Assurity®

Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

GROUP POLICYHOLDER APPLICATION

PLEASE PRINT WITH BLACK INK

POLICYHOLDER INFORMATION

Group Name City of Crete		Group's Tax I.D. No. 47-6006154
Address 243 East 13th St PO Box 86 (Street Address) Crete (City) NE (State) (ZIP+4)		Type of Group ☒ Employer ☐ Association/Union
Contact Name Jody Fiehtner		Contact Title Human Resources
Contact Phone No. (402) 826-4312	Contact Fax No. ( )	Contact Email jody.fiehtner@crete.ne.gov

1. Details of any subsidiaries or affiliates to be insured no
2. What is the group's industry? 911102 , Executive offices, state and local
3. Waiting period for current participants: no waiting period Waiting period for new participants: first of the month following date of hire
4. Total number of actively-at-work benefit-eligible employees? (do not include those on leave of absence) 63
5. How many hours are required for benefit eligibility? 30
6. Do you allow benefit changes or cancellations throughout the year? ☒ Yes ☐ No
   If YES, what type of changes/cancellations: ☐ Any ☒ Only life-changing events ☒ Only cancellations ☐ Other *(Specify)* _____
7. Does this insurance replace existing insurance with any company? If YES, provide details below.

Company Name	Group/Policy Number	Termination Date *(MM/DD/YYYY)*
Mutual of Omaha	G000AXNG	06 / 30 / 2025
		/ /

8. Requested effective date of insurance 07 / 01 / 2025 *(MMDDYYYY)*
9. Mail policies to: ☒ Insured ☐ Other (Specify)

NOTE: There is an "actively employed" requirement for coverage to be in force. Any employee unable to perform the material and substantial duties of their regular occupation will not be insured until this requirement is satisfied.

ENROLLMENT INFORMATION

Open enrollment period 6/1-6/30 What is the enrollment timeframe for new hires? ☐ Continuously ☐ Quarterly ☒ Annually

BILLING INFORMATION

1. Refund money to? ☐ Policyholder ☐ Participant
2. What is the billing method? ☒ Payroll deduction ☐ Other (Specify) _____

   How would you like to be billed? ☐ Ahead ☐ Arrears

   What is the payroll deduction frequency?

   ☐ Weekly (52) ☐ Bi-weekly (26) ☐ Semi-Monthly (24) ☒ Monthly (12) ☐ 9thly ☐ 10thly ☐ 13thly ☐ Other _____

   Do you want your monthly bill to reflect your premiums based on your payroll deduction frequency? ☐ Yes ☐ No

   If NO, how would you like them to appear? _____
3. Do you need the billing split up by location or employee class? ☐ Yes ☐ No
   if YES, please provide details _____
4. Where are the billings sent? ☒ Group ☐ TPA ☐ Other (Specify) _____
5. If billing information is different from what is listed in Group Address, please provide

BILLING INFORMATION – Continued

Third party administration (TPA) must be approved by and under contract with Assurity. If a TPA is involved, please provide the information below

Name _____

Address _____
Street Address *City* *State* *Zip Code*

Additional information or details _____

PRODUCT INFORMATION – Policy and rider availability, features and rates may vary by state

CRITICAL ILLNESS

Policy Type	Benefit Packages	Benefit Amount Options	Optional Riders	Paid By
☒ Critical Illness	See worksite proposal ID #256077 for benefit and rider details.			☐ Participant Paid ☐ Group Paid ☐ Other (Specify)

ACCIDENT EXPENSE

Policy Type	Benefit Packages	Optional Riders	Paid By
☒ 24-hour Accident Expense ☐ Off-the-job Accident Expense Premium paid by: ☐ pre-tax deduction ☐ after-tax deduction	See worksite proposal ID #256077 for benefit and rider details.		☐ Participant Paid ☐ Group Paid ☐ Other (Specify)

SHORT-TERM DISABILITY INCOME

Policy Type	Benefit Packages	Industry Class	Optional Riders	Paid By
☐ Off-the-job Accident and Sickness Disability Income ☐ 24-Hour Accident and Sickness Disability Income ☐ Off-the-job Accident-only Disability Income ☐ 24-Hour Accident-only Disability Income				☐ Participant Paid ☐ Group Paid ☐ Other (Specify)

HOSPITAL INDEMNITY

Benefit Packages	Policy Type	Benefit Options	Optional Riders	Paid By
☐ Tier 1 ☐ Tier 2 ☐ Tier 3 ☐ Basic Care ☐ Prime ☐ Flexible				☐ Participant Paid ☐ Group Paid ☐ Other (Specify)

TERM LIFE

Policy Type	Optional Riders	Paid By
☐ 10-Year ☐ 20-Year ☐ To Age 70		☐ Participant Paid ☐ Group Paid ☐ Other (Specify)

WHOLE LIFE

Policy Type	Optional Riders	Paid By
☐ Whole Life Employee/Member ☐ Whole Life Spouse ☐ Whole Life Child		☐ Participant Paid ☐ Group Paid ☐ Other (Specify)

SERVICING AGENT INFORMATION

Agent Name _____ Agent No. _____
First *Middle* *Last*

Phone No. _(_____)_____ Fax No. _(_____)_____ Email Address _____

BROKER OF RECORD

Agent or Agency Name _____ Agent or Agency ID No. _____

ENROLLMENT FIRM

Enrollment Firm being used (if applicable) _____

AUTHORIZATION AND AGREEMENT

The undersigned policyholder and/or authorized representative: 1) understands and represents to the best of their knowledge and belief that the statements made in this application, are true and complete; and 2) further agrees by payment of the required premium, if approved for coverage to the following:

1. The policyholder will: a) make the insurance coverage available to all eligible employees/members and their eligible dependents and to distribute information and documents to employees/members as needed to facilitate such coverage and b) provide notice of applicable continuation rights, if any, to eligible employees/members and dependents.
2. The policyholder will deduct premiums as necessary from the wages of participating employees/members and remit them to Assurity Life Insurance Company.
3. All employees/members applying for coverage are: a) employees of the employer; b) receive salary or wages documented on state and/or federal payroll reports; and c) meet any other eligibility requirements for coverage.

The undersigned policyholder and/or authorized representative acknowledges that the plan for which they are applying includes minimum participation requirements. If a sufficient number or percentage of eligible employees/members fails to enroll and the minimum participation requirements for the plan are not met, the insurance may not become effective. The undersigned policyholder and/or authorized representative acknowledges that compliance with federal and state employment laws is solely the responsibility of the policyholder.

Any person who knowingly, 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 shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Signed at _____ on _____/_____/_____

City *State* *Date (MM/DD/YYYY)*

_____ _____

Group Representative Signature *Title*

_____ _____

Signature of Licensed Agent *Print Agent Name* *Agent No.*

Assurity Life Insurance Company
P.O. Box 82533 | Lincoln, NE 68501-2533

800-869-0355 | assurity.com

ELECTRONIC DELIVERY OF GROUP MASTER POLICY AND CERTIFICATES OF INSURANCE

The certificate of insurance and its accompanying notices (the "Certificate") provides important information to employees or members about their coverage under the Assurity Group Master Policy. Because of its responsibility for delivering the Certificate(s) to the employees or members, the Group Policyholder has the right to receive a paper copy of the Certificate(s) and the Group Master Policy. However, as a service to the Group Policyholder, Assurity will provide the following electronic delivery service in place of such paper copies:

- Assurity will provide the Group Master Policy to the Group Policyholder by email address provided by the Group Policyholder and/or to a secure group policyholder web portal designated by Assurity.
- On behalf of the Group Policyholder, Assurity will deliver the Certificate(s) electronically to the employees or members on its customer portal, MyAssurity.com (or other website address, as Assurity may designate). To access their individual Certificate, the employees or members will be required to create a MyAssurity account. The employees or members will receive instructions from Assurity via the email address provided at enrollment on how to access their Certificate, and will need a personal computer with internet access, appropriate browser software, and Adobe Acrobat, to do so. If no email address for an employee or member is provided, or if Assurity receives notice the email to the employee or member was undeliverable, Assurity will mail the Certificate to the address of the employee or member on file.

Electronic delivery may be limited in some states and/or by product.

By checking 'No' and signing below, you do not consent to electronic delivery, and Assurity will mail the Group Master Policy to you and the Certificate(s) to the employees or members on your behalf.

By checking 'Yes' and signing below, you are authorizing and affirmatively consenting to electronic delivery as described above in place of receiving paper versions of the Certificate(s) and Group Master Policy.

☐ Yes, I consent to electronic delivery.
☐ No, I do not consent to electronic delivery.

If you do not check either box, your signature below serves as your consent to electronic delivery as described above and in place of receiving paper versions of the Certificate(s) and Group Master Policy.

_____ _____ / / _____

Employer Signature *Date (MM/DD/YYYY)*