

STANDARD INSURANCE COMPANY
Employee Benefits - Regional Accounts
900 SW Fifth Ave. Portland, OR 97204-1282

**Application for Group Insurance
For Use in Florida**

Please type or print

REQUESTED EFFECTIVE DATE 10-01-09

APPLICANT

Full Legal Name of Group (Exactly as it is to be shown in the policy.)

Nassau County Board of County Commissioners

Street Address 96161 Nassau Place

City Yulee

State FL

Zip Code 32097

Phone Number (904) 491-7332

FAX Number (904) 321-5926

Group Contact Chili Pope

Contact's Title Human Resource Director

Contact's Phone No. if different (_____) _____

Contact's FAX No. if different (_____) _____

Nature of Business County Government

INSURANCE COVERAGE REQUESTED

- | | | | | |
|---|---|--|---|--------------------------------|
| <input type="checkbox"/> Life Only | <input type="checkbox"/> Supplemental Life | <input type="checkbox"/> Dental/Employees | <input checked="" type="checkbox"/> LTD | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Life & AD&D | <input type="checkbox"/> Additional/Optional Life | <input type="checkbox"/> Dental/Employees and Dep(s) | <input type="checkbox"/> STD | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Dependent Life | <input type="checkbox"/> Stand Alone AD&D | <input type="checkbox"/> Dental/Orthodontia | <input type="checkbox"/> LTD with Transitional Duty Agreement | |

OTHER INSURANCE

A. Does this insurance supplement other insurance? Yes No

If yes, specify for each line of coverage and Insurance Carrier: _____

B. Does this insurance replace existing insurance? Yes No

If yes, specify for each existing line of coverage: _____

- Please submit a copy of each inforce policy, certificate or plan document.

Effective date of Prior Plan: _____

Termination date of Prior Plan: _____

ACTIVE WORK REQUIREMENT: A person must meet an Active Work requirement to become insured. Members who have not met an Active Work requirement are not insured until returning to work for one full day and meeting all other contractual requirements.

Initial: [Signature] *Note: Some members who do not meet an Active Work requirement may be eligible for Waiver of Premium with a prior carrier. The Active Work requirement does not apply to Dental coverage.*

APPLICANT AGREES THAT: I hereby apply for Group Insurance as provided in the attached proposal.

The above information is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance.

If the requested insurance is acceptable to Standard Insurance Company under its current rules and practices and is legally permissible, a Group Policy will be issued in the language customarily used by Standard. It will be effective on the date determined by Standard. No producer has the authority to guarantee the acceptability of the requested insurance.

Standard may issue separate Group Policies if more than one coverage is requested in this Application. The insurance, if approved, will be subject to Standard Insurance Company's usual underwriting requirements, including the exclusions and limitations in the Group Policy and, if applicable, Evidence Of Insurability. The effective date of insurance for which a person is required to submit satisfactory Evidence Of Insurability will be determined in accordance with the terms of the Group Policy, subject to the Active Work requirement. No premiums will be collected or paid by the Applicant for such insurance until notification of approval.

No material describing coverage under the Group Policy will be distributed by the Applicant to any person to be insured without the prior written consent of Standard Insurance Company.

Premium rate quotations were based on data submitted to Standard. Final premium rates will be determined by the actual composition of the group.

The consideration for any Group Policy which may be issued is this Application and the payment of premiums. Payment of premium after receipt of the Group Policy is acceptance of the terms of the Group Policy.

This Application is made a part of the Group Policy.

Applicant authorizes the producer, broker of record, or consultant to receive information regarding the applicant's claims status and experience that the applicant has a right to receive and which is reasonably necessary to assist the applicant in conducting a review of the information.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive an insurance company, files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

[Signature] Barry V. Holloway, Chairman

Signature and Title of Applicant's Authorized Representative

10-14-09

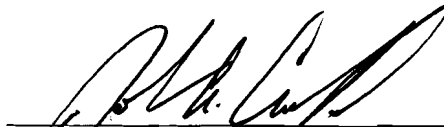
Date

(Must be signed or submitted prior to the requested effective date.)

Initial Deposit \$ _____

STANDARD INSURANCE COMPANY APPLICATION FORM
EMPLOYEE LONG TERM DISABILITY

ATTESTATION: ONLY TO AUTHENTICITY
AS TO CHAIRMAN'S SIGNATURE:



John A. Crawford
EX-OFFICIO CLERK *BAK 10/14/09*

APPROVED AS TO FORM BY THE
NASSAU COUNTY ATTORNEY



DAVID A. HALLMAN, ESQ.



New Business Submission Checklist for Nassau County Government Policy Number: _____

To ensure your application for group insurance is processed correctly and in a timely manner, we will need the following:

- Application for Group Insurance.** Please review application and verify it has been completed in its entirety (ensure Active Work is initialed, effective date is included, signature and date present, etc.).
- Check for first month's premium (based upon premium information from the sold proposal),** payable to Standard Insurance Company (for New York sitused cases, payable to The Standard Life Insurance Company of New York).
- Copy of "Sold" Proposal and any e-mail exceptions not documented in proposal.**
- Prior Carrier policy and a copy of their most recent billing statement (if applicable).**
- Complete Census,** including each employee's First and Last name, Date of Birth, Date of Hire, Occupation, Social Security # (if list billing or using the Electronic Enrollment Tool), Insured Earnings and Gender. **Please e-mail census to your sales representative in Microsoft Excel format.**

If...	Then...
Voluntary or contributory coverages were sold	The census should include: <ul style="list-style-type: none"> • Elected benefit information for employee, spouse and child • Spouse's name and date of birth (if spouse benefits were sold) <ul style="list-style-type: none"> <input type="checkbox"/> Check here if domestic partner wording should be in contract.
Dental and/or Vision was sold	Submit enrollment forms. Include: <ul style="list-style-type: none"> • Address • Dependent elections with names • Dependent relationship (child, spouse, domestic partner) <ul style="list-style-type: none"> <input type="checkbox"/> Check here if domestic partner wording should be in contract. • Dates of birth of each dependent electing coverage

Other completed forms if applicable:

- Medical History Statements** **STD Tax Service Agreement** **Health Advocate Implementation Form**

Form of Organization (select one)

- Association C-Corporation S-Corporation Government / Public Unit
 Limited Liability Company Partnership Sole Proprietorship School District

Certificates / Summary Plan Descriptions

Are separate Certificates by class needed? YES NO

Certificates will be available through AdminEASE (online policy administration tool). If you have different requirements, please describe: Please send the certificates in hardcopy to the City.

Billing Information (check desired billing type)

- List Bill** The Standard provides a detailed monthly bill identifying each employee, insured amounts and premium by line of coverage.
- Self-Admin / Summary Bill** The Standard provides a generic monthly statement showing total insured volume and total number of lives. The group is responsible for tracking eligibility and changes. Groups with 100 or more employees without vision or dental coverage will be set up with self-admin billing.

Billing Divisions or Categories? YES NO If YES, please provide (on a separate page) the following information regarding all divisions: Name of division, Name of billing contact, address, city, state, ZIP code and phone number.
See the attached sheet.

Will The Standard administer COBRA for dental or vision? YES NO If YES, there will be a rating impact if not included at the time of proposal.

Eligibility Waiting Period for Current Employees (select one)

- All are eligible regardless of length of service.
- Only those who have satisfied the waiting period as selected below are eligible.

Eligibility Waiting Period for New Employees hired after policy effective date (select one)

- First of the month coinciding with or next following 90 days as a member
Example using 30 days: Date of hire 4/1, effective date 5/1. Date of hire 4/2, effective date 6/1.
- First day after _____ days as a member.
- First day of the month following date of hire.
- First day of the month coinciding with or next following becoming a member
Example: Date of hire 4/1, effective date 4/1. Date of hire 4/2, effective date 5/1.
- No waiting period. **Elected and contracted employees.**
- Check here if you require employees to be enrolled in the medical plan to participate in Standard plan(s).
- Other (if different Eligibility Waiting Period for each coverage or Class requested, please describe in detail): _____

Credit Time Served (select one) How to credit time served for employees that do not currently meet the definition of a Member for coverage, but at some point in the future have a status change that meets the Member definition? Example changes: Part-time to full-time, hourly to salaried, union to non-union.

- Employee Eligibility Waiting Period begins the date of the status change.
- Employee Eligibility Waiting Period is shortened by the period of time the employee was employed before he or she met the Member Definition (credit prior service).

ERISA* Plan year ends on: _____ / _____ (mm/dd)

N/A Plan numbers for: LTD _____ STD _____ Life _____ Dental _____ Vision _____
(i.e. 501, 502, etc.) *ERISA info is required except for church and public group.

Definition of Earnings (select one) Earnings definition will automatically include base salary, commissions averaged over 12 months, shift differential pay, Internal Revenue Code 401(k), 403 (b), or 457 deferred compensation, executive nonqualified deferred compensation and contributions to fringe benefits under an Internal Revenue Code Section 125 plan.

- Normal wording as stated above.
- All of the above, except commissions.
- Base salary only, does not include commissions or shift differential.
- Wording for S-Corporation / Limited Liability.
- If any other compensation is to be included or excluded, please describe: _____
- Include bonuses averaged over 36 months. If bonuses included in earnings, you must provide a census which includes bonus information. Census includes bonuses? YES NO

Definition of a Member Describe the person to be insured. Include separate descriptions if they vary by coverage. Select one.

- All active employees and partners (if partnership) regularly working 30* (or 20) or more hours per week.
- Other* (describe, including required hours per week): See Attached.

*Rates may vary if member definition covers employee who work less than 30 hours per week or retirees.

Is member required to be covered under the employer-sponsored medical plan to be insured for coverages in force with The Standard? YES NO

For Contributory or Voluntary Products

- For Voluntary or Contributory products, update birthdates: Annually, each January On policy anniversary
- Each month
- For Voluntary or Contributory Life, is spouse premium based on spouse age? YES NO N/A
- For Voluntary or Contributory Spouse Life, is spouse age reduction based on spouse age? YES NO N/A

For Dental or Vision Premium N/A

For Dental Premium:

Is the employee portion of the premium paid through a Section 125 / POP plan? YES NO

What is the Section 125 plan year? Calendar year Other ____ / ____

Premium Contributions

Employer Contributions: Does Employer pay 100% of premium for each coverage requested? Please include information for employees and dependents. YES NO

If NO, what percentage of premium does Employer pay? \$ _0_
For each coverage requested, please provide detail below.

Do you "gross up" salary for tax-free benefits on LTD? YES NO

Group Information

Executive correspondence contact (name): Chili Pope

Phone no.: 904-491-7332

E-mail: c pope@nassaucountyfl.com

Administrative / Claims contact (name): Tina Keiter Same as Executive

Phone no.: 904-491-7332

E-mail: tkeiter@nassaucountyfl.com

Mailing address (if different than Policyholder's): 96161 Nassau Place Yulee, FL 32097

Billing contact (name): Debbie Keiter Same as Executive or Administrative

Phone no.: 904-491-7332

E-mail: dkeiter@nassaucountyfl.com

Which contact should be used for online policy administration (AdminEASE) setup? Executive Administrative / Claims Billing

Affiliates? YES NO If YES, please provide (on a separate page) the following information regarding all affiliates: Full legal name, address, city, state, ZIP code, Employer Tax ID No. and nature of business.

Is there a Third Party Administrator (TPA) involved? YES NO If yes, we will soon contact you for more information.

Advance Notification of Renewals will be the greater of 31 days or the state mandated period. If you require something different, Please specify 60. Note: This request may require underwriting approval.

Federal Tax ID 591663042

Billing grace period will be 31 days. If you require something different, please specify _____. Note: This request may require underwriting approval.

Broker / Commission Information

Broker 1 name: Lon Bryan

Firm name: L B Bryan & Company

Phone no.: 904-280-4647

E-mail: lbryan@lbbryan.com

Commission level: Normal Flat 10 % None Other: _____

Commission split (by product): _____

Commissions payable to: Firm Individual Producer ID: 0000027495

Broker 2 name (if applicable): _____ Firm Name: _____

Phone No.: _____ E-mail: _____

Commission level: Normal Flat ____ % None Other: _____

Commission split (by product): _____

Commissions payable to: Firm Individual Producer ID: _____

Additional Comments:

The Standard Long Term Disability Billing Divisions/Categories

Please set up Nassau County Board of County Commissioner's bills as follows:

Division Numbers:

- 01 BOCC
- 02 Clerk of Courts
- 03 Property Appraiser
- 04 Supervisor of Elections
- 05 Tax Collector
- 06 Sheriff's Department

Within Each Division Category Numbers Should Be:

- 1 Elected Officials
- 2 All Other Full-Time Employees

This billing will mirror our current Life Insurance billing for The Standard, with the exception that it is not necessary to segregate out Local 630 employees as with the Life.

The Standard Long Term Disability Eligible Employees

Nassau County's Eligibility Employees will be as follows:

Division Numbers:

- 01 Employees are required to work a minimum of 32 hours a week.
- 02 Employees are required to work a minimum of 21 hours a week.
- 03 Employees are required to work a minimum of 21 hours a week.
- 04 Employees are required to work a minimum of 32 hours a week.
- 05 Employees are required to work a minimum of 32 hours a week.
- 06 Employees are required to work a minimum of 40 hours a week.