PUBLIC NOTICE

(FP/SOQ # 2024-017)

The City of Mercedes is accepting sealed proposals to include Statement of Qualifications for the City of Mercedes Employees' Voluntary Supplemental Insurances Including Sect. 125 Cafeteria Plan Health and Wellness Programs. until 10:00 AM, August 14, 2024. Bid product specifications criteria will be available and can be obtained on the City's website at www.cityofmercedes.com or at the Office of the City Secretary, 400 South Ohio, Mercedes, Texas 78570 on Tuesday, July 26, 2024.

POSTED ON THIS THE 26TH DAY OF JULY, 2024.

/s/Joselynn Castillo, City Secretary

CITY OF MERCEDES

REQUEST FOR PROPOSALS/STATEMENT OF QUALIFICATIONS

(EMPLOYEES VOLUNTARY SUPPLEMENTAL INSURANCES INCLUDING SECTION 125 CAFETERIA PLAN HEALTH AND WELLNESS PROGRAMS)

DUE: Monday, August 19, 2024, 2:00PM -

City Manager's Office

Effective Coverage: October 1, 2024

BID# 2024-017

Request for Proposal for Employees Voluntary Supplemental Insurance including Sect. 125 Cafeteria Plan Health and Wellness Programs/Statement of Qualifications

SECTION I: OVERVIEW

The City of Mercedes is a local government municipality and has approximately One Hundred Fifteen (115) benefit eligible employees, and five elected officials.

The City of Mercedes is accepting Sealed Proposals for EMPLOYEES' SUPPLEMENTAL (ANCILLARY) INSURANCE PRODUCTS INCLUDING SECT. 125 CAFETERIA PLAN HEALTH AND WELLNESS PROGRAMS ALONG WITH STATEMENT OF QUALIFICATIONS including, but not limited to: Accident, Cancer, Critical Illness, Short Term/Long Term Disability, Hospital, and Voluntary Term Life/AD&D. The City's current supplemental insurances are provided by Aflac.

The deadline to provide seven (7) sets of written proposals and one (1) USB is Monday, August 19, 2024 at 2:00 PM. Said proposals are to be sealed, clearly marked **"2024-017 - EMPLOYEES VOLUNTARY SUPPLEMENTAL INSURANCE** INCLUDING SECTION 125 CAFETERIA PLAN HEALTH AND WELLNESS PROGRAMS" and addressed to: City Manager Alberto Perez, and delivered to 400 S. Ohio, Mercedes, TX 78570. The proposals shall be opened as soon thereafter as possible in the City Manager's office. Any proposals received after the time for opening shall be returned unopened. Proposals submitted via faxes or emails will not be accepted.

Specifications are available and can be obtained on the City's website at cityofmercedes.com or at the office of the City Secretary, 400 South Ohio, Mercedes, Texas, 78570, (956) 565-3114 ext. 138, beginning Friday, July 26, 2024 at 4:00PM.

Each bidder shall furnish the information required on the proposal forms.

The City of Mercedes reserves the right to postpone, to accept or to reject any or all proposals, or to waive any informalities in the proposal process and will select on the best value to the City. Proposals may be held by the City of Mercedes for a period not to exceed sixty (60) days from the date of the opening for the purpose of reviewing the proposals and investigation of the proposer's qualifications and making recommendation to the City of Mercedes for contract award.

INDEMNIFICATION CLAUSE

The Respondent hereby agrees to protect, defend, indemnify and hold the CITY OF MERCEDES and its employees, agents, officers and servants free and harmless from all losses, claims, liens, demands and causes of action of every kind and character including, but not limited to, the amounts of judgments , penalties, interests, court costs, legal fees, and all other expenses incurred by the City of Mercedes arising in favor of any party, including claims, liens, debts, personal injuries, including employees of the City of Mercedes, death or damages to property (including property of the City of Mercedes) and without limitation by enumeration, all other claims or demands of every character occurring or in any ways incident to, in connection with or arising directly or indirectly out of this contract. Respondent agrees to investigate, handle, respond to, provide defense for and defend any such claims, demand, or suit at the sole expense of the Respondent. In addition, the Respondent shall protect, defend, indemnify and hold the City of Mercedes and its employees, agents, officers and servants free and harmless from all losses, claims, liens, demands and causes of action relating to, for, or on account of the use of patented appliances, products or processes, and he shall pay all royalties and charges which are legal and equitable. Evidence of such payment or satisfaction shall be submitted upon request of the City Manager, as a necessary requirement in connection with the final estimate for payment in which such patented appliance, products or processes are used. Respondent also agrees to bear all other costs and

expenses related thereto, even if the claim or claims alleged are groundless, false or fraudulent. This provision is not intended to create any cause of action in favor of any third party against Respondent or the City of Mercedes or to enlarge in any way the Respondent's liability but is intended solely to provide for indemnification of the City of Mercedes from liability from damages or injuries to third persons or property arising from Respondent's performance hereunder.

CLARIFICATIONS

Respondent shall carefully examine the solicitation documents to include: proposal forms, specifications/requirements, Instructions, attachments and/or exhibits. Any changes, additions, or clarifications to the RFP/SOQ are made by amendments (addenda). Any respondent in doubt as to the true meaning of any part of the RFP/SOQ or other documents may request an interpretation from the City Manager by posting their question by email to aperez@cityofmercedes.com, and cc to jcastillo@cityofmercedes.com .

If a company, firm or person is asked to make a presentation to the Mayor and City Commission, all expenses associated with travel, lodging, meals, etc., shall be borne by the firm. By the same token any expenses(s) incurred by the respondents in putting together their proposal shall be the responsibility of the respondent. The City of Mercedes shall not be responsible for any reimbursements to any firm.

Please direct your questions to Alberto Perez, City Manager (aperez@cityofmercedes.com) and cc: Joselynn Castillo, City Secretary (jcastillo@cityofmercedes.com). The deadline for questions is Wednesday, August 14, 2024 by 2:00pm.

The City Commission may request to hear a maximum five (5) minute verbal presentations from qualified insurance companies at the City Commission meeting to be held tentatively on September 3, 2024, at 6:30 PM or as close to that date as possible, and will evaluate the proposals based on the following minimum criteria:

a. **Proposed schedule of benefits and monthly premium**
b. **Claims administration process and member communication**
c. **Qualifications and related experience of vendor**

Requirements/Specifications

The required contents and limitations for the preparation of the RFP are described in this section. Failure to provide the requested information or adhere to any City limitations may result in disqualification of the submitted response.

Seeking a 3-year rate guarantee for all Voluntary Products as follows: Accident, Cancer, Critical Illness, Short Term/Long Term Disability, Hospital, and Voluntary Life. (Note: Current Disability Insurance and Life Insurance Plans are not Section 125 Products.) The City's current supplemental insurance provider is provided by Aflac. (Note: The City does not currently offer Supplemental Life/AD&D but has added this coverage to this RFP.)

The City of Mercedes reserves the right to award one or multiple insurance carriers. The effective date of voluntary coverage is being changed to 10/01/2024 (previous effective date was 12/01/2023).

All voluntary products are 100% paid for by the employees. Premiums will be payroll deducted. Only the awarded voluntary products will be eligible for payroll deduction.

The City of Mercedes employs approximately **115** employees. Proposed Insurance Plans should be available for election to permanent employees who work 30 hours or more. This includes full-time employees. Part-time, seasonal, and contract employees are not eligible for coverage.

The City of Mercedes utilizes Employee Navigator as their Benefit Administration System.

The City of Mercedes' has retained Yvonne M. Ortegon, Ortegon Insurance Agency, LLC, as its current Agent of Record. This RFP is not a solicitation for services for Agent of Record or any other agent/brokers services at this time.

Plan Designs

All products should be on a "No Loss-No Gain Basis" provision for pre-existing conditions for the term of the contract. (City does not want any employee to either lose credit for satisfying or partially satisfying the carrier's pre-existing conditions limitations). Preferred that pre-existing conditions be waived for the duration of the contract term. With the exception of the disability plan, employees should have the option to enroll dependents subject to their own coverage on desired plan.

- Each plan must include a Summary of Benefits and Coverage such as covered benefits, final rate sheet, and coverage limitations. Other plan description documents such as flyers that are not customized to City's RFP requirements will not satisfy this request.

- Summary of Benefits should be separated in Tabs & Labeled by Description of Benefit.

1. **Voluntary Accident Plan** must be 24-hour coverage (on and off the job) and be submitted with a high/low option. This product must be offered on a guarantee issued basis for every year. We request at minimum three (3) year rate guarantee. Proposal should indicate whether coverage is portable for members who voluntarily or involuntarily terminate employment or upon an employee's retirement. See current summary of benefits for entire benefits currently being offered.

2. **Voluntary Cancer Plan** must be submitted with a high/low option. This product must be offered on a guarantee issued basis with pre-existing conditions waived every year. Your company must explain Pre-Existing Provisions. The Cancer Plan should include a cancer wellness reimbursement

of at least $50.00 per calendar year. We request at minimum three (3) year rate guarantee. Proposal should indicate whether coverage is portable for members

who voluntarily or involuntarily terminate employment or upon an employee's retirement. See current summary of benefits for entire benefits currently being offered. Currently only one plan is offered. This plan is currently an individual product. There is no certificate of coverage.

3. **Voluntary Combined Short Term and Long-Term Disability** should be income replacement insurance with different options of elimination periods and benefit periods, i.e., educator/political subdivision plans. The City of Mercedes desires an income replacement plan with various periods and maximum benefit periods. The City of Mercedes desires this benefit to be offered on a guarantee issued basis annually throughout the term of the contract. Evidence of insurability should be waived each year within the term of the contract. Your company definition of disability is required. Your company must define pre-existing provisions in the proposal. **A Waiver of Premium Rider is required for this product.** We are seeking at minimum a three (3) year own occupation definition-along with offset requirements. We request at minimum three (3) year rate guarantee. See current summary of benefits for entire benefits currently being offered.

4. **Voluntary Critical Illness Plan** must be submitted with a high/low option. Requesting face amounts of $10,000 for the low plan and $15,000 for the high plan. This product must be offered on a guarantee issued basis every year. The Critical Illness Plan should include wellness reimbursement of at least $50.00 per calendar year. We request at minimum three (3) year rate guarantee. Proposal should indicate whether coverage is portable for members who voluntarily or involuntarily terminate employment or upon an employee's retirement. See current summary of benefits for entire benefits currently being offered. Rates are issue age.

5. **Voluntary Hospital Confinement Indemnity** must be submitted with a high/low option. Requesting benefits for: one-time hospital admission, daily allowance for ICU confinement, daily allowance for hospital room confinement, allowance for outpatient surgery, invasive diagnostic exams, health screening, medical diagnostic and imaging. Proposal should indicate whether coverage is portable for members who voluntarily or involuntarily terminate employment or upon an employee retirement. We request at minimum three (3) year rate guarantee. Proposal should include a quote with a Waiver of Premium Rider, if available. See current summary of benefits for entire benefits currently being offered. Please submit proposals for the requested benefits and current benefits. The City will choose which plan it prefers to offer.

6. **Voluntary Term Life/AD&D Plan** offered should include options for spouse and/or dependent coverage. Term year should be on a 10, 15, 20, and 30-year term. Product must be offered on a "Guaranteed Issue Basis" for all members with no medical exam. Proposal should indicate whether coverage is portable for members who voluntarily or involuntarily terminate employment or upon an employee retirement. We request at minimum three (3) year rate guarantee. Proposal should include a quote with a Waiver of Premium Rider, if available. Final complete rate table for employees, spouse, child(ren) by defined benefit amount. Currently this benefit is not being offered.

7. **Section 125 Health and Wellness Program** offered should include benefits offered that are outside the standard preventative care benefits offered through group medical insurance. The City of Mercedes will only entertain a self-insured medical reimbursement plan (SIMRP). Fixed indemnity plans will not be considered. Please provide the services provided through the plan such as but not limited to tele-health, wellness program, scans, prescription, etc. Include details on the software, tools, resources, etc. that are part of your program. Include the supplemental insurance carrier plan designs and information for all voluntary products listed above. The City will not entertain the disability insurance or the term life/AD&D insurance plan premiums as pre-tax deductions. Please include all pre-tax savings for both the City of Mercedes and its employees. Provide detailed information on all aspects of your program and any associated costs/fees. This is a new program that is not currently in place.

The City of Mercedes reserves the right to postpone, to accept or to reject any or all proposals, or to waive any informalities in the proposal process and will select on the best value to the City.

SECTION II: COMPANY PROFILE

1. In order for the PROPOSALS to be considered, the PLAN DESIGN MUST be equal or better to the existing plans (current Plans are attached hereto EXHIBIT A).

2. The selected company should agree to submit monthly list billings in excel format, by employee and dependents, including full social security numbers, showing separate dollar amounts for individual employee(s) and for each of the coverage(s).

3. Tell us briefly about your company's history, years in business, growth, and the local office that will serve our account.

4. Provide information regarding your company's financial stability to ensure continued services throughout the Agreement term. Acceptable documentation would be the most current financial statements and a copy of the independent audit conducted within the last year.

5. Describe the amount of professional liability and/or errors and omissions insurance currently carried by your company. Provide certificates of insurance.

    - Regarding the Sect. 125 Health and Wellness programs, describe the amount of indemnified and reinsurance amounts your company hold. Provide certificates of all policies.

7. Please list three (3) present and three (3) past clients similar to the City of Mercedes within the past five (5) years and the length of your professional relationship with them. Please provide a contact name and telephone number for each reference.

8. Regarding Section 125 Health and Wellness Programs, provide a list of clients similar to the City of Mercedes and length professional relationship with them. Please provide a contact name and telephone number for at least three (3) references.

SECTION III: PRODUCT & SERVICE

1. Please provide the name, title, professional experience and role for all individuals that would be assigned to our account as the carrier's point of contact (claims processing, billing, etc.)

2. Confirm that your company and members of the team assigned to the City of Mercedes account are properly licensed and qualified to provide the services requested in this RFP.

3. Describe the cost containment strategy you would use to assist the City of Mercedes in maintaining benefits that attract and retain a strong workforce.

4. Provide an implementation plan, including who is responsible for each activity. i.e.

contact, enrollment, follow-up, etc.

5. The City of Mercedes currently utilizes Employee Navigator (ENAV) as their electronic enrollment system. Is your company software able to support ENAV?Does your company accept/support Electronic Data Interchange (EDI) Feed System Requirements?

6. List the proposed product(s) that are being included in this RFP and attach any proposed contract(s) that the City of Mercedes will be expected to sign.

7. Any added fees must be disclose by: claims, administrative expenses, commission, and other (specify) expenses, if any.

8. Include any implementation/tech credits your company provides.

9. Are the Benefits portable? Can the employees take the benefits when they leave employment with the City of Mercedes and continue paying on their own.?

SECTION IV: COMPLIANCE/LEGAL

1. How does your company monitor benefits legislation, compliance and new products in employee benefits?

2. Regarding the Section 125 Health and Wellness Program, what is your compliance policy.

    a. Does your company have an Opinion Letter addressing the IRS Chief Counsel Memos from your tax law firm? If so, please attach as part of your response. If not, please explain.

    b. What measures does your company have to hold your clients harmless? Please explain in detail.

3. Describe how your organization maintains client records in a HIPPA compliant environment.

4. Within the last five (5) years has the vendor, or any officer or employee of the vendor been a defending party in a legal proceeding before a court related to the provision of product and/or services? Has the vendor, or any officer or employee been the subject of a governmental regulatory agency inquiry, investigation, or charge?

5. Regarding the Section 125 Health and Wellness Program, please include your policies and procedures relating to the compliance of your program.

SECTION V: RESERVATION

Depending on the proposals received and the measure of terms of services to be provided, the City of Mercedes reserves the right to reject any and all proposals if deemed in its best interest.

The Deadline to submit the RFP/Statement of Qualifications is 2:00 PM Monday, August 19, 2024.

Multiple proposals from the same carrier/insurance company will not be accepted. The City of Mercedes will only accept proposals directly from insurance companies.

The City of Mercedes retains Yvonne M. Ortegon, Ortegon Insurance Agency, LLC, as its Agent of Record. The City of Mercedes is not solicitating services for Agent of Record or any other agent/brokers services.

SECTION VI: CRITERIA EVALUATION

In Determining to Whom to Award a contract, the City shall consider the following:

1.) The Purchase Price;

2) The Reputation of the Vendor and of the Vendor's Goods or Services;

3) The Quality of the Vendors goods or services;

4.) The extent to which the goods or services meet the City needs;

5.) The vendor's past relationship with the City;

6.) The total long-term cost to the City to acquire the vendor's goods or services;

7.) Any other relevant factor specifically listed in the request for proposals;

8.) The Proposal must be submitted so that a separate tab clearly indicates the cost

for the product(s) and the coverages.

SECTION VI: ATTACHMENTS

For all lines of coverage, the following information is included:

- Comprehensive census for all eligible employees and their elections in Excel format:
  - Gender, DOB, Home Zip Code, DOH, Effective Date, Product, Line of coverage (including elections, volumes, premiums, etc.), salary, employee type (hourly/salary), and occupation.

Aflac – Accident, Cancer, Critical Illness, Disability, and Hospital

- Summary of Benefits
- Rate Sheet
- Certificates of Coverage
- Experience Report - Not available per carrier because the group has been active less than 12 months on these group policies. Prior to these group policies, all were individual policies.

The following will not be provided:

- Renewal Rates
- Billing Statements
- Commissions – City of Mercedes requests each carrier to include standard commission rates.

Request for Proposal for Supplemental Insurance

By submitting this proposal the potential vendor certifies the following:

1. **This proposal is signed by an authorized representative**
2. **All costs have been determined and included in the proposal**
3. **All terms and conditions under the Requirements/Specifications included in the RFP are understood and agreed upon, if any exceptions please specify**
4. **A valid State of Texas insurance license can be provided**
5. **Submitted proposal is valid for sixty {60} days**
6. **Members of the City Commission or City Manager have not been contacted about your company or your products. Any contact with any member of the City Commission to promote your company will disqualify your company from the proposal process.**
7. **Enrollment of employees shall be done so that coverage is effective October 1, 2024. An alternate date more beneficial to the City and the Employees would be considered; however would have to be clearly specified and explained.**

In compliance with this Request for Proposal, and subject to all conditions herein, the undersigned offers and agrees to provide all the services proposed contained in this proposal if accepted.

Name _____

Address _____

_____

Phone _____

Email Address:

_____

Signature _____

EXHIBITS

(For Supplemental Insurance Proposals/Statement of Qualifications)

EXHIBIT A	EMPLOYEE CENSUS, SUMMARY OF BENEFITS FOR EACH PRODUCT, CERTIFICATES OF COVERAGE, AND ANY EXPERIENCE REPORTS
EXHIBIT B	CONFIDENTAIAL DISCLOSURE STATEMENT
EXHIBIT C	NON-COLLUSION STATEMENT
EXHIBIT D	CONFLICT OF INTEREST QUESTIONNAIRE
EXHIBIT E	IMPLEMENTATION OF HOUSE BILL 1295
EXHIBIT F	PROPOSAL SPECIFICATION REQUIREMENTS

EXHIBIT A

ELIGIBLE CENSUS AND ADDITIONAL PLAN INFORMATION

(Please contact the City Secretary's office to obtain this Exhibit)
(956) 565-3114 ex. 138 or 161 or by email to:
jcastillo@cityofmercedes.com

Group Accident Insurance

HIGH PLAN

Plan Benefits

(Benefit provisions may vary by situs state)

Initial Accident Treatment Category- High	Employee	Spouse	Child
Initial Treatment - once per accident, within 7 days of the accident			
ER/Urgent Care	$200	$200	$200
ER/Urgent Care with X-Ray	$250	$250	$250
Doctor's Office	$100	$100	$100
Doctor's Office with X-Ray	$150	$150	$150
Ambulance - once per day, within 90 days of the accident			
Maximum number of payments per covered accident: No Maximum			
Ground	$400	$400	$400
Air	$1,200	$1,200	$1,200
Major Diagnostic Testing - within six months of the accident Maximum number of diagnostic tests per covered accident: 1	$200	$200	$200
Emergency Room Observation - within 7 days of the accident			
Maximum number of 24-hour periods of observation per covered accident: No Maximum			
Short Observation Period (4-24 Hours)	$50	$50	$50
Long Observation Period (24+ Hours)	$100	$100	$100
Prescriptions - within six months of the accident Maximum number of filled prescriptions per covered accident: 2	$5	$5	$5
Pain Management - within six months of the accident Maximum number of payments per covered accident: 1	$100	$100	$100
Blood/Plasma/Platelets - within six months of the accident Maximum number of days per covered accident: 3	$200	$200	$200
Concussion - once per accident, within six months of the accident	$500	$500	$500
Traumatic Brain Injury - once per accident, within six months of the accident	$5,000	$5,000	$5,000
Coma - once per accident We will pay the amount shown if the insured is in a coma lasting 30 days or more as a result of a covered accident	$10,000	$10,000	$10,000
Burns - once per accident, within six months of the accident			
Second Degree Burns			
Less than 10%	$100	$100	$100
At least 10%, but less than 25%	$200	$200	$200
At least 25%, but less than 35%	$500	$500	$500
35% or more	$1,000	$1,000	$1,000
Third Degree Burns			
Less than 10%	$1,000	$1,000	$1,000
At least 10%, but less than 25%	$5,000	$5,000	$5,000
At least 25%, but less than 35%	$10,000	$10,000	$10,000
35% or more	$20,000	$20,000	$20,000
Emergency Dental Work - once per accident, within six months of the accident			
Repair with Crown	$200	$200	$200
Extraction	$50	$50	$50
Eye Injury - removal of a foreign body	$250	$250	$250

Dislocations - once per accident, within 90 days of the accident

Dislocation Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip	$6,000	$6,000	$6,000	$3,000	$3,000	$3,000
Knee	$3,900	$3,900	$3,900	$1,950	$1,950	$1,950
Shoulder	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Foot/Ankle	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Hand	$2,100	$2,100	$2,100	$1,050	$1,050	$1,050
Lower Jaw	$1,800	$1,800	$1,800	$900	$900	$900
Wrist	$1,500	$1,500	$1,500	$750	$750	$750
Elbow	$1,200	$1,200	$1,200	$600	$600	$600
Finger/Toe	$480	$480	$480	$240	$240	$240

Lacerations - once per accident, within 7 days of the accident			
Lacerations requiring stitches			
Under 5 centimeters	$100	$100	$100
5 to 15 centimeters	$400	$400	$400
Over 15 centimeters	$800	$800	$800
Lacerations not requiring stitches	$50	$50	$50

Group Accident Insurance

Fracture - once per covered accident, within 90 days of the accident

Fracture Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip/Thigh	$8,000	$8,000	$8,000	$4,000	$4,000	$4,000
Vertebrae/Sternum	$7,200	$7,200	$7,200	$3,600	$3,600	$3,600
Pelvis	$6,400	$6,400	$6,400	$3,200	$3,200	$3,200
Skull (Depressed)	$6,000	$6,000	$6,000	$3,000	$3,000	$3,000
Leg	$4,800	$4,800	$4,800	$2,400	$2,400	$2,400
Forearm/Hand/Wrist	$4,000	$4,000	$4,000	$2,000	$2,000	$2,000
Foot/Ankle/Kneecap	$4,000	$4,000	$4,000	$2,000	$2,000	$2,000
Shoulder Blade/Collar Bone	$3,200	$3,200	$3,200	$1,600	$1,600	$1,600
Lower Jaw	$3,200	$3,200	$3,200	$1,600	$1,600	$1,600
Skull (Simple)	$2,800	$2,800	$2,800	$1,400	$1,400	$1,400
Upper Arm/Upper Jaw	$2,800	$2,800	$2,800	$1,400	$1,400	$1,400
Facial Bones (except teeth)	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Vertebral Processes/Sacrum	$1,600	$1,600	$1,600	$800	$800	$800
Coccyx/Rib/Finger/Toe	$640	$640	$640	$320	$320	$320

Outpatient Surgery and Anesthesia (per day) - within one year of the accident Performed in a Hospital or Ambulatory Surgical Center Maximum number of payments per covered accident: No Maximum	$400	$400	$400
Performed in a Doctor's Office, Urgent Care Facility or Emergency Room Maximum number of payments per covered accident: 2	$50	$50	$50
Facilities Fee for Outpatient Surgery - within one year of the accident Payable once per each Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	$100	$100	$100
Inpatient Surgery and Anesthesia (per day) - within one year of the accident Maximum number of payments per covered accident: No Maximum	$1,000	$1,000	$1,000
Transportation - within six months of the accident Maximum number of payments per covered accident: 3 Minimum Required Distance (miles): 100			
Plane	$500	$500	$500
Any ground transportation	$200	$200	$200

(Surgical procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.)

Hospitalization Category - High	Employee	Spouse	Child
Hospital Admission (per confinement) - once per accident, within six months of the accident Maximum number of admissions per covered accident: 1	$1,250	$1,250	$1,250
Hospital Confinement (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 365	$300	$300	$300
Hospital Intensive Care (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 30	$400	$400	$400
Intermediate Intensive Care Step-Down Unit (per day) - within six months of the accident Maximum days of confinement per covered accident: 30	$200	$200	$200
Family Member Lodging (per day) - within six months of the accident Maximum days of lodging per covered accident: 30 Minimum Required Distance (miles): 100	$200	$200	$200

Group Accident Insurance

After Care Category - High	Employee	Spouse	Child
Appliances - within six months of the accident			
Cane Maximum number of appliances per covered accident: No Maximum	$40	$40	$40
Ankle Brace Maximum number of appliances per covered accident: No Maximum	$40	$40	$40
Walking Boot Maximum number of appliances per covered accident: No Maximum	$100	$100	$100
Walker Maximum number of appliances per covered accident: No Maximum	$100	$100	$100
Crutches Maximum number of appliances per covered accident: No Maximum	$100	$100	$100
Leg Brace Maximum number of appliances per covered accident: No Maximum	$100	$100	$100
Cervical Collar Maximum number of appliances per covered accident: No Maximum	$100	$100	$100
Wheelchair Maximum number of appliances per covered accident: No Maximum	$400	$400	$400
Knee Scooter Maximum number of appliances per covered accident: No Maximum	$400	$400	$400
Body Jacket Maximum number of appliances per covered accident: No Maximum	$400	$400	$400
Back Brace Maximum number of appliances per covered accident: No Maximum	$400	$400	$400
Accident Follow-Up Treatment - within 6 months of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$50	$50	$50
Post Traumatic Stress Disorder (PTSD) - once per accident, within 6 months of the accident	$200	$200	$200
Rehabilitation Unit (per day) Maximum number of days per confinement: 31 No more than 62 days total per calendar year for each insured	$100	$100	$100
Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 10	$50	$50	$50
Chiropractic or Alternative Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$30	$30	$30

Life Changing Events Category - High	Employee	Spouse	Child
Dismemberment - once per accident, within six months of the accident			
Single Loss	$12,500	$5,000	$2,500
Double Loss	$25,000	$10,000	$5,000
Loss of one or more fingers or toes	$1,250	$500	$250
Partial Dismemberment (includes at least one joint of a finger or toe)	$125	$125	$125
Paralysis - once per accident, diagnosed by a doctor within six months of the accident			
Paraplegia	$5,000	$5,000	$5,000
Quadriplegia	$10,000	$10,000	$10,000
Prosthesis - once per accident Maximum number of prosthetic devices per covered accident: 2	$3,000	$3,000	$3,000
Prosthesis Repair/Replacement - once per prosthetic device, within three years of initial Prosthesis payment	$3,000	$3,000	$3,000
Residence/Vehicle Modification - once per accident, within one year of the accident	$2,000	$2,000	$2,000

Wellness Rider - High	Employee	Spouse	Child
Amount paid will be based on the certificate year in which the wellness test was performed: Maximum number of payments per calendar year, per insured: 1			
Year 1 - Once per calendar year	$25	$25	$25
Year 2 - Once per calendar year	$50	$50	$50
Year 3 - Once per calendar year	$50	$50	$50
Year 4 - Once per calendar year	$50	$50	$50
Year 5 - Once per calendar year	$75	$75	$75
Year 6+ - Once per calendar year	$75	$75	$75

Group Accident Insurance

Accidental Death Rider	Employee	Spouse	Child
Accidental Death - within 90 days of the accident			
Accidental Death	$50,000	$25,000	$10,000
Accidental Common-Carrier Death	$100,000	$50,000	$20,000

Please request a sample policy for full benefit provisions and descriptions.

Group Accident Insurance

Premium Rates - High Plan

Monthly Premiums

Coverage	Premium
Employee	$22.04
Employee and Spouse	$35.29
Employee and Child(ren)	$45.90
Family	$59.15

The premium and product availability indicated in this proposal are subject to change as a result of final underwriting.

Group Accident Insurance

Plan Description

The Aflac Group Accident plan provides cash benefits ***directly to your employees*** (unless otherwise assigned) that help with out-of-pocket expenses - medical and nonmedical - associated with treatment in the event of a covered accident.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Benefit Amounts	See Premium Rates and Plan Benefits for available options
Coverage	24 Hour
Covered Insureds	Available for all family members Spouse-only and Child-only coverage is not available
Guaranteed-Issue	The base accident product is always offered on a guaranteed-issue basis
Enrollment Assumptions	Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.
Requirement for Group Billing	To establish group billing, 25 distinct individuals must be paying premiums
Payment Method	Payroll Deducted
Waiting Period	There is no waiting period
Benefit Reductions	No reduction at any age
Rate Guarantee	2 Years
Portability	2019 Portability
Eligibility	Employees must be actively-at-work on the application date and the effective date. They must work at least 16 hours per week and have been continuously employed for the duration set by the employer. Seasonal and temporary employees are not eligible. Dependents are eligible, but only if the employee is eligible and participates.
Successor Insured	Included
Successor Insured Waiver of Premium	Not Included
Issue Ages	Employee: 18+ Spouse: 18+ Children: Under age 26
Termination Age	None
Certificate Effective Date	Coverage is effective on the billing effective date Note: Benefits are not payable for accidents that occurred prior to the effective date of coverage

Group Accident Insurance

LOW PLAN

Plan Benefits

(Benefit provisions may vary by situs state)

Initial Accident Treatment Category- Low	Employee	Spouse	Child
Initial Treatment - once per accident, within 7 days of the accident			
ER/Urgent Care	$100	$100	$100
ER/Urgent Care with X-Ray	$125	$125	$125
Doctor's Office	$50	$50	$50
Doctor's Office with X-Ray	$75	$75	$75
Ambulance - once per day, within 90 days of the accident			
Maximum number of payments per covered accident: No Maximum			
Ground	$200	$200	$200
Air	$600	$600	$600
Major Diagnostic Testing - within six months of the accident Maximum number of diagnostic tests per covered accident: 1	$100	$100	$100
Emergency Room Observation - within 7 days of the accident			
Maximum number of 24-hour periods of observation per covered accident: No Maximum			
Short Observation Period (4-24 Hours)	$25	$25	$25
Long Observation Period (24+ Hours)	$50	$50	$50
Prescriptions - within six months of the accident Maximum number of filled prescriptions per covered accident: 2	$5	$5	$5
Pain Management - within six months of the accident Maximum number of payments per covered accident: 1	$50	$50	$50
Blood/Plasma/Platelets - within six months of the accident Maximum number of days per covered accident: 3	$100	$100	$100
Concussion - once per accident, within six months of the accident	$250	$250	$250
Traumatic Brain Injury - once per accident, within six months of the accident	$2,500	$2,500	$2,500
Coma - once per accident We will pay the amount shown if the insured is in a coma lasting 30 days or more as a result of a covered accident	$5,000	$5,000	$5,000
Burns - once per accident, within six months of the accident			
Second Degree Burns			
Less than 10%	$50	$50	$50
At least 10%, but less than 25%	$100	$100	$100
At least 25%, but less than 35%	$250	$250	$250
35% or more	$500	$500	$500
Third Degree Burns			
Less than 10%	$500	$500	$500
At least 10%, but less than 25%	$2,500	$2,500	$2,500
At least 25%, but less than 35%	$5,000	$5,000	$5,000
35% or more	$10,000	$10,000	$10,000
Emergency Dental Work - once per accident, within six months of the accident			
Repair with Crown	$100	$100	$100
Extraction	$25	$25	$25
Eye Injury - removal of a foreign body	$125	$125	$125

Dislocations - once per accident, within 90 days of the accident

Dislocation Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Knee	$1,950	$1,950	$1,950	$975	$975	$975
Shoulder	$1,500	$1,500	$1,500	$750	$750	$750
Foot/Ankle	$1,200	$1,200	$1,200	$600	$600	$600
Hand	$1,050	$1,050	$1,050	$525	$525	$525
Lower Jaw	$900	$900	$900	$450	$450	$450
Wrist	$750	$750	$750	$375	$375	$375
Elbow	$600	$600	$600	$300	$300	$300
Finger/Toe	$240	$240	$240	$120	$120	$120

Lacerations - once per accident, within 7 days of the accident			
Lacerations requiring stitches			
Under 5 centimeters	$50	$50	$50
5 to 15 centimeters	$200	$200	$200
Over 15 centimeters	$400	$400	$400
Lacerations not requiring stitches	$25	$25	$25

Group Accident Insurance

Fracture - once per covered accident, within 90 days of the accident

Fracture Schedule	Open Reduction			Closed Reduction		
	Employee	Spouse	Child	Employee	Spouse	Child
Hip/Thigh	$4,000	$4,000	$4,000	$2,000	$2,000	$2,000
Vertebrae/Sternum	$3,600	$3,600	$3,600	$1,800	$1,800	$1,800
Pelvis	$3,200	$3,200	$3,200	$1,600	$1,600	$1,600
Skull (Depressed)	$3,000	$3,000	$3,000	$1,500	$1,500	$1,500
Leg	$2,400	$2,400	$2,400	$1,200	$1,200	$1,200
Forearm/Hand/Wrist	$2,000	$2,000	$2,000	$1,000	$1,000	$1,000
Foot/Ankle/Kneecap	$2,000	$2,000	$2,000	$1,000	$1,000	$1,000
Shoulder Blade/Collar Bone	$1,600	$1,600	$1,600	$800	$800	$800
Lower Jaw	$1,600	$1,600	$1,600	$800	$800	$800
Skull (Simple)	$1,400	$1,400	$1,400	$700	$700	$700
Upper Arm/Upper Jaw	$1,400	$1,400	$1,400	$700	$700	$700
Facial Bones (except teeth)	$1,200	$1,200	$1,200	$600	$600	$600
Vertebral Processes/Sacrum	$800	$800	$800	$400	$400	$400
Coccyx/Rib/Finger/Toe	$320	$320	$320	$160	$160	$160

Outpatient Surgery and Anesthesia (per day) - within one year of the accident Performed in a Hospital or Ambulatory Surgical Center Maximum number of payments per covered accident: No Maximum	$200	$200	$200
Performed in a Doctor's Office, Urgent Care Facility or Emergency Room Maximum number of payments per covered accident: 2	$25	$25	$25
Facilities Fee for Outpatient Surgery - within one year of the accident Payable once per each Outpatient Surgery and Anesthesia Benefit (in a hospital or ambulatory surgical center).	$50	$50	$50
Inpatient Surgery and Anesthesia (per day) - within one year of the accident Maximum number of payments per covered accident: No Maximum	$500	$500	$500
Transportation - within six months of the accident Maximum number of payments per covered accident: 3 Minimum Required Distance (miles): 100			
Plane	$250	$250	$250
Any ground transportation	$100	$100	$100

(Surgical procedures may include, but are not limited to, surgical repair of: ruptured disc, tendons/ligaments, hernia, rotator cuff, torn knee cartilage, skin grafts, joint replacement, internal injuries requiring open abdominal or thoracic surgery, exploratory surgery (with or without repair), etc., unless otherwise noted due to an accidental injury.)

Hospitalization Category - Low	Employee	Spouse	Child
Hospital Admission (per confinement) - once per accident, within six months of the accident Maximum number of admissions per covered accident: 1	$625	$625	$625
Hospital Confinement (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 365	$150	$150	$150
Hospital Intensive Care (per day) - within 6 months of the accident Maximum days of confinement per covered accident: 30	$200	$200	$200
Intermediate Intensive Care Step-Down Unit (per day) - within six months of the accident Maximum days of confinement per covered accident: 30	$100	$100	$100
Family Member Lodging (per day) - within six months of the accident Maximum days of lodging per covered accident: 30 Minimum Required Distance (miles): 100	$100	$100	$100

Group Accident Insurance

After Care Category - Low	Employee	Spouse	Child
Appliances - within six months of the accident			
Cane Maximum number of appliances per covered accident: No Maximum	$20	$20	$20
Ankle Brace Maximum number of appliances per covered accident: No Maximum	$20	$20	$20
Walking Boot Maximum number of appliances per covered accident: No Maximum	$50	$50	$50
Walker Maximum number of appliances per covered accident: No Maximum	$50	$50	$50
Crutches Maximum number of appliances per covered accident: No Maximum	$50	$50	$50
Leg Brace Maximum number of appliances per covered accident: No Maximum	$50	$50	$50
Cervical Collar Maximum number of appliances per covered accident: No Maximum	$50	$50	$50
Wheelchair Maximum number of appliances per covered accident: No Maximum	$200	$200	$200
Knee Scooter Maximum number of appliances per covered accident: No Maximum	$200	$200	$200
Body Jacket Maximum number of appliances per covered accident: No Maximum	$200	$200	$200
Back Brace Maximum number of appliances per covered accident: No Maximum	$200	$200	$200
Accident Follow-Up Treatment - within 6 months of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$25	$25	$25
Post Traumatic Stress Disorder (PTSD) - once per accident, within 6 months of the accident	$100	$100	$100
Rehabilitation Unit (per day) Maximum number of days per confinement: 31 No more than 62 days total per calendar year for each insured	$50	$50	$50
Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 10	$25	$25	$25
Chiropractic or Alternative Therapy - beginning within 90 days of the accident Initial treatment is received within 7 days of the accident Maximum number of visits per covered accident: 6	$15	$15	$15

Life Changing Events Category - Low	Employee	Spouse	Child
Dismemberment - once per accident, within six months of the accident			
Single Loss	$6,250	$2,500	$1,250
Double Loss	$12,500	$5,000	$2,500
Loss of one or more fingers or toes	$625	$250	$125
Partial Dismemberment (includes at least one joint of a finger or toe)	$62.50	$62.50	$62.50
Paralysis - once per accident, diagnosed by a doctor within six months of the accident			
Paraplegia	$2,500	$2,500	$2,500
Quadriplegia	$5,000	$5,000	$5,000
Prosthesis - once per accident Maximum number of prosthetic devices per covered accident: 2	$1,500	$1,500	$1,500
Prosthesis Repair/Replacement - once per prosthetic device, within three years of initial Prosthesis payment	$1,500	$1,500	$1,500
Residence/Vehicle Modification - once per accident, within one year of the accident	$1,000	$1,000	$1,000

Wellness Rider - Low	Employee	Spouse	Child
Amount paid will be based on the certificate year in which the wellness test was performed: Maximum number of payments per calendar year, per insured: 1			
Year 1 - Once per calendar year	$15	$15	$15
Year 2 - Once per calendar year	$30	$30	$30
Year 3 - Once per calendar year	$30	$30	$30
Year 4 - Once per calendar year	$30	$30	$30
Year 5 - Once per calendar year	$60	$60	$60
Year 6+ - Once per calendar year	$60	$60	$60

Group Accident Insurance

Accidental Death Rider	Employee	Spouse	Child
Accidental Death - within 90 days of the accident			
Accidental Death	$50,000	$25,000	$10,000
Accidental Common-Carrier Death	$100,000	$50,000	$20,000

Please request a sample policy for full benefit provisions and descriptions.

Group Accident Insurance

Premium Rates - Low Plan

Monthly Premiums

Coverage	Premium
Employee	$13.76
Employee and Spouse	$21.00
Employee and Child(ren)	$26.08
Family	$33.32

The premium and product availability indicated in this proposal are subject to change as a result of final underwriting.

Group Critical Illness Insurance

Plan Description

The Aflac Group Critical Illness Plan provides cash benefits when an insured person is diagnosed with a covered critical illness-and these benefits are paid directly to your employees (unless otherwise assigned). The plan provides a lump-sum benefit to help with out-of-pocket medical expenses and the living expenses that can accompany a covered critical illness. It is also H.S.A.-compatible.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Benefit Amounts	See Premium Rates and Plan Benefits for available options
Spouse Coverage	Up to 50% of the face amount elected by the employee
Child Coverage	Up to 50% of the face amount elected by the employee
Guaranteed Issue Amounts	**Employee:** Up to $20,000 **Spouse:** Up to $10,000 **Participation Requirement:** 0%
Requirement for Group Billing	To establish group billing, 25 distinct individuals must be paying premiums
Payment Method	Payroll Deducted
Pre-existing Condition Exclusion	None
Waiting Period	There is no waiting period
Benefit Reductions	No reduction at any age
Rate Guarantee	2 Year(s)
Portability/Continuation	Evergreen
Rate Type	Attained Age
Eligibility	**Work Week Hours:** Employee must work at least 16 hours per week **Length of Employment:** No minimum requirement; set by employer
Waiver of Premium	After 90 days of total disability for an employee due to a covered critical illness, we will fully waive all premiums for the duration specified in the certificate
Successor Insured Waiver of Premium	Not Included
Separation Period - Additional Diagnosis/ Reoccurrence	**Additional Diagnosis:** 6 consecutive months **Reoccurrence:** 6 consecutive months
Successor Insured	Included
Issue Ages	**Employee:** 18+ **Spouse:** 18+ **Children:** Under age 26
Termination Age	None
Certificate Effective Date	Coverage is effective on the billing effective date

Group Critical Illness Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Base Benefits	
Heart Attack (Myocardial Infarction)	100%
Sudden Cardiac Arrest	100%
Coronary Artery Bypass Surgery	100%
Major Organ Transplant*	100%
Bone Marrow Transplant (Stem Cell Transplant)	100%
Kidney Failure (End-Stage Renal Failure)	100%
Stroke (Ischemic or Hemorrhagic)	100%
Type I Diabetes	100%

*25% of this benefit is payable for Insureds placed on a transplant list for a major organ transplant

Cancer Benefits	
Cancer (Internal or Invasive)	100%
Non-Invasive Cancer	25%
Skin Cancer	$1000 per calendar year
Metastatic Cancer	25%

Health Screening Benefit	
Health Screening (payable for employee and spouse only)	$50
Health Screening (payable for dependent children)	100% of the Health Screening Amount
Payable per calendar year	1

Specified Diseases Rider	
Tier 1 – Adrenal Hypofunction (Addison's Disease), Cerebrospinal Meningitis, Diphtheria, Encephalitis, Huntington's Chorea, Legionnaire's Disease, Lyme Disease, Malaria, Muscular Dystrophy, Myasthenia Gravis, Necrotizing Fasciitis, Osteomyelitis, Poliomyelitis (Polio), Rabies, Sickle Cell Anemia, Systemic Lupus, Systemic Sclerosis (Scleroderma), Tetanus, Tuberculosis	25%
Tier 2 Human Corona Virus Only	
Hospitalization: 4+days	10%
Hospitalization: 10+days	25%
Hospitalization: Intensive Care Unit (ICU)	40%

Please request a sample policy for full benefit provisions and descriptions.

Group Critical Illness Insurance

Premium Rates

Employee Uni-Tobacco Monthly Premiums

Age	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000	$35,000	$40,000	$45,000	$50,000
18-25	$1.97	$3.94	$5.91	$7.88	$9.86	$11.83	$13.80	$15.77	$17.74	$19.71
26-30	$2.70	$5.40	$8.11	$10.81	$13.51	$16.21	$18.91	$21.61	$24.32	$27.02
31-35	$3.51	$7.02	$10.52	$14.03	$17.54	$21.05	$24.56	$28.07	$31.57	$35.08
36-40	$4.60	$9.20	$13.80	$18.40	$23.00	$27.60	$32.19	$36.79	$41.39	$45.99
41-45	$6.06	$12.13	$18.19	$24.25	$30.32	$36.38	$42.44	$48.51	$54.57	$60.63
46-50	$8.02	$16.04	$24.06	$32.08	$40.10	$48.12	$56.14	$64.16	$72.18	$80.20
51-55	$12.50	$25.00	$37.50	$50.00	$62.51	$75.01	$87.51	$100.01	$112.51	$125.01
56-60	$15.14	$30.28	$45.42	$60.56	$75.70	$90.84	$105.98	$121.12	$136.26	$151.40
61-65	$24.58	$49.17	$73.75	$98.33	$122.91	$147.50	$172.08	$196.66	$221.25	$245.83
66+	$39.16	$78.33	$117.49	$156.66	$195.82	$234.99	$274.15	$313.32	$352.48	$391.65

Spouse Uni-Tobacco Monthly Premiums

Age	$5,000	$7,500	$10,000	$12,500	$15,000	$17,500	$20,000	$22,500	$25,000
18-25	$1.97	$2.96	$3.94	$4.93	$5.91	$6.90	$7.88	$8.87	$9.86
26-30	$2.70	$4.05	$5.40	$6.75	$8.11	$9.46	$10.81	$12.16	$13.51
31-35	$3.51	$5.26	$7.02	$8.77	$10.52	$12.28	$14.03	$15.79	$17.54
36-40	$4.60	$6.90	$9.20	$11.50	$13.80	$16.10	$18.40	$20.70	$23.00
41-45	$6.06	$9.09	$12.13	$15.16	$18.19	$21.22	$24.25	$27.28	$30.32
46-50	$8.02	$12.03	$16.04	$20.05	$24.06	$28.07	$32.08	$36.09	$40.10
51-55	$12.50	$18.75	$25.00	$31.25	$37.50	$43.75	$50.00	$56.25	$62.51
56-60	$15.14	$22.71	$30.28	$37.85	$45.42	$52.99	$60.56	$68.13	$75.70
61-65	$24.58	$36.87	$49.17	$61.46	$73.75	$86.04	$98.33	$110.62	$122.91
66+	$39.16	$58.75	$78.33	$97.91	$117.49	$137.08	$156.66	$176.24	$195.82

Group Critical Illness Insurance

Benefits Summary

(Benefit provisions vary by situs state)

Where applicable, covered conditions must be caused by underlying diseases as defined in the plan. Benefits will be based on the face amount in effect on the critical illness date of diagnosis.

Initial Diagnosis

An insured may receive up to 100% of his face amount upon the diagnosis of a covered critical illness.

Additional Diagnosis

Once benefits have been paid for a covered critical illness, we will pay benefits for each different critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Reoccurrence

Once benefits have been paid for a covered critical illness, benefits are payable for that same critical illness when the date of diagnosis is separated by at least 6 consecutive months.

Health Screening Benefit

The Health Screening Benefit is payable once per calendar year for health screening tests performed as the result of preventive care, including tests and diagnostic procedures ordered in connection with routine examinations. See Master Policy for the full list of covered health screening tests.

Specified Diseases Rider

Tier 1 - Benefits are payable if an insured is diagnosed with one of the diseases listed. For any subsequent Tier 1 specified disease to be payable, the two dates of diagnosis for Tier 1 diseases must satisfy the separation period for Reoccurrence.
Tier 2 – Benefits are payable if an insured is diagnosed with one of the diseases listed and such diagnosis results in either a period of Hospital confinement or a period of Hospital Intensive Care Unit confinement as a direct result of the disease. For any subsequent Tier 2 specified disease to be payable, the two dates of diagnosis for Tier 2 diseases must satisfy the separation period for Reoccurrence.

We will pay this benefit as long as the insured is unable to perform two or more activities of daily living. The insured must continue to be under the regular and appropriate care of a doctor. Loss of the ability to perform activities of daily living must occur after the effective date.

Group Life Insurance

Plan Description

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Coverage Type	Guaranteed Issue Only
Spouse Coverage	Included
Child Coverage	Included
Guaranteed-Issue Amounts	**Employee:** Up to $50,000 **Spouse:** Lessor of $25,000 or 50% of Employee benefit **Child:** $25,000 **Participation Requirement:** 10%
Benefit Reduction	50% at Age 70 or 10 years from Certificate Issuance
Contribution Method	Employee Paid
Payment Method	Payroll Deducted
Waiting Period	There is no waiting period
Portability	Yes (Employee and Spouse Only)
Rate Type	Issue Age
Eligibility	**Work Week Hours:** Employee must work at least 16 hours per week **Length of Employment:** Set by employer
Issue Ages	**Employee:** 18-70 **Spouse:** 18-70 **Child:** Under age 26
Termination Age	Age 120
Certificate Effective Date	Coverage is effective on the billing effective date
Requirement for Group Billing	To establish group billing, 25 distinct individuals must be paying premiums

Group Life Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Basic Death Benefit	
Basic Death Benefit	**Included**

Accidental Death Benefit Rider	
This benefit provides an additional benefit equal to the insured's face amount if the insured dies within 180 days of direct accidental bodily injuries.	
Termination Age	**Age 70 or 10 years from Certificate issuance**

Accelerated Benefit Rider	
Terminal Illness	**Included**
Chronic Conditions	**Included**
Elimination Period	**90 days**
Payment Options	**Periodic Payments: 25 monthly payments equal to 4% of Life Insurance Benefit** **One-Time Lump Sum: 50% of Life Insurance Benefit**

Extension of Benefits Rider
This rider extends benefits payable for a Chronic Condition when the Periodic Payments Method is selected under the Accelerated Benefit Rider.

Waiver of Premium Rider	
After the Certificateholder is Totally Disabled for six continuous months, premiums will be waived for up to 24 months.	
Termination Age	**Age 70 or 10 years from Certificate issuance**

Child Term Rider	
Benefit Amount	**$25,000**
Termination Age	**26th Birthday**

Dependent child coverage is not eligible for portability but may be eligible for conversion to an Individual life insurance policy.

Group Life Insurance

Premium Rates

Employee Non-Tobacco Monthly Premiums					
Issue Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**
18-25	$4.68	$9.35	$14.03	$18.70	$23.38
26-30	$5.43	$10.87	$16.30	$21.73	$27.17
31-35	$6.43	$12.85	$19.28	$25.70	$32.13
36-40	$8.05	$16.10	$24.15	$32.20	$40.25
41-45	$10.39	$20.78	$31.18	$41.57	$51.96
46-50	$13.55	$27.10	$40.65	$54.20	$67.75
51-55	$18.74	$37.48	$56.23	$74.97	$93.71
56-60	$27.58	$55.17	$82.75	$110.33	$137.92
61-65	$35.61	$71.22	$106.83	$142.43	$178.04
66-70	$54.60	$109.20	$163.80	$218.40	$273.00

Spouse Non-Tobacco Monthly Premiums					
Issue Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**
18-25	$2.60	$5.21	$7.81	$10.42	$13.02
26-30	$3.03	$6.07	$9.10	$12.13	$15.17
31-35	$3.59	$7.18	$10.76	$14.35	$17.94
36-40	$4.49	$8.98	$13.47	$17.97	$22.46
41-45	$5.76	$11.53	$17.29	$23.05	$28.81
46-50	$7.38	$14.77	$22.15	$29.53	$36.92
51-55	$9.90	$19.81	$29.71	$39.62	$49.52
56-60	$13.93	$27.86	$41.79	$55.72	$69.65
61-65	$20.50	$41.00	$61.50	$82.00	$102.50
66-70	$31.15	$62.31	$93.46	$124.62	$155.77

Employee Tobacco Monthly Premiums

Issue Age	$10,000	$20,000	$30,000	$40,000	$50,000
18-25	$6.08	$12.17	$18.25	$24.33	$30.42
26-30	$7.33	$14.65	$21.98	$29.30	$36.63
31-35	$9.22	$18.43	$27.65	$36.87	$46.08
36-40	$11.61	$23.22	$34.82	$46.43	$58.04
41-45	$14.89	$29.78	$44.68	$59.57	$74.46
46-50	$19.72	$39.43	$59.15	$78.87	$98.58
51-55	$26.87	$53.73	$80.60	$107.47	$134.33
56-60	$39.84	$79.68	$119.53	$159.37	$199.21
61-65	$55.78	$111.55	$167.33	$223.10	$278.88
66-70	$82.89	$165.78	$248.67	$331.57	$414.46

Spouse Tobacco Monthly Premiums

Issue Age	$5,000	$10,000	$15,000	$20,000	$25,000
18-25	$3.44	$6.88	$10.33	$13.77	$17.21
26-30	$4.15	$8.31	$12.46	$16.62	$20.77
31-35	$5.24	$10.48	$15.71	$20.95	$26.19
36-40	$6.59	$13.18	$19.76	$26.35	$32.94
41-45	$8.40	$16.81	$25.21	$33.62	$42.02
46-50	$11.00	$22.00	$33.00	$44.00	$55.00
51-55	$14.66	$29.32	$43.98	$58.63	$73.29
56-60	$21.08	$42.15	$63.23	$84.30	$105.38
61-65	$32.16	$64.32	$96.48	$128.63	$160.79
66-70	$47.33	$94.67	$142.00	$189.33	$236.67

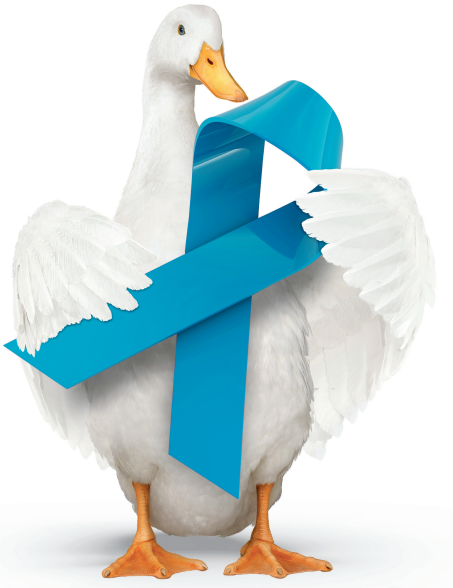
Child Term Rider Monthly Premiums

Age Band	$25,000
Under age 26	$10.42

Aflac
Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – HIGH PLAN

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.



THE POLICY IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

B70375RTX IC(3/23)

Benefits overview Choose the Policy and Riders that Fit Your Needs

BENEFIT:	DESCRIPTION:
INITIAL DIAGNOSIS	Named Insured or Spouse: $7,500 Dependent Child: $15,000 Payable once per covered person, per lifetime
RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY	Self-Administered: $600 per calendar month Physician Administered: $2,000 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month
ANNUAL CARE	$750 on the anniversary date of diagnosis; lifetime maximum of five annual $750 payments per covered person
CANCER SCREENING	One $100 benefit per calendar year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)	$350 per covered person, per lifetime
ADDITIONAL OPINION	$400 per covered person, per lifetime
HORMONAL THERAPY	$40 once per calendar month
TOPICAL CHEMOTHERAPY	$200 once per calendar month
ANTINAUSEA	$150 once per calendar month
STEM CELL AND BONE MARROW TRANSPLANTATION	$10,000; lifetime maximum of $10,000 per covered person Donor Benefit: $150 for stem cell donation, or $1,000 for bone marrow donation Payable one time per covered person
BLOOD AND PLASMA	Inpatient: $75 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: $250 per day, per covered person
SURGICAL/ANESTHESIA	$140-$5,000 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed $6,250; no lifetime maximum on the number of operations
SKIN CANCER SURGERY	Laser or Cryosurgery: $50 Excision of lesion of skin without flap or graft: $250 Flap or graft without excision: $375 Excision of lesion of skin with flap or graft: $600 Maximum daily benefit will not exceed $600. No lifetime maximum on the number of operations
PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)	$350 per covered person, per lifetime
HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS	Named Insured or Spouse: $300 Dependent Child: $375
HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE	Named Insured or Spouse: $600 Dependent Child: $750

OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE	$300 per day, per covered person
EXTENDED-CARE FACILITY	$150 per day; limited to 30 days in each calendar year, per covered person
HOME HEALTH CARE	$150 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person
HOSPICE CARE	$1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person
NURSING SERVICES	$150 per day; payable for only the number of days the Hospital Confinement Benefit is payable
SURGICAL PROSTHESIS	$3,000; lifetime maximum of $6,000 per covered person
NONSURGICAL PROSTHESIS	$250 per occurrence, per covered person; lifetime maximum of $500 per covered person
BREAST RECONSTRUCTION	Breast Tissue/Muscle Reconstruction Flap Procedures: $3,000 Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $700 Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $350 Permanent Areola Repigmentation (on the diseased breast): $150 Maximum daily benefit will not exceed $3,000
OTHER RECONSTRUCTIVE SURGERY	Facial Reconstruction: $700 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed $700
EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION	$1,500 for a covered person to have oocytes extracted and harvested $250 for the storage of a covered person's oocyte(s) or sperm $250 for embryo transfer Lifetime maximum of $2,000 per covered person
AMBULANCE	$250 ground $2,000 air ambulance
TRANSPORTATION	$.50 cents per mile for transportation; payable up to a combined maximum of $1,500, per round trip
LODGING	$80 per day; limited to 90 days per calendar year
WAIVER OF PREMIUM	Yes
CONTINUATION OF COVERAGE	Yes
OPTIONAL RIDERS:	**DESCRIPTION:**
INITIAL DIAGNOSIS BUILDING BENEFIT RIDER	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.
SPECIFIED-DISEASE BENEFIT RIDER	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:

Initial diagnosis	Hospitalization	
$2,000	30 days or less; $400 per day	31 days or more; $800 per day

DEPENDENT CHILD RIDER	$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child

Aflac | Rate Sheet

Aflac Cancer Protection Assurance | B70300

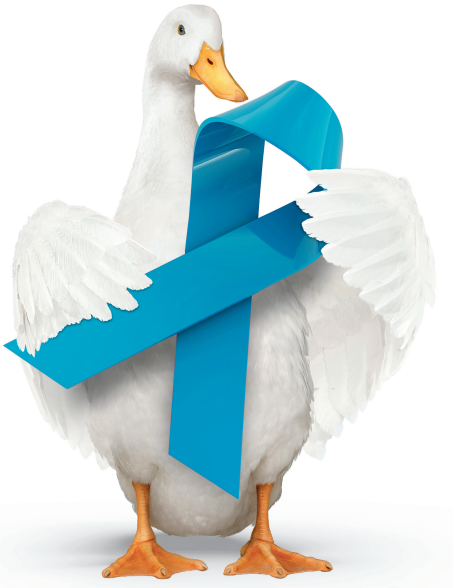
Biweekly rates

Age Range	Individual	Named Insured / Spouse Only	One Parent Family	Two Parent Family
18 to 75	$21.86	$37.32	$21.86	$37.32

Aflac
Cancer Protection Assurance

CANCER INDEMNITY INSURANCE – LOW PLAN

We've been dedicated to helping provide peace of mind and financial security for more than 60 years.



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Underwritten by:
American Family Life Assurance Company of Columbus
Worldwide Headquarters | 1932 Wynnton Road | Columbus, Georgia 31999

B70275RTX IC(3/23)

Benefits overview Choose the Policy and Riders that Fit Your Needs

BENEFIT:	DESCRIPTION:
INITIAL DIAGNOSIS	Named Insured or Spouse: $5,000 Dependent Child: $10,000 Payable once per covered person, per lifetime
RADIATION THERAPY, CHEMOTHERAPY, IMMUNOTHERAPY OR EXPERIMENTAL CHEMOTHERAPY	Self-Administered: $375 per calendar month Physician Administered: $1,600 per calendar month This benefit is limited to one self-administered treatment and one physician-administered treatment per calendar month
ANNUAL CARE	$500 on the anniversary date of diagnosis; lifetime maximum of five annual $500 payments per covered person
CANCER SCREENING	One $75 benefit per calendar year, per covered person Benefit increases to three screenings per calendar year after the diagnosis for internal cancer or an associated cancerous condition
PROPHYLACTIC SURGERY (DUE TO A POSITIVE GENETIC TEST RESULT)	$250 per covered person, per lifetime
ADDITIONAL OPINION	$300 per covered person, per lifetime
HORMONAL THERAPY	$25 once per calendar month
TOPICAL CHEMOTHERAPY	$150 once per calendar month
ANTINAUSEA	$100 once per calendar month
STEM CELL AND BONE MARROW TRANSPLANTATION	$7,000; lifetime maximum of $7,000 per covered person Donor Benefit: $100 for stem cell donation, or $750 for bone marrow donation Payable one time per covered person
BLOOD AND PLASMA	Inpatient: $50 times the number of days paid under the Hospital Confinement Benefit, per covered person Outpatient: $175 per day, per covered person
SURGICAL/ANESTHESIA	$100-$3,400 Anesthesia: additional 25% of the Surgery Benefit Maximum daily benefit will not exceed $4,250; no lifetime maximum on the number of operations
SKIN CANCER SURGERY	Laser or Cryosurgery: $35 Excision of lesion of skin without flap or graft: $170 Flap or graft without excision: $250 Excision of lesion of skin with flap or graft: $400 Maximum daily benefit will not exceed $400. No lifetime maximum on the number of operations
PROPHYLACTIC SURGERY (WITH CORRELATING INTERNAL CANCER DIAGNOSIS)	$250 per covered person, per lifetime
HOSPITALIZATION CONFINEMENT FOR 30 DAYS OR LESS	Named Insured or Spouse: $200 Dependent Child: $250
HOSPITALIZATION CONFINEMENT FOR 31 DAYS OR MORE	Named Insured or Spouse: $400 Dependent Child: $500

OUTPATIENT HOSPITAL SURGICAL ROOM CHARGE	$200 per day, per covered person
EXTENDED-CARE FACILITY	$100 per day; limited to 30 days in each calendar year, per covered person
HOME HEALTH CARE	$100 per day; limited to 10 days per hospitalization, per covered person; and 30 days per calendar year, per covered person
HOSPICE CARE	$1,000 for first day; $50 per day thereafter; $12,000 lifetime maximum per covered person
NURSING SERVICES	$100 per day; payable for only the number of days the Hospital Confinement Benefit is payable
SURGICAL PROSTHESIS	$2,000; lifetime maximum of $4,000 per covered person
NONSURGICAL PROSTHESIS	$175 per occurrence, per covered person; lifetime maximum of $350 per covered person
BREAST RECONSTRUCTION	Breast Tissue/Muscle Reconstruction Flap Procedures: $2,000 Breast Reconstruction (occurring within 5 years of breast cancer diagnosis): $500 Breast Symmetry (on the nondiseased breast occurring within 5 years of breast reconstruction): $220 Permanent Areola Repigmentation (on the diseased breast): $100 Maximum daily benefit will not exceed $2,000
OTHER RECONSTRUCTIVE SURGERY	Facial Reconstruction: $500 Anesthesia: additional 25% of the Other Reconstructive Surgery Benefit Maximum daily benefit will not exceed $500
EGG HARVESTING, STORAGE (CRYOPRESERVATION) AND IMPLANTATION	$1,000 for a covered person to have oocytes extracted and harvested $200 for the storage of a covered person's oocyte(s) or sperm $200 for embryo transfer Lifetime maximum of $1,400 per covered person
AMBULANCE	$250 ground $2,000 air ambulance
TRANSPORTATION	$.40 cents per mile for transportation; payable up to a combined maximum of $1,200, per round trip
LODGING	$65 per day; limited to 90 days per calendar year
WAIVER OF PREMIUM	Yes
CONTINUATION OF COVERAGE	Yes
OPTIONAL RIDERS:	**DESCRIPTION:**
INITIAL DIAGNOSIS BUILDING BENEFIT RIDER	This benefit will increase the amount of your Initial Diagnosis Benefit, as shown in the policy, by $100 for each unit purchased, up to five units, for each covered person on the anniversary date of coverage, while coverage remains in force.
SPECIFIED-DISEASE BENEFIT RIDER	When a covered person is diagnosed with any of the diseases listed in the Specified-Disease Rider:

Initial diagnosis	Hospitalization	
$2,000	30 days or less; $400 per day	31 days or more; $800 per day

DEPENDENT CHILD RIDER	$10,000 when a covered dependent child is diagnosed as having internal cancer or an associated cancerous condition; payable only once for each covered dependent child

Aflac | Rate Sheet

Aflac Cancer Protection Assurance | B70200

Biweekly rates

Age Range	Individual	Named Insured / Spouse Only	One Parent Family	Two Parent Family
18 to 75	$15.46	$26.60	$15.46	$26.60

Group Hospital Indemnity Insurance

Plan Description

The Aflac Group Hospital Indemnity Plan provides cash benefits ***directly to your employees*** (unless otherwise assigned) that help pay for some of the costs - medical and nonmedical - associated with a covered hospital stay due to a sickness or accidental injury.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Benefit Amounts	See Premium Rates and Plan Benefits for available options
Coverage	Available for all family members Spouse-only and Child-only coverage is not available
Guaranteed Issue Amounts	Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first anniversary, late enrolles are eligible to enroll on a guaranteed-issue basis.
Enrollment Assumptions	Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.
Requirement for Group Billing	To establish group billing, 25 distinct individuals must be paying premiums
Payment Method	Payroll Deducted
Pre-existing Condition Exclusion	None
Pregnancy Limitation	None
Waiting Period	There is no waiting period
Benefit Reductions	No reduction at any age
Rate Guarantee	2 Years
Portability/Continuation	2019 Portability
Eligibility	Employees must be actively-at-work on the application date and the effective date. They must work at least 16 hours per week. Seasonal and temporary employees are not eligible. Dependents are eligible, but only if the employee is eligible and participates.
Successor Insured	Included
Successor Insured Waiver of Premium	Not Included
Issue Ages	**Employee:** 18+ **Spouse:** 18+ **Children:** Under age 26
Termination Age	None
Certificate Effective Date	Coverage is effective on the billing effective date

Group Hospital Indemnity Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Hospitalization Benefits - High	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	**$2,000**
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	**$200**
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$200**
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$100**

Please request a sample policy for full benefit provisions and definitions.

Group Hospital Indemnity Insurance

Premium Rates

Monthly Premiums

Coverage	Premium
Employee	$33.10
Employee and Spouse	$64.60
Employee and Child(ren)	$50.94
Family	$82.44

The rates and product availability indicated in this proposal are subject to change as a result of final underwriting.

Group Hospital Indemnity Insurance

Plan Description

The Aflac Group Hospital Indemnity Plan provides cash benefits ***directly to your employees*** (unless otherwise assigned) that help pay for some of the costs - medical and nonmedical - associated with a covered hospital stay due to a sickness or accidental injury.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Benefit Amounts	See Premium Rates and Plan Benefits for available options
Coverage	Available for all family members Spouse-only and Child-only coverage is not available
Guaranteed Issue Amounts	Guaranteed-issue coverage is offered to all eligible applicants during the initial enrollment and for new hires thereafter. At the group's first anniversary, late enrolles are eligible to enroll on a guaranteed-issue basis.
Enrollment Assumptions	Enrollments take place once each 12-month period. Late enrollees cannot enroll outside of an annual enrollment period.
Requirement for Group Billing	To establish group billing, 25 distinct individuals must be paying premiums
Payment Method	Payroll Deducted
Pre-existing Condition Exclusion	None
Pregnancy Limitation	None
Waiting Period	There is no waiting period
Benefit Reductions	No reduction at any age
Rate Guarantee	2 Years
Portability/Continuation	2019 Portability
Eligibility	Employees must be actively-at-work on the application date and the effective date. They must work at least 16 hours per week. Seasonal and temporary employees are not eligible. Dependents are eligible, but only if the employee is eligible and participates.
Successor Insured	Included
Successor Insured Waiver of Premium	Not Included
Issue Ages	**Employee:** 18+ **Spouse:** 18+ **Children:** Under age 26
Termination Age	None
Certificate Effective Date	Coverage is effective on the billing effective date

Group Hospital Indemnity Insurance

Plan Benefits

(Benefit provisions may vary by situs state)

Hospitalization Benefits - Low	
Hospital Admission (per confinement) Once per covered sickness or accident per calendar year	**$500**
Hospital Confinement (per day) Maximum confinement period: 31 days per covered sickness or covered accident	**$100**
Hospital Intensive Care (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$100**
Intermediate Intensive Care Step-Down Unit (per day) Maximum confinement period: 10 days per covered sickness or covered accident	**$50**

Please request a sample policy for full benefit provisions and definitions.

Monthly Premiums

Coverage	Premium
Employee	$14.42
Employee and Spouse	$24.76
Employee and Child(ren)	$20.72
Family	$31.06

The rates and product availability indicated in this proposal are subject to change as a result of final underwriting.

Group Short-Term Disability Insurance

Plan Description

The Aflac Group Disability Advantage insurance plan provides for payment of a monthly disability benefit when a covered employee is disabled and unable to work due to an injury or sickness. Benefit payments begin after any applicable elimination period is satisfied and continue during disability, up to the disability benefit period.

Features and Plan Provisions (specific benefit provisions may vary by situs state)	
Benefit Amounts	$300 to $6,000
Coverage	Non-Occupational
Guaranteed Issue Amounts	Monthly benefit of up to $3,000 **Participation Requirement:** 0%
Requirement for Group Billing	25 Payors
Payment Method	Payroll Deducted
Maximum Income Replacement	60% of the employee's base annual pay (up to 40% in states with state disability benefits)
Pre-existing Condition Exclusion	12/12
Rate Guarantee	1 Year(s)
Portability/Continuation	Standard Portability (An employee's coverage may be continued when eligibility or employment ends. Coverage will end on the date the group plan is terminated.)
Waiver of Premium	Not Included
Eligibility	Employee must work at least 19 hours per week with a base annual pay of at least $9,000.
Issue Ages	***Employee:*** 18-74
Termination Age	None

Group Short-Term Disability Insurance

Pre-Existing Conditions

Pre-Existing Condition Limitation

Pre-existing Condition is an illness, disease, infection, disorder, pregnancy, or injury that existed within the 12-month period before the effective date of coverage.

For a condition to have been pre-existing:
- A doctor must have advised, diagnosed, or treated the covered employee, **or**
- Symptoms existed that would ordinarily cause a prudent person to seek medical advice or treatment.

We will not pay benefits for any disability resulting from or affected by a pre-existing condition if the disability was diagnosed within the 12-month period after the effective date of coverage.

We will not reduce or deny a claim for benefits for any disability due to a pre-existing condition that was diagnosed more than 12-months after the effective date of coverage.

Pregnancy Limitation

Within the first nine months of the effective date of coverage, we will not pay benefits for a disability that is caused by, or occurs as a result of, pregnancy or childbirth. Disability due to complications of pregnancy will be covered to the same extent as a covered sickness.

After this coverage has been in force for nine months from the effective date of coverage, disability benefits for childbirth will be payable. The maximum period of disability allowed for disability due to childbirth is six weeks for non-cesarean delivery and eight weeks for cesarean delivery, less the elimination period, unless proof is furnished that disability continues beyond these time frames due to complications of pregnancy.

Please request a sample policy for full benefit descriptions and definitions.

Separate Periods of Disability

Same or Related Conditions

Separate periods of disability resulting from the **same condition or a related condition** are considered a continuation of the prior disability if they are not separated by 180 days or more.

Once the maximum Disability Benefit has been paid, the covered employee will not be eligible for a new Disability Benefit due to the **same or a related condition for 180** days after **all** the following conditions are met:
- The employee has been released by a doctor from the prior disability.
- The employee is no longer disabled.
- The employee is no longer qualified to receive any disability benefits under the certificate.

After the disability benefit period, the employee may continue coverage if **all** of the following conditions are met:
- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group master policy is still in force upon return to work.

Unrelated Causes

Separate periods of disability resulting from unrelated causes **are** considered a continuation of the prior disability if they are not separated by the covered employee returning to work at a full-time job for **30 consecutive days**, during which the employee is performing the material and substantial duties of that job.

Once the maximum Disability Benefit has been paid, the employee will not be eligible for a new Benefit for disability due to an unrelated cause, until 30 consecutive days after all the following conditions are met:
- The employee has been released by a doctor from a prior disability.
- The employee is no longer qualified to receive any disability benefits under this certificate.

After the disability benefit period, the employee may continue coverage if all of the following conditions are met:
- The employee returns to work within 90 days after the benefit period ends.
- Premium payments for the coverage resume upon return to work.
- The group Policy is still in force upon

Group Short-Term Disability Insurance

Elimination Period: 0/7 Days
Benefit Duration: 3 Months

Monthly Rates per $100 of monthly benefit			
Age Band	**18-49**	**50-64**	**65-74**
Premium Rate	$2.55	$2.74	$3.24

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
$9,000 or more	$300	$7.66	$8.21	$9.73
$9,000 to $9,999	$400	$10.22	$10.94	$12.97
$10,000 to $11,999	$500	$12.77	$13.68	$16.21
$12,000 to $13,999	$600	$15.32	$16.42	$19.45
$14,000 to $15,999	$700	$17.88	$19.15	$22.70
$16,000 to $17,999	$800	$20.43	$21.89	$25.94
$18,000 to $19,999	$900	$22.98	$24.63	$29.18
$20,000 to $21,999	$1,000	$25.54	$27.36	$32.42
$22,000 to $23,999	$1,100	$28.09	$30.10	$35.67
$24,000 to $25,999	$1,200	$30.65	$32.83	$38.91
$26,000 to $27,999	$1,300	$33.20	$35.57	$42.15
$28,000 to $29,999	$1,400	$35.75	$38.31	$45.39
$30,000 to $31,999	$1,500	$38.31	$41.04	$48.64
$32,000 to $33,999	$1,600	$40.86	$43.78	$51.88
$34,000 to $35,999	$1,700	$43.41	$46.51	$55.12
$36,000 to $37,999	$1,800	$45.97	$49.25	$58.36
$38,000 to $39,999	$1,900	$48.52	$51.99	$61.61
$40,000 to $41,999	$2,000	$51.08	$54.72	$64.85
$42,000 to $43,999	$2,100	$53.63	$57.46	$68.09
$44,000 to $45,999	$2,200	$56.18	$60.20	$71.33
$46,000 to $47,999	$2,300	$58.74	$62.93	$74.58
$48,000 to $49,999	$2,400	$61.29	$65.67	$77.82
$50,000 to $51,999	$2,500	$63.84	$68.40	$81.06
$52,000 to $53,999	$2,600	$66.40	$71.14	$84.30
$54,000 to $55,999	$2,700	$68.95	$73.88	$87.55
$56,000 to $57,999	$2,800	$71.51	$76.61	$90.79
$58,000 to $59,999	$2,900	$74.06	$79.35	$94.03
$60,000 to $61,999	$3,000	$76.61	$82.08	$97.27
$62,000 to $63,999	$3,100	$79.17	$84.82	$100.51
$64,000 to $65,999	$3,200	$81.72	$87.56	$103.76
$66,000 to $67,999	$3,300	$84.27	$90.29	$107.00

Group Short-Term Disability Insurance

Elimination Period: 0/7 Days
Benefit Duration: 6 Months

Monthly Rates per $100 of monthly benefit			
Age Band	**18-49**	**50-64**	**65-74**
Premium Rate	$3.45	$4.02	$5.03

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
$9,000 or more	$300	$10.34	$12.07	$15.08
$9,000 to $9,999	$400	$13.78	$16.09	$20.11
$10,000 to $11,999	$500	$17.23	$20.11	$25.14
$12,000 to $13,999	$600	$20.68	$24.13	$30.17
$14,000 to $15,999	$700	$24.12	$28.16	$35.20
$16,000 to $17,999	$800	$27.57	$32.18	$40.22
$18,000 to $19,999	$900	$31.02	$36.20	$45.25
$20,000 to $21,999	$1,000	$34.46	$40.22	$50.28
$22,000 to $23,999	$1,100	$37.91	$44.25	$55.31
$24,000 to $25,999	$1,200	$41.35	$48.27	$60.33
$26,000 to $27,999	$1,300	$44.80	$52.29	$65.36
$28,000 to $29,999	$1,400	$48.25	$56.31	$70.39
$30,000 to $31,999	$1,500	$51.69	$60.34	$75.42
$32,000 to $33,999	$1,600	$55.14	$64.36	$80.45
$34,000 to $35,999	$1,700	$58.58	$68.38	$85.47
$36,000 to $37,999	$1,800	$62.03	$72.40	$90.50
$38,000 to $39,999	$1,900	$65.48	$76.43	$95.53
$40,000 to $41,999	$2,000	$68.92	$80.45	$100.56
$42,000 to $43,999	$2,100	$72.37	$84.47	$105.59
$44,000 to $45,999	$2,200	$75.81	$88.49	$110.61
$46,000 to $47,999	$2,300	$79.26	$92.52	$115.64
$48,000 to $49,999	$2,400	$82.71	$96.54	$120.67
$50,000 to $51,999	$2,500	$86.15	$100.56	$125.70
$52,000 to $53,999	$2,600	$89.60	$104.58	$130.72
$54,000 to $55,999	$2,700	$93.05	$108.61	$135.75
$56,000 to $57,999	$2,800	$96.49	$112.63	$140.78
$58,000 to $59,999	$2,900	$99.94	$116.65	$145.81
$60,000 to $61,999	$3,000	$103.38	$120.67	$150.84
$62,000 to $63,999	$3,100	$106.83	$124.70	$155.86
$64,000 to $65,999	$3,200	$110.28	$128.72	$160.89
$66,000 to $67,999	$3,300	$113.72	$132.74	$165.92

Group Short-Term Disability Insurance

Elimination Period: 7/7 Days
Benefit Duration: 3 months

Monthly Rates per $100 of monthly benefit			
Age Band	**18-49**	**50-64**	**65-74**
Premium Rate	$2.48	$2.67	$3.08

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
$9,000 or more	$300	$7.43	$8.01	$9.25
$9,000 to $9,999	$400	$9.91	$10.68	$12.33
$10,000 to $11,999	$500	$12.38	$13.36	$15.41
$12,000 to $13,999	$600	$14.86	$16.03	$18.49
$14,000 to $15,999	$700	$17.34	$18.70	$21.57
$16,000 to $17,999	$800	$19.81	$21.37	$24.65
$18,000 to $19,999	$900	$22.29	$24.04	$27.74
$20,000 to $21,999	$1,000	$24.77	$26.71	$30.82
$22,000 to $23,999	$1,100	$27.24	$29.38	$33.90
$24,000 to $25,999	$1,200	$29.72	$32.05	$36.98
$26,000 to $27,999	$1,300	$32.20	$34.72	$40.06
$28,000 to $29,999	$1,400	$34.67	$37.39	$43.14
$30,000 to $31,999	$1,500	$37.15	$40.07	$46.23
$32,000 to $33,999	$1,600	$39.63	$42.74	$49.31
$34,000 to $35,999	$1,700	$42.10	$45.41	$52.39
$36,000 to $37,999	$1,800	$44.58	$48.08	$55.47
$38,000 to $39,999	$1,900	$47.06	$50.75	$58.55
$40,000 to $41,999	$2,000	$49.53	$53.42	$61.63
$42,000 to $43,999	$2,100	$52.01	$56.09	$64.72
$44,000 to $45,999	$2,200	$54.49	$58.76	$67.80
$46,000 to $47,999	$2,300	$56.96	$61.43	$70.88
$48,000 to $49,999	$2,400	$59.44	$64.11	$73.96
$50,000 to $51,999	$2,500	$61.92	$66.78	$77.04
$52,000 to $53,999	$2,600	$64.39	$69.45	$80.12
$54,000 to $55,999	$2,700	$66.87	$72.12	$83.21
$56,000 to $57,999	$2,800	$69.35	$74.79	$86.29
$58,000 to $59,999	$2,900	$71.82	$77.46	$89.37
$60,000 to $61,999	$3,000	$74.30	$80.13	$92.45
$62,000 to $63,999	$3,100	$76.77	$82.80	$95.53
$64,000 to $65,999	$3,200	$79.25	$85.47	$98.61
$66,000 to $67,999	$3,300	$81.73	$88.15	$101.70

Group Short-Term Disability Insurance

Elimination Period: 7/7 Days
Benefit Duration: 6 months

Monthly Rates per $100 of monthly benefit			
Age Band	**18-49**	**50-64**	**65-74**
Premium Rate	$3.39	$3.87	$4.89

Annual Salary Range	Monthly Benefit	AGE 18-49	AGE 50-64	AGE 65-74
$9,000 or more	$300	$10.17	$11.60	$14.68
$9,000 to $9,999	$400	$13.57	$15.47	$19.57
$10,000 to $11,999	$500	$16.96	$19.34	$24.46
$12,000 to $13,999	$600	$20.35	$23.20	$29.35
$14,000 to $15,999	$700	$23.74	$27.07	$34.24
$16,000 to $17,999	$800	$27.13	$30.94	$39.13
$18,000 to $19,999	$900	$30.52	$34.81	$44.03
$20,000 to $21,999	$1,000	$33.92	$38.67	$48.92
$22,000 to $23,999	$1,100	$37.31	$42.54	$53.81
$24,000 to $25,999	$1,200	$40.70	$46.41	$58.70
$26,000 to $27,999	$1,300	$44.09	$50.27	$63.59
$28,000 to $29,999	$1,400	$47.48	$54.14	$68.48
$30,000 to $31,999	$1,500	$50.87	$58.01	$73.38
$32,000 to $33,999	$1,600	$54.26	$61.88	$78.27
$34,000 to $35,999	$1,700	$57.66	$65.74	$83.16
$36,000 to $37,999	$1,800	$61.05	$69.61	$88.05
$38,000 to $39,999	$1,900	$64.44	$73.48	$92.94
$40,000 to $41,999	$2,000	$67.83	$77.35	$97.83
$42,000 to $43,999	$2,100	$71.22	$81.21	$102.73
$44,000 to $45,999	$2,200	$74.61	$85.08	$107.62
$46,000 to $47,999	$2,300	$78.00	$88.95	$112.51
$48,000 to $49,999	$2,400	$81.40	$92.81	$117.40
$50,000 to $51,999	$2,500	$84.79	$96.68	$122.29
$52,000 to $53,999	$2,600	$88.18	$100.55	$127.18
$54,000 to $55,999	$2,700	$91.57	$104.42	$132.08
$56,000 to $57,999	$2,800	$94.96	$108.28	$136.97
$58,000 to $59,999	$2,900	$98.35	$112.15	$141.86
$60,000 to $61,999	$3,000	$101.75	$116.02	$146.75
$62,000 to $63,999	$3,100	$105.14	$119.89	$151.64
$64,000 to $65,999	$3,200	$108.53	$123.75	$156.53
$66,000 to $67,999	$3,300	$111.92	$127.62	$161.43

EXHIBIT B

CONFIDENTIAL DISCLOSURE STATEMENT

CONFIDENTIAL DISCLOSURE STATEMENT

For purposes of complying with the Texas Public Information Act (the "Act"), we are asking that VENDORS interested in submitting a response to a City's request for bids, proposals or qualifications statements INCLUDE A STATEMENT (THIS FOR M } STATING WHETHER NONE, ALL, OR SOME OF THE INFORMATION SUBMITTED WITH THEIR RESPONSES IS CONSIDERED BY THE COMPANY AS CONFIDENTIAL BECAUSE IT MEETS ONE OR MORE OF THE EXCEPTIONS LISTED IN THE ACT.

Failure by the company(s} to fill out and sign this form, will release City of Mercedes of any liabilities in the event Cit y of Mercedes releases information included in their bids, proposals or qualifications statements responses as a result of complying with a request for public records under the Act.

If the Confidential Disclosure Statement is properly filed, and City of Mercedes receives a request for public records under the Act related to such vendor's response, City of Mercedes will seek an opinion from the Texas Attorney General's Office as required.

This Confidential Disclosure Statement is being made by:

_____ to City of Mercedes for the
(Vendor Name)

purpose of non-disclosure of various materials included in this package.

The rights and obligations of the parties with respect to such information are as follows:

1. "Disclosing Party" means a party that discloses Confidential Information under this Request. "Receiving Party" means a party that receives Confidential Information under this Request.

2. "Confidential Information" means information of any kind which is obtained by Receiving Party from Disclosing Party relating to this ***Request and which, by appropriate marking,*** *is* ***identified as confidential and proprietary at the time of disclosure.***

3. Notwithstanding the foregoing, Confidential Information shall not include any information that:

   a) is publicly available prior to the Effective Date, or becomes publicly available thereafter through no breach of this Request by the Receiving Party;

   b) was known to the Receiving Party prior to the date of disclosure or becomes known to the Receiving Party thereafter from a third party that has no obligation to Disclosing Party to keep such information confidential;

   c) is independently developed by the Receiving Party without the benefit of Confidential Information of the Disclosing Party, as evidenced by written records; **or**

   d) must be produced by the Receiving Party pursuant to an order of a court of competent jurisdiction or a valid subpoena, provided that the Receiving Party

promptly notifies the Disclosing Party and cooperates reasonably with the Disclosing Party's efforts to contest or limit the scope of such order.

4. The Receiving Party agrees that it will maintain the Confidential Information in confidence using a reasonable standard of care, and no less than the standard of care taken to protect its or his/her own confidential information, and will use such Confidential Information solely for the purposes of evaluating its or his/her interest in participating in a future Requests.

5. **As stated above, in the event City of Mercedes receives a request for public records under the Act related to the vendor's response. City of Mercedes will seek an opinion from the Texas Attorney General's Office as required.**

6. This Agreement shall not be construed as an obligation to enter into a Purchasing Agreement or any other subsequent relationship or agreement.

_____ **(vendor)** wishes to have the following pages protected under this agreement and not be released to a third party. The following pages are not to be disclosed unless City of Mercedes receives authorization via an opinion from the Texas Attorney General's Office:

D NONE of the Pages in this Request for Proposal is Confidential

D ALL Pages in this Request for Proposal are Confidential

D ONLY Pages are labeled as Confidential

Name of Company or Firm: _____

By: _____ Title: _____

Signature: _____ Date: _____

EXHIBIT C

NON-COLLUSION STATEMENT

"NON-COLLUSION STATEMENT'

BY THE SIGNATURE BELOW, THE SIGNATORY FOR THE BIDER AFFIRMS THAT THEY ARE DULY AUTHORIZED TO EXECUTE THIS CONTRACT$_1$ THAT THIS COMPANY, FIRM, PARTNERSHIP OR INDIVIDUAL HAS NOT PREPARED THIS PROPOSAL IN COLLUSION WITH ANY OTHER BIDER, AND THAT THE CONTENTS OF THIS PROPOSAL AS TO PRICES, TERMS OR CONDITIONS OF SAID BID HAVE NOT BEEN COMMUNICATED BY THE UNDERSIGNED NOR BY ANY EMPLOYEE OR AGENT TO ANY OTHER PERSON ENGAGED IN THIS TYPE OF BUSINESS PRIOR TO THE OFFICIAL OPENING OF THIS BID. FURTHER, THE SIGNATORY AFFIRM, THAT THEY, OR ANY REPRESENTATIVE OF THE COMPANY, DID NOT CONTACT ANY EMPLOYEE OR MEMBER OF THE CITY COMMISSION OF THE CITY OF MERCEDES AT ANY TIME DURING THE SOLICITATION PROCESS FROM INITIAL ADVERTISEMENT THROUGH AWARD TO DISCUSS THE CONTENTS OF THIS PROPOSAL, OTHER THAN CITY MANAGER'S OFFICE PRIOR TO THE AWARDING OF THIS PROPOSAL. I UNDERSTAND THAT FAILURE TO OBSERVE THIS PROCEDURE MAY CAUSE THE BID TO BE REJECTED. I ALSO AFFIRM THAT NO OFFICER OR STOCKHOLDER OF THE RESPONDENT (BIDDER) IS A MEMBER OF THE STAFF, OR RELATED TO ANY EMPLOYEE OR MEMBER OF THE CITY COMMISSION OF THE CITY OF MERCEDES EXCEPT AS NOTED HEREIN:

_____

_____

By signing this bid, the vendor (Bidder) makes the assurance that vendor has not been debarred or suspended from conducting business with the U.S. Government according to Executive Order 12549 entitled „Debarment and Suspension."

COMPANY _____ EMPLOYER I.D. NO._____

ADDRESS_____

CITY, STATE, ZIP CODE _____

PHONE _____FAX _____

EMAIL _____

BIDDER (SIGNATURE) _____

PRINTED NAME _____

POSITION WITH COMPANY _____

EXHIBIT D

CONFLICT OF INTEREST QUESTIONNAIRE (FORM CIQ)

CONFLICT OF INTEREST QUESTIONNAIRE

FORM CIQ

For vendor doing business with local governmental entity

This questionnaire reflects changes made to the law by H.B. 23, 84th Leg., Regular Session.

This questionnaire is being filed in accordance with Chapter 176, Local Government Code, by a vendor who has a business relationship as defined by Section 176.001(1-a) with a local governmental entity and the vendor meets requirements under Section 176.006(a).

By law this questionnaire must be filed with the records administrator of the local governmental entity not later than the 7th business day after the date the vendor becomes aware of facts that require the statement to be filed. *See* Section 176.006(a-1), Local Government Code.

A vendor commits an offense if the vendor knowingly violates Section 176.006, Local Government Code. An offense under this section is a misdemeanor.

OFFICE USE ONLY

Date Received

1 **Name of vendor who has a business relationship with local governmental entity.**

2 ☐ **Check this box if you are filing an update to a previously filed questionnaire.** (The law requires that you file an updated completed questionnaire with the appropriate filing authority not later than the 7th business day after the date on which you became aware that the originally filed questionnaire was incomplete or inaccurate.)

3 **Name of local government officer about whom the information is being disclosed.**

_____

Name of Officer

4 **Describe each employment or other business relationship with the local government officer, or a family member of the officer, as described by Section 176.003(a)(2)(A). Also describe any family relationship with the local government officer. Complete subparts A and B for each employment or business relationship described. Attach additional pages to this Form CIQ as necessary.**

A. Is the local government officer or a family member of the officer receiving or likely to receive taxable income, other than investment income, from the vendor?

☐ Yes ☐ No

B. Is the vendor receiving or likely to receive taxable income, other than investment income, from or at the direction of the local government officer or a family member of the officer AND the taxable income is not received from the local governmental entity?

☐ Yes ☐ No

5 **Describe each employment or business relationship that the vendor named in Section 1 maintains with a corporation or other business entity with respect to which the local government officer serves as an officer or director, or holds an ownership interest of one percent or more.**

6 ☐ Check this box if the vendor has given the local government officer or a family member of the officer one or more gifts as described in Section 176.003(a)(2)(B), excluding gifts described in Section 176.003(a-1).

7

_____ _____

Signature of vendor doing business with the governmental entity Date

CONFLICT OF INTEREST QUESTIONNAIRE
For vendor doing business with local governmental entity

A complete copy of Chapter 176 of the Local Government Code may be found at http://www.statutes.legis.state.tx.us/Docs/LG/htm/LG.176.htm. For easy reference, below are some of the sections cited on this form.

Local Government Code § 176.001(1-a): "Business relationship" means a connection between two or more parties based on commercial activity of one of the parties. The term does not include a connection based on:

(A) a transaction that is subject to rate or fee regulation by a federal, state, or local governmental entity or an agency of a federal, state, or local governmental entity;

(B) a transaction conducted at a price and subject to terms available to the public; or

(C) a purchase or lease of goods or services from a person that is chartered by a state or federal agency and that is subject to regular examination by, and reporting to, that agency.

Local Government Code § 176.003(a)(2)(A) and (B):

(a) A local government officer shall file a conflicts disclosure statement with respect to a vendor if:

***

(2) the vendor:

(A) has an employment or other business relationship with the local government officer or a family member of the officer that results in the officer or family member receiving taxable income, other than investment income, that exceeds $2,500 during the 12-month period preceding the date that the officer becomes aware that

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor;

(B) has given to the local government officer or a family member of the officer one or more gifts that have an aggregate value of more than $100 in the 12-month period preceding the date the officer becomes aware that:

(i) a contract between the local governmental entity and vendor has been executed; or

(ii) the local governmental entity is considering entering into a contract with the vendor.

Local Government Code § 176.006(a) and (a-1)

(a) A vendor shall file a completed conflict of interest questionnaire if the vendor has a business relationship with a local governmental entity and:

(1) has an employment or other business relationship with a local government officer of that local governmental entity, or a family member of the officer, described by Section 176.003(a)(2)(A);

(2) has given a local government officer of that local governmental entity, or a family member of the officer, one or more gifts with the aggregate value specified by Section 176.003(a)(2)(B), excluding any gift described by Section 176.003(a-1); or

(3) has a family relationship with a local government officer of that local governmental entity.

(a-1) The completed conflict of interest questionnaire must be filed with the appropriate records administrator not later than the seventh business day after the later of:

(1) the date that the vendor:

(A) begins discussions or negotiations to enter into a contract with the local governmental entity; or

(B) submits to the local governmental entity an application, response to a request for proposals or bids, correspondence, or another writing related to a potential contract with the local governmental entity; or

(2) the date the vendor becomes aware:

(A) of an employment or other business relationship with a local government officer, or a family member of the officer, described by Subsection (a);

(B) that the vendor has given one or more gifts described by Subsection (a); or

(C) of a family relationship with a local government officer.

EXHIBIT E

IMPLEMENTATION OF HOUSE BILL 1295

Implementation of House ·sill 1295

Certificate of Interested Parties (Form 1295):

In 2015, the Texas Legislature adopted House Bill 1295, which added section 2252.908 of the Government Code. The law states that a governmental entity or state agency may not enter into certain contracts with a business entity unless the business entity submits a disclosure of interested parties to the governmental entity or state agency at the time the business entity submits the signed contract to the governmental entity or state agency.

The law applies (with a few exceptions) only to a contract between a business entity and a governmental entity or state agency that either (1) requires an action or vote by the governing body of the entity or agency before the contract may be signed or (2) has a value of at least $1 million. The disclosure requirement applies to a contract entered into on or after January 1, 2016.

Changed or Amended Contracts:

Form 1295 is only required for a change made to an existing contract in certain circumstances: (1) if a Form 1295 was not filed for the existing contract, then a filing is only required if the changed contract either requires an action or vote by the governing body or the value of the changed contract is at least $1 million; or (2) if a Form 1295 was filed for the existing contract, then another filing is only required for the changed contract if there is a change to the information disclosed in the Form 1295, the changed contract requires an action or vote by the governing body, or the value of the changed contract increases by at least $1 million.

As required by law, the Commission adopted the Certificate of Interested Parties form (Form 1295) on October 5, 2015. The Commission also adopted rules (Chapter 46) to implement the law. The Commission does not have any additional authority to enforce or interpret sectio 2252.908 of the Government Code.

Filing Process:

A business entity must use the Form 1295 filing application the Commission created to enter the required information on Form 1295 and print a copy of the completed form. Once entered into the filing application, the completed form will include a unique certification number, called a "certification of filing."

An authorized agent of the business entity must sign the printed copy of the form affirming under the penalty of perjury that the completed form is true and correct.

The completed, printed, and signed Form 1295 bearing the unique certification of filing number must be filed with the governmental body or state agency with which the business entity is entering into the contract.

Acknowledgement by State Agency or Governmental Entity:

The governmental entity or state agency must acknowledge receipt of the filed Form 1295 with the certification of filing, using the Commission's filing application, not later than the 30th day after the date the governing body or state agency receives the Form 1295. The Commission will post the completed Form 1295 to its website within seven business days after the governmental entity or state agency acknowledges receipt of the form.

Additional Information: Section 2252.908, Government Code.

Certificate of Interested Parties {Form 1295)**

****This is a sample form for illustration purposes only. DO NOT FILL OUT THIS SAMPLE FORM. Form 1295 MUST BE FILED ELECTRONICALLY! Paper copies and PDF copies of this sample form are not accepted!**

CERTIFICATE OF INTERESTED PARTIES

FORM 1295

Complete Nos. 1 - 4 and 6 if there are interested parties.
Complete Nos. 1, 2, 3, 5, and 6 if there are no interested parties.

OFFICE USE ONLY

1 Name of business entity filing form, and the city, state and country of the business entity's place of business.

2 Name of governmental entity or state agency that is a party to the contract for which the form is being filed.

3 Provide the identification number used by the governmental entity or state agency to track or identify the contract, and provide a description of the services, goods, or other property to be provided under the contract.

4 Name of Interested Party	City, State, Country (place of business)	Nature of Interest (check applicable)	
		Controlling	Intermediary

5 Check only if there is NO Interested Party. ☐

6 UNSWORN DECLARATION

My name is _____, and my date of birth is _____.

My address is _____, _____, _____, _____, _____.
(street) (city) (state) (zip code) (country)

I declare under penalty of perjury that the foregoing is true and correct.

Executed in _____ County, State of _____ , on the _____ day of _____, 20_____.
(month) (year)

_____
Signature of authorized agent of contracting business entity
(Declarant)

ADD ADDITIONAL PAGES AS NECESSARY

EXHIBIT F

PROPOSAL SPECIFICATION REQUIREMENTS

CITY OF MERCEDES

PROPOSAL SPECIFICATION REQUIREMENTS

{TO BE FILLED! N BY OFFEROR AND SUBMITTED WITH PROPOSAL)

Is this proposal in conformance with the enclosed specifications?

Yes_____ No_____

If the answer is no, offeror must identify and explain each exception taken, with reference to each page and paragraph to which the exception will apply.

It should be understood that if no exception is taken the vendor should supply all items as specified at the time of sale. Failure to indicate any difference in products offered proposed in this proposal may be deemed sufficient grounds of a vendor proposal.

Comments:_____

_____

_____

_____

_____

_____

_____

_____ _____

Date Company Name