AMERICAN FIDELITY
a different opinion

AMERICAN FIDELITY ASSURANCE COMPANY
9000 Cameron Parkway, P.O. Box 25523, Oklahoma City, Oklahoma 73125

Home Office Use Only	
Group Disability Income Policy Number	G123-

Application for group insurance is hereby made to American Fidelity Assurance Company based on the following:

1. Full Legal Name of Policyholder: Fremont County
2. Mailing Address: 615 Macon Ave Canon City, CO 81212
3. Physical Address (if different):
4. Telephone Number: 719-276-7411 Fax Number:
5. Group Type: ☐ Association ☐ Corporation ☐ Sole Proprietorship or Partnership ☐ Education ☒ Other Municipality
6. The following coverage is applied for: ☒ Group Disability Income ☐ Group Critical Illness ☐ Group Hospital Indemnity ☐ Supplemental/Limited Benefit ☐ Other:
7. Designation of Class or Classes Eligible for Coverage. ☐ As determined by each firm or employer. ☒ Other

   Please refer to the rate attachment.

8. Minimum Standards: Before this Policy or the insurance of additional persons or a change in class takes effect, the following applicable minimum standards must be met in order to issue coverage and maintain eligibility. The participation requirements are as follows:

   The greater of 15% participation or 10 lives.

   If these standards are not met, it is agreed that the Company may terminate the Policy.
9. The premium is due on the first of each month. The initial premium rate is detailed in the rate attachment.
10. Effective Date: Original Policy Effective Date: January 1, 2024 Policy Amended Effective:

    If this application is approved by the Company, it is desired that the Policy takes effect at 12:01 AM at the place where the Policy is delivered. It is agreed that the coverage of an eligible person will not take effect until the first premium has been paid by or on behalf of such eligible person.
11. ☒ Non-ERISA Group

    ☐ ERISA Acknowledgment: The Employer named below acknowledges that the Employee Retirement Income Security Act of 1974 (ERISA), as amended or other laws, if applicable, may require that the Employer be responsible for certain duties or obligations with respect to the Employer or Employer's Employees and Dependents under any certificate under such Group Policy or Policies.
12. ☐ By checking this box, the Policyholder agrees, until such time as the Policyholder revokes consent, to electronic delivery of Policy documents via secure e-mail by American Fidelity Assurance Company in lieu of regular U.S. Mail delivery satisfying all delivery requirements under the Policy. The Policyholder understands the Policyholder must: use a computer that has Adobe® Reader® 8.0 or newer, available free on www.adobe.com, have an Internet connection, and an e-mail address. The Policyholder may revoke this consent or request paper copies by contacting American Fidelity Assurance Company in writing at 9000 Cameron Parkway, Oklahoma City, OK 73114 or calling 1-800-662-1113.

    Designated electronic transmittal e-mail address of the Policyholder:

13. The Policyholder declares that to the best of their knowledge and belief the statements and answers shown on this application are true and complete. The Policyholder understands and agrees that: (a) the application will form a part of any Policy issued; (b) no information given to, or acquired by, any representative of the Company will bind the Company unless it appears in writing on this application; (c) no waiver or modification will bind the Company unless it is in writing and is signed by an Executive Officer of the Company; (d) only those persons eligible under the terms of the Policy or policies issued will be covered; (e) Insurance will become effective on the requested Effective Date, unless written notice is provided of a different Effective Date; and (f) if this application is not approved, no insurance is in effect at any time, and any premium the Company has received will be returned.

14. The Policyholder hereby requests American Fidelity Assurance Company to issue and deliver the Group Certificates of Insurance for the coverage applied. It is understood that the Employer will make payroll deductions for the Employee portion (and any Dependent portion if applicable) of any premium. The Employer will provide any necessary documentation requested by the Company which establishes that all eligibility, underwriting, and participation requirements of the plan are met. The Employer will also report additions, changes, employment terminations, and other information necessary to the administration of the Policy(ies) to the Company within 31 days after the effective date of such additions, changes, and employment terminations.

FRAUD WARNING: 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.

DWayne McFall — **Printed Signature**

Commissioner — **Title**

Dwayne McFall — **Signature** (Must be signed by a person authorized to make a legally binding decision for the Policyholder)

10-4-23 — **Date**

Agent Signature

Date

01470A

Agent Number

To be attached to and made a part of master application AGM110CO for policy number G123- issued by:

AMERICAN FIDELITY ASSURANCE COMPANY

Covering all persons who are on Active Employment as employees of the Employer

FREMONT COUNTY

The following monthly premium rates take effect January 1, 2024

MONTHLY PREMIUM					
		ELIMINATION PERIOD		MAX DISABILITY PERIOD	
PLAN	RATE*	INJURY	SICKNESS	INJURY	SICKNESS
014801-1	$3.90	7 days	7 days	SSNRA	SSNRA
014803-2	$3.34	30 days	30 days	SSNRA	SSNRA
014805-4	$2.36	90 days	90 days	SSNRA	SSNRA
014807-6	$1.56	180 days	180 days	SSNRA	SSNRA

*Rates per $100 monthly disability benefit

RIDERS	BENEFIT AMOUNT	PREMIUM
Cobra Premium Limited Benefit Rider	$300	$4.50
	$400	$6.00
	$500	$7.50
	$600	$9.00
Hospital Indemnity Limited Benefit Rider	$150	$9.00
Critical Illness Limited Benefit Rider	$10,000	$14.12
	$15,000	$19.00
	$20,000	$23.88
	$25,000	$28.76
Spousal Disability Income Rider	$500	$8.66
	$1,000	$17.32