and its attachments materially change between the date of this Application and the inception of the proposed coverage, the undersigned will immediately report the change in writing to CAIC.
- Failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the premium grace period(s). The Applicant will owe and agrees to pay the premium due for any period a Group Policy was in force. Applicant will be responsible for notifying members of the termination.
- Applicant agrees to offer the insurance provided under a Group Policy to all present and future members in eligible classes as defined in a Group Policy.
- Only those members of eligible classes who meet all the eligibility requirements are to be covered under a Group Policy. If applicable, participation requirements must be met before a Group Policy will become effective and that such requirements must be maintained while the Group Policy is in force to prevent termination of the Group Policy.
- Unless otherwise agreed to in writing with CAIC, Applicant is responsible for all employment and tax requirements pertaining to providing benefits to covered persons.
- Applicant will maintain and furnish any records necessary to administer a Group Policy.
- Coverage under a Group Policy can be terminated in accordance with its terms and conditions.
- It is understood and agreed if a Group Policy is issued, the Applicant will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, if any, and that CAIC may rely on this information in adjudicating any claim under a Group Policy.
- It is the Applicant's responsibility to deliver the Certificate of Coverage to the Certificateholder.
- Applicant will deliver any required notices given to them by CAIC to participating employees of the plan.

**The undersigned represents that, to the best of their knowledge and belief, the above information and statements in this Application are complete and true.** All statements are deemed representations and not warranties. I agree to accept the terms and provisions of the Group Policy, including its riders, endorsements or amendments, if any. I have read and acknowledge the applicable fraud warning below. A signed copy of this form received by electronic transmission will be deemed to be an original. If the Application is accepted by CAIC, it will be attached to and made part of an issued Group Policy

**I am authorized by the Applicant to sign this form.**

**I intend to sign this form electronically.**



**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.**

Representative of the Policyholder  Dan LaMontagne (Printed Name)	 (Signature)	Date  4/8/2024
Title  County Manager	State of Signature  NC	

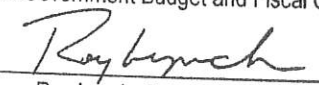
The final Application placed on file with CAIC must be signed. Keep a copy of this Application for your records.

References to "CAIC" refer to Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated.

References to "Group Policy" or "Group Policy(ies)" refer to the group insurance policy(ies), group insurance contract(s) or group insurance agreement(s) issued to the Applicant by CAIC upon approval of this Application.

**Commissions: Your premium purchases insurance coverage from CAIC, as well as the services of any CAIC-appointed licensed independent agent or broker identified in this Application for group insurance.** CAIC has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which CAIC has made to your producer, or other material relationships your producer may have with CAIC, you may contact your producer or your CAIC account representative.

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

  
Roy Lynch, Finance Officer



# CONTINENTAL AMERICAN INSURANCE COMPANY

PO Box 427 • Columbia, South Carolina 29202

Phone: 800.433.3036

Fax: 877.856.2269 Email:

## GROUP INSURANCE APPLICATION

The purpose of the Application is to request:

- Issuance of new coverage
- Add an affiliate company
- Reinstatement
- Add Eligible Classes
- Change in existing coverage(s)
- Add new benefits
- Remove Eligible Classes
- Name or Organizational Change

Class(es) added/removed \_\_\_\_\_

List the Policy Numbers to be amended: \_\_\_\_\_

I. APPLICANT INFORMATION			
Full Corporate/Legal Name of Group		Employer Tax ID No. (EIN)	
CHATHAM COUNTY Government		56 - 6000284	
Applicant is a: <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Labor Union <input type="checkbox"/> Trust <input type="checkbox"/> Other: _____ SIC Code: _____			
Address			
P.O. Box 1809	Pittsboro	NC	27312
Number/Street:	City:	State:	Zip:
Physical Address (if different)			
12 East Street	Pittsboro	NC	27312
Number/Street:	City:	State:	Zip:
Any changes to the mailing address should be sent in writing to the address at the top of this form. This Application will be considered updated upon our receipt of the change.			
Authorized Person/Officer Name: _____		Authorized Person/Officer Title: _____	
Contact Name: _____		Contact Title: _____	
Contact Phone: _____		Contact E-Mail: _____	
ERISA Plan: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, identify the Plan Number: _____			
Are any Subsidiaries/Affiliates/Divisions to be covered? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, add the name(s) below. If no, state None.			

II. COVERAGE ELECTIONS	
Coverages Underwritten by Continental American Insurance Company	Group Policy Situs State:
Coverage	Requested Effective date: 7/1/2024
<input checked="" type="checkbox"/> Term Life	
Optional Term Life Coverages	
<input checked="" type="checkbox"/> Child Term Rider	<input checked="" type="checkbox"/> Accidental Death Benefit Rider
<input checked="" type="checkbox"/> Waiver of Premium Rider	<input checked="" type="checkbox"/> Accelerated Benefit Rider
	<input checked="" type="checkbox"/> Restoration Rider

III. REPLACEMENT		
Current Group Coverage	Replacing with CAIC	Proposed Effective Date
<input type="checkbox"/> Term Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	

IV. CLASSES ELIGIBLE FOR COVERAGE
<input type="checkbox"/> Regular full-time Employees between age 18 and 70
<input type="checkbox"/> Regular part-time Employees between age 18 and 70
<input type="checkbox"/> Spouses of eligible Employees between age 18 and 70 under age 70 at least age 18
<input type="checkbox"/> Other:
"Full-time Employee" is one who works 30 hours or more per week. A part-time Employee is one who works 19 hours or more per week. An Employee must be Actively at Work on the date they apply and on the date Group Term Life Insurance is to become effective. An Employee must have completed 1 months of continuous service before being eligible.
<b>Other Eligibility Requirements:</b> _____
Number of eligible Employees: 629 on Date:

V. PARTICIPATION REQUIREMENTS TO KEEP POLICY IN FORCE
Minimum number of Employees enrolled: <b>25 Distinct Individuals</b>
Minimum percentage of eligible Employees enrolled: _____

VI. PREMIUM DATA
<input type="checkbox"/> Premium paid with application \$ _____
<input type="checkbox"/> Initial premium will be submitted at a later date as agreed to by CAIC and the Applicant.
Premium Payment Mode: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually
Unless otherwise agreed upon by the Applicant and CAIC, the Applicant will collect premium contributions from participating Employees, if any, and forward to CAIC when due. The Applicant will maintain records of premium contributions from Employees while this agreement remains in force and for two (2) years after it terminates.
If the Applicant pays the entire cost for the Employees for any plan of insurance, 100% of the eligible Employees must be covered under the plan.
Will the Employees be required to contribute toward the cost of the insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, Applicant will notify us in writing of the contribution amounts for each eligible class and each line of coverage.

VII. RATE GUARANTEE
Rates are guaranteed for <u>1</u> year(s) from the Group Policy Effective Date. In accordance with the Policy termination provisions, the Policy may be terminated prior to the end of the rate guarantee time period.

VIII. AGREEMENTS AND AUTHORIZATIONS
<b>By signing this Application, you, as the Applicant's authorized representative, understand and agree to the following:</b>
Application is for the group insurance plans indicated above on the basis of the information contained in this Application, the enrollment data, and available experience. CAIC's group underwriting rules will be used to determine whether the Applicant, if accepted, will be issued a Group Policy.
The Application in its entirety, and any other required information, is subject to CAIC's approval before insurance can become effective. Insurance will become effective on the effective date shown above unless CAIC sends written notice of a different effective date.
The Applicant acknowledges that it has selected the coverage specified in the Application based upon written information provided by CAIC. All material terms of coverage are set forth in the plan documents. Applicant agrees to make payroll and other records directly related to the coverages provided under a Group Policy available to CAIC for inspection, at CAIC's expense, at the Applicant's office, during regular business hours, upon advance written request. This paragraph survives termination of the Group Policy.
<b>Applicant Agrees:</b>

- Premium rate quotes were based on data submitted to CAIC. Final premium rates will be determined by the actual composition of the group. Initial premium is due on or before the effective date of the Group Policy.
- Payment of premium after receipt of a Group Policy is acceptance of the terms of a Group Policy.
- No agent or producer may change or waive any of the provisions of this Application or of any plan(s) of insurance. No one except an officer of CAIC may make or modify the contract, and no waiver is valid unless it is in writing and signed by an officer of CAIC and the Applicant.
- If the representations contained in this Application and its attachments materially change between the date of this Application and the inception of the proposed coverage, the undersigned will immediately report the change in writing to CAIC.
- Failure to pay billed premiums will result in automatic termination of insurance coverage at the end of the premium grace period(s). The Applicant will owe and agrees to pay the premium due for any period a Group Policy was in force. Applicant will be responsible for notifying members of the termination.
- Applicant agrees to offer the insurance provided under a Group Policy to all present and future members in eligible classes as defined in a Group Policy.
- Only those members of eligible classes who meet all the eligibility requirements are to be covered under a Group Policy. If applicable, participation requirements must be met before a Group Policy will become effective and such requirements must be maintained while the Group Policy is in force to prevent termination of the Group Policy.
- Unless otherwise agreed to in writing with CAIC, Applicant is responsible for all employment and tax requirements pertaining to providing benefits to covered persons.
- Applicant will maintain and furnish any records necessary to administer a Group Policy.
- Coverage under a Group Policy can be terminated in accordance with its terms and conditions.
- The availability of a plan or program may vary by geographic service area.
- It is understood and agreed if a Group Policy is issued, the Applicant will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, if any, and that CAIC may rely on this information in adjudicating any claim under a Group Policy.
- It is the Applicant's responsibility to deliver the Certificate of Insurance to the Certificateholder.
- Applicant will deliver any required notices given to them by CAIC to participating Employees of the plan.

The undersigned represents that, to the best of their knowledge and belief, the above information and statements in this Application are complete and true. All statements are deemed representations and not warranties. A signed copy of this form received by electronic transmission will be deemed to be an original. If the Application is accepted by CAIC, it will be attached to and made part of an issued Group Policy.

I am authorized by the Applicant to sign this form. I agree to accept the terms and provisions of the Group Policy, including its riders, endorsements or amendments, if any. I have read and acknowledge the applicable fraud warning below.


**Electronic Signature:** I understand that there is a right to execute this Application through an electronic signature. To the extent that the Application is signed electronically, the electronic signature is the legally binding equivalent to the handwritten signature.

I intend to sign this form electronically.

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 by the Applicant's Authorized Representative

Writing Producer or Broker Information

Signature:   
 Print Name: Dan La Montagne  
 Title: County Manager  
 Address where signed  
 Address: \_\_\_\_\_

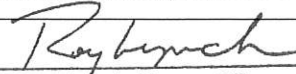
Signature: \_\_\_\_\_  
 Print Name: \_\_\_\_\_  
 License Number: \_\_\_\_\_ State: \_\_\_\_\_  
 Commission: \_\_\_\_\_  
 Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Date: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Email: \_\_\_\_\_  
 Date: \_\_\_\_\_

This instrument has been pre-audited in the manner required by the Local Government Budget and Fiscal Control Act.

Commission: \_\_\_\_\_ Date: \_\_\_\_\_

  
 Roy Lynch, Finance Officer

The final Application placed on file with CAIC must be signed. Keep a copy of this Application for your records.

References to "CAIC" refer to Continental American Insurance Company, a wholly-owned subsidiary of Aflac Incorporated.

References to "Group Policy" refer to the group insurance policy, group insurance contract or group insurance agreement issued to the Applicant by CAIC upon approval of this Application.

**Commissions: Your premium purchases insurance coverage from CAIC, as well as the services of any CAIC-appointed licensed independent agent or broker identified in this Application for group insurance.** CAIC has various programs for compensating producers (agents, brokers and consultants). If you would like information regarding compensation programs for which your producer is eligible, payments (if any) which CAIC has made to your producer, or other material relationships your producer may have with CAIC, you may contact your producer or your CAIC account representative.