Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION

Renewal APPLICATION by CITY OF JONESBORO ARKANSAS

(hereinafter called "Policyholder")

For a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

GROUP INFORMATION

Legal Name Of Business: CITY OF JONESBORO ARKANSAS	
D/B/A : CITY OF JONESBORO ARKANSAS	
Street Address: 300 South Church Street	
City,State,Zip: Jonesboro,AR,72401	County :Craighead
Mailing Address : (if different from street) P O BOX 1845	
City,State,Zip: Jonesboro,AR,72403	
Telephone # - 870-933-4640	
Fax # -	
Fed. Tax I.D # 71-6013749	
Exec. Contact : Harold Perrin	E-Mail :
Group Administrator : Dewayne Douglas	E-Mail : ddouglas@jonesboro.org
Primary SIC Code : 9199	SIC Description:General Government, NEC
Business Type : Government	
Agent : MADONNA LEE	Agent's Lic # : 2195777
Agent's Company : SUNSTAR INSURANCE OF ARKANSAS	Agent's Tax ID :46-0800597

POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual.The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

PROXY

The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting.The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting.This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting.

BENEFIT SELECTION

PREFERRED PROVIDER ORGANIZATION (PPO) PPO $700 deductible

Requested Effective Date,Pending approval is : **1/1/2021**
Waiting Period Note : Effective Date is the first day of the month following the Waiting Period.
Date of Open Enrollment: December
If a month is not specified, the Group's open enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution	
1	FULL TIME	30 Days	Employee 71% Dependent 71%	
2	RETIREES	0 Days	Employee 0% Dependent 0%	

Note: *The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage of Employees' premium specified above.*

Maximum Dependent Age :26

Mandated Mental Health Parity :Yes

Please Indicate whether a HRA, or mechanisms utilized to reduce the employee's portion of health plan costs, is either in place or planned to be purchased. **No**
Rates offered for this plan are contingent on assertions submitted by the insurance applicant (or its agent) that there is no HRA or other funding mechanism in place, nor intent to purchase such an arrangement. Upon evidence to the contrary, the group health plan is subject to termination.

Deductible : $700	Deductible CarryOver : No
Family Deductible : 3	Basis : Fulfillment
CoInsurance : 80%/60%	In-Network Calendar Year Coinsurance Max: $2,875/$8,625
Family Calendar Year Coinsurance Max: 3	Basis : Fulfillment
Out-of-Network Calendar Year Coinsurance Max:None/None	
Lifetime Maximum: Unlimited	Traditional Wellness
Prescription Drug Rider Plan: $15/$40/$60 Standard Formulary With Step Therapy	
Mail Order Drug - 2x Copay(100 Days)	Out Of Pocket Definition : Embedded
Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage.	
PPO Optional Benefits:	
Office Visit Copayment - $40	Maternity - Elected
Supplemental Accidental Endorsement - Declined	ER Copayment -$100
Blue Card	Inpatient Copay - None
Arkansas Mandated Offer Benefit Riders:	
You Must Elect or Reject Each Rider:	
Mammography - Reject	Substance Abuse - Reject
Psychiatric Condition - Reject	TMJ* - Reject
Hearing Aid - Reject	

*Rejection of the TMJ Benefit Rider means covered benefits provided to Covered Persons will not include temporomandibular Joint disorders (TMJ) or craniomandibular disorders.

Term Life and AD&D through USAble Life is not Provided

RATES - PPO $700 deductible

Two Tier Composite	Total Premium	Service Fee	Total Amount
Employee	$496.26	$4.96	$501.22
Family	$1,066.16	$10.66	$1,076.82

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

Grandfather Status - Our records indicate that your health plan is grandfathered.

Please confirm if you agree with the grandfathered status as indicated above.

✔ Yes, I agree with the status as shown.

____ No, I disagree with the status as shown because _____

BENEFIT SELECTION

RX ONLY Drug Only Custom

Requested Effective Date,Pending approval is : **1/1/2021**

Waiting Period Note :Effective Date is the first day of the month following the Waiting Period.

Date of Open Enrollment: December

If a month is not specified, the Group's open enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution	
Class 4	RX only ELECTED OFFICIALS W20 YRS CNT SC-RX	0 Days	Employee 25% Dependent 0%	

Maximum Dependent Age: 26

Mandated Mental Health Parity: True

Prescription Drug Rider Plan: $15/$40/$60 Standard Formulary With Step Therapy Mail Order Drug - 2x Copay

Based on actuarial review, this drug benefit option is creditable to the standard Medicare Part D prescription coverage.

?

RATES - Drug Only Custom

One Tier Composite	Total Premium	Service Fee	Total Amount
Employee	$124.06	$1.25	$125.31

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

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Please confirm if you agree with the grandfathered status as indicated above.

✔ Yes, I agree with the status as shown.

____ No, I disagree with the status as shown because _____

ATTESTATIONS

COBRA

Group health plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines. We offer the services of a vendor, "WageWorks", to assist you in administering Cobra (no additional cost).
Both full time and part time employees are counted to determine if a plan is subject to Cobra. Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.[1]

(Yes✔) (No__) As an employer, are you currently obligated by law to comply with COBRA?

(Yes__) (No✔) Do you want to use the services of WageWorks?

(Yes__) (No✔) If yes, are you currently contracting directly with WageWorks?

1 COBRA Handbook 2009, ¶4.03[E][2]; 26 CFR §54.4980B-2 Q/A 5(e).
2 42 CFR §411.170.

Medical Loss Ratio - The determination of Large and Small Groups is based upon the average number of employees employed by the employer on business days during the preceding calendar year. The Public Health Services Act §2791(e) provides

(1) The term "large employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

(2) The term "small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 50 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

The policyholder is a :
Small Employer _____
Large Employer ____✔____ (if selected please check one of the following)
51-100 Employees _____ 101+ Employees____✔____

L Policyholder to Distribute and Account for Premium Rebates

In the event federal or state law requires the Company to rebate a portion of an annual premium payment, Company will pay the Policyholder the total rebate applicable to the Policy, and Policyholder shall use the amount of the rebate that is proportionate to the total amount of premium paid by all Employees under the policy for the benefit of Employees in one of the following ways, at the option of the Policyholder:

1.For all Employees covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the Employees' portion of premium for the subsequent policy year;
2.For Employees covered, at the time the rebate is received by the policyholder, under the group health plan option for which the Company is providing a rebate, to reduce the Employees portion of premium for the subsequent policy year;
3. A cash refund to Employees enrolled in the group health plan option, at the time the rebate is received by the policyholder, for which the Company is providing a rebate; and
4.The reduction in future premium or the cash refund provided under paragraphs 1, 2 or 3 of this section may, at the option of the policyholder, be: divided evenly among such Employees divided based on each Employee's actual contributions to premium; or apportioned in a manner that reasonably reflects each Employee's contributions to premium.
5.The portion of a rebate based upon former Employees' contributions to premium must be aggregated and used for

the benefit of current Employees in the group health plan in any manner permitted by this section.
Policyholder will indemnify the Company in the event the Company suffers any fines , penalties or expenses, including reasonable attorney's fees, due to the Policyholder's failure to carry out its obligations under this Section L of the Group Policy.

EMPLOYEE INFORMATION
MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS

Under the Medicare Secondary Payer Rules, it is the Employer's responsibility to annually inform Arkansas Blue Cross of proper employee counts for the purpose of determining payment priority between Medicare and Arkansas Blue Cross. Arkansas Blue Cross is required to furnish these counts to the Centers for Medicare and Medicaid Services (CMS).

Full-Time= means an active employee with a minimum of 30 hrs/week & 48 weeks/year.

	In State	Out Of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	505		505
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	74		74
COBRA Continuees (Enrolling):			0
Life ONLY Contracts			
Total Enrolling and Waiving:			579
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			579

Minimum Number of Insured Employees. To meet large group enrollment guidelines a group must have at least fifty one full-time enrolled employees.Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as small group upon renewal.

Minimum Participation Requirements. Employees covered through other comprehensive major medical-type coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 25% of the full-time employees must enroll.

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

Special Group Considerations Form# 23-2432	Description:Contin for City Cnsl Mbrs and Elected Officials
Special Group Considerations Form# 23-2170	Description:Continuation for Municipal Emps 55+
Special Group Considerations Form# 23-2242	Description:$100 ER co-pay
Special Group Considerations Form# 23-2186	Description:no deductible carryover
Special Group Considerations Form# 23-2232	Description:retiree elected officials RX

SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield.**I also understand that my signature below represents my agreement and acceptance of the premium rate schedule.**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at Jonesboro, AR, this _____ day of November 2020
(City, State)

City of Jonesboro [full legal name of Policyholder]

By: _____ Harold Perrin
Authorized Signature — Printed Name

Mayor
Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

✔ I will provide the applicant with a signed copy of this application.

_____ I have emailed the applicant a signed copy of this application.

_____ 2195777 / 46-0800597
Agent Signature — Insurance License # / Agency Fed. TaxID #

MADONNA LEE
Agent Printed Name

_____
Date

SBC

The Patient Protection and Affordable Care Act (PPACA) mandates a Summary of Benefits and Coverage (SBC) document be created for every health insurance plan. An SBC that applies to this plan(s) can be found online at www.arkansasbluecross.com/esbc.After we receive and process your signed contract, you may access the SBC(s) for this plan by going to our SBC locator tool and entering the following unique identifier(s) into the SBC locator:

249060

249061

Groups with more than one plan type may have more than one link. You may download an electronic copy (PDF) of the appropriate SBC(s) to fulfill distribution requirements as mandated by the Patient Protection and Affordable Care Act (PPACA).Copies of your SBC will also be available on Blueprint for Employers. A printed version is available by calling your group service representative.

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

11/2/2020

Group Name: CITY OF JONESBORO ARKANSAS

300 South Church Street
Jonesboro , AR 72401

Group Number: 011649

Proposal-ID : 62439

Dear Group Administrator:

Please be advised that the current benefit you offer (PPO Custom,Drug Only Custom), meets the minimum essential coverage requirements as defined in § 5000A of the Internal Revenue Code (employer-sponsored plan), and provides minimum value within the meaning of § 36B(c)(2)(C)(ii). Effective 1/1/2021, employers are required by law to inform their employees of coverage options under the new health care law. You will find the compliant notification document at this link: https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/coverage-options-notice . Please distribute copies of this notice to all your employees.

If you have any questions or concerns, please contact your agent or an Arkansas Blue Cross representative. We are happy to help you through the implementation of this new requirement.

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION

Renewal APPLICATION by CITY OF JONESBORO ARKANSAS
(hereinafter called "Policyholder")

For a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

GROUP INFORMATION

Legal Name Of Business: CITY OF JONESBORO ARKANSAS
D/B/A : CITY OF JONESBORO ARKANSAS
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Mailing Address : (if different from street) P O BOX 1845
City,State,Zip: Jonesboro,AR,72403
Telephone # - 870-933-4640
Fax # -
Fed. Tax I.D # 71-6013749

Exec. Contact :Harold Perrin	E-Mail :
Group Administrator : Dewayne Douglas	E-Mail : ddouglas@jonesboro.org
Primary SIC Code : 9199	SIC Description:General Government, NEC
Business Type : Government	
Agent :MADONNA LEE	Agent's Lic # : 2195777
Agent's Company : SUNSTAR INSURANCE OF ARKANSAS	Agent's Tax ID :46-0800597

POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual.The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

COBRA ADMINISTRATION

COBRA - Group vision plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines.We offer the services of a vendor, "WageWorks", to assist you in administering Cobra (no additional cost).Both full time and part time employees are counted to determine if a plan is subject to Cobra.Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

(Yes ✔) (No__)As an employer, are you currently obligated by law to comply with COBRA?

(Yes__)(No ✔) Do you want to use the services of WageWorks?

(Yes__)(No ✔) If yes, are you currently contracting directly with WageWorks?

BENEFIT SELECTION

VOLUNTARY VISION VOLUNTARY VSP CHOICE PLAN GOLD

Customized Plan : No

Requested Effective Date,Pending approval is : 01/01/2021

Waiting Period Note :Effective Date is the first day of the month following the Waiting Period.

Date of Open Enrollment: December

If a month is not specified, the Group's open enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution	
1	ALL FULL TIME EMPLOYEES	1 Month	Employee 0% Dependent 0%	
2	RETIREES	0 Days	Employee 0% Dependent 0%	

Note: *Employer contribution is 0% to 49%.*

Eye Health Examination inclusive of Dialation: 12 Months

Spectacle Lens: 12 Months | **Frames:** 24 Months

Contact Lens Evaluation,Fitting & Follow-up Care: 12 Months

Contact Lens(in lieu of eyeglasses): 12 Months

Eye Health Examination Copayment: $10 | **Spectacle Lens Copayment:** $20

Contact Lens Evaluation, Fitting & Follow-Up Care Copayment: 15% discount/$60 max

Elective Contact Lenses :$150 | **Frame Allowance :** NA

Out-Of-Network Coverage

Eye Examination: Once every 12 Months, $45 | **Frames:** Once every 24 Months, $70

Spectacle Lens:

Single Vision Lens: Once every 12 Months , $30 | **Bifocal/Progressive Lens:** Once every 12 Months, $50

Trifocal Lens: Once every 12 Months, $65 | **Lenticular Lens:** Once every 12 Months, $100

Elective Contact Lens: Once every 12 Months, $105

Medically Necessary Contact Lens(with prior approval): $210

Minimum Participation Requirements and Minimum Number of Insured Employees: This policy may be terminated by the Company if the number of insured Employees falls below five (5) insured Employees.

RATES - VOLUNTARY VSP CHOICE PLAN GOLD

Two Tier Composite	Total Premium
Employee	$9.00
Family	$21.06

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

EMPLOYEE INFORMATION
MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS

Full-Time= means an active employee with a minimum of 30 hrs/week & 48 weeks/year.

	In State	Out Of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):	371		371
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	208		208
COBRA Continuees (Enrolling):			
Total Enrolling and Waiving:			579
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			579

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

PROXY

"The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting.The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting.This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting."

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This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield.**I also understand that my signature below represents my agreement and acceptance of the premium rate schedule**.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at Jonesboro, AR, this _____ day of November 2020
(City, State)

City of Jonesboro [full legal name of Policyholder]

By: _____ Harold Perrin
Authorized Signature — Printed Name

Mayor
Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

✔ I will provide the applicant with a signed copy of this application.

_____I have emailed the applicant a signed copy of this application.

2195777 / 46-0800597

_____ _____
Agent Signature — Insurance License # / Agency Fed. TaxID #

MADONNA LEE

_____ _____
Agent Printed Name — Date