application Group Dental and/or Vision Insurance

Administrative Office: Philadelphia, PA / Home Office: Chicago, IL

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

See reverse side for additional information

1. **Applicant's Legal Name** Fremont County

2. **Doing Business As** _____

3.

_____
P.O. Box / ZIP Code

615 Macon Ave. Ste 106
Street Address

Canon City, CO 81212
City / State / ZIP

(719) 276-7411 (719) 276-7412
Phone No. Fax No.

alicia.stone@fremontco.com
E-mail Address Tax I.D. No.

4. **What is the nature of your business or industry?**

Government

5. **Eligibility**

Total Number of Eligible Employees 338

Employees in Waiting Period . . . . . _____

6. **Are any classes or locations excluded?** . . . . . ☐ Yes ☒ No
Are domestic partners included? . . . . . ☒ Yes ☐ No
Are retirees included? . . . . . ☐ Yes ☒ No
(If yes, please use reverse side for explanation.)

7. **Are any subsidiary and/or affiliated companies to be insured?** . . . . . ☐ Yes ☒ No
(If yes, please use reverse side to list name and location.)

8. **How many hours per week equals full time employment?** 30

9. **Employee Participation**

Employer contributes 0% of employee premium.

☐ **Tied-to-Medical** (All employees covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all employees must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☒ **Voluntary** (Policyholder does not contribute toward premium, 100% contribution by employee.)

10. **Dependent Participation:**

Employer contributes 0% of dependent premium.

☐ **Tied-to-Medical** (All eligible dependents covered on employer's medical plan must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory** (Policyholder contributes 100% of premiums. All employees must be insured, except those listed under excluded classes or locations.)

☐ **Non-Contributory**, except covered elsewhere (If policyholder contributes 100% of premiums, all eligible dependents must be insured, except those listed under excluded classes or locations and those covered elsewhere.)

☐ **Contributory** (Policyholder is required to contribute to the employee premium and must contribute at least 25% of the total employee and dependent premium.)

☒ **Voluntary** (Policyholder does not contribute toward premium, 100% contribution by employee.)

11. **Section 125 Plan**

Election Period 1/1/2025-12/31/2025

Plan Year 1/1/2025-12/31/2025

12. Employee welfare benefit plans that are subject to ERISA must satisfy various reporting, disclosure and related obligations. These requirements include the provisioning of a Summary Plan Description or SPD. The certificate of coverage can serve as an SPD if certain information is additionally disclosed. Please check one of the following (failure to respond shall be considered a positive response for A. and a negative response for B.).

A. ☐ **Plan is subject to ERISA (complete question 12.B.)**

☒ **Plan is NOT subject to ERISA — Church or Govt. employer or other safe-harbor exception** (see DOL Reg. §2510.3-1(j))

THIS POLICY DOES NOT INCLUDE COVERAGE OF PEDIATRIC DENTAL SERVICES AS REQUIRED UNDER THE AFFORDABLE CARE ACT. COVERAGE OF PEDIATRIC DENTAL SERVICES IS AVAILABLE FOR PURCHASE IN THE STATE OF COLORADO AND CAN BE PURCHASED AS A STAND-ALONE PLAN. PLEASE CONTACT YOUR INSURANCE CARRIER, AGENT, OR CONNECT FOR HEALTH COLORADO TO PURCHASE EITHER A PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE OR AN EXCHANGE-QUALIFIED STAND-ALONE DENTAL PLAN THAT INCLUDES PEDIATRIC DENTAL COVERAGE.

B. ☐ **Applicant requests that Reliance Standard Life Ins. Co. prepare a SPD for its dental and/or vision plan** . . . . . ☐ Yes ☒ No

If yes, the company is to prepare a SPD. The following information is required under ERISA and MUST be included in the SPD.

Plan No. _____ Plan Fiscal Year End Date_____

Plan Administrator:

Name: _____

Address: _____

City, State, ZIP_____

Phone No. _____ Plan Fiscal Year_____

Please Note: Applicant remains responsible for **ensuring** that SPD form provided by Reliance Standard Life Ins. Co. is complete and accurate and satisfies applicable laws and regulations. Moreover, applicant remains responsible for providing its plan participants with SPD updates as required by applicable law and regulations.

13. Waiting Period

see belo for those employed on or before the policy effective date.

see belo for those employed after the new policy effective date.

☐ month(s) ☐ calendar days ☐ working days

14. Effective Date and Termination Date

☐ Immediate

☒ First of Month Effective date / End of Month Termination date

☐ Other

15. Premium Payment Mode (In advance)

☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ Payroll Deduction (To choose this option, employee must pay employee and dependent premium.)

If policy effective date is other than first of the month, is a first of the month premium due date desired? . . . ☐ Yes ☐ No

Billing Options

☐ Home Office ☐ Third-Party Administration

_____
Contact Name

_____
Title

_____
Street Address

_____
City / State / ZIP

_____
Phone No. Fax No.

_____
E-mail Address

16. The following coverages are applied for:

Employee & Dependents Benefits

☒ Dental ☒ Orthodontia ☒ Eye Care

☐ Other _____

Employee Only Benefits

☐ Dental ☐ Orthodontia ☐ Eye Care

☐ Other _____

This insurance shall be effective on: _____
(Premiums due prior to the coverage period.)

17. Policy and Certificate Delivery (select one)

A. **eCert*/ePolicy** (*generic cert, non-personalized)

☐ via PDF format sent via e-mail to:
alicia.stone@fremontco.com

☒ via eService and member portal

B. **Paper policy/personalized certificates**

☐ Initial employees only

☐ Subsequently added employees

Note: eCert will be available on member portal for all members.

18. Insurance requested on this application will replace the coverage(s) checked.

Coverages: ☒ Dental ☒ Orthodontia ☒ Eye Care

☐ Other _____

Name of Current Carrier Delta Dental/UMR

Policy No. _____

☒ Coverage applied for is replacing comparable coverage now or previously in force with another carrier.

☐ It is intended that the insurance coverage applied for be in addition to, supplemented by, or supplemental to any similar coverage now in force, or to be in force, with this or any other carrier.

12/31/2024 Termination Date

1/1/2020 Original Effective Date

Item 6: Exclusions

a. Classes, include reason for exclusion.

b. Locations, if location is different from applicant's, list city and state.

Item 7: Subsidiary and/or affiliated companies to be insured. List names and locations.

Plan Design and Proposed Rate

Additional Remarks Waiting Period: 1st of the month following 30 days

Agreements

This application will be subject to review and approval by the Home Office of Reliance Standard Life Insurance Co. If this application is accepted, the final rates and benefits will be based on verification of this information and final enrollment numbers. This applicant represents that he/she has read the statements and answers to the above questions and that they are complete and true to the best of his/her knowledge and belief. Any policy including riders issued as a result of this application will, with this application, be the entire insurance contract. If this application is accepted at the Home Office of Reliance Standard Life Insurance Co., group insurance at the Company's rates and under the terms applied for shall take effect as of the date set forth in the policy. If this application is not accepted, any premium advanced shall be refunded.

Statements

Note for Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Signed at: City Canon City State Colorado Date 9-26-24

Signed by: (Policyholder Representative)

Printed name and title Dwayne McFall Commissioner Chairman

Signature

Soliciting Agent: I understand and agree that if I'm not already appointed with Reliance Standard Life Insurance Company, I must apply to and be appointed with Reliance Standard before I present this product to any client.

Printed Name Bradley J Gauthreaux -- Choice Insurance Services, LLC

Signature

The policy provides dental and/or vision benefits only. Review your policy carefully.

Was a binder check received? ☐ Yes ☒ No If yes, then amount $_____.

Check received by (agent) _____ **Authorized by** (policyholder)_____

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO RELIANCE STANDARD LIFE INSURANCE COMPANY.
DO NOT MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE PAYEE BLANK.NM