Transamerica Life Insurance Company Home Office: Cedar Rapids, IA

# Life and Health

	RANSAME	ERICA Admir	nistrative Of r Rapids, IA	fice: P.C	. Box 21	9		Group Application and Agreement	
<b>*</b>	LIFE INSURANCE	COMPANI	Tax ID N		1			Website Address:	
Name of	f Group: Lexington Fayette U	rban County Government	61-0858			SIC Code:	9121	Proporto / Maroos.	
Street A	ddress: 200 East Main St		City: Lexi	ngton		State: KY		Zip Code: 40507	
			Email Ad	dress:		Phone #:		Fax#;	
Contact	Name: Kashene Horton		khorton	@lexingto	nky.g	859-258-	3066	859-258-3956	
Nature o	of Group: Legislative Bodies		# of Emp 3575	loyees:		#Eligib	le for Cove 3100	erage: # of Years in Existence:	
ou here ur eligi reeme	ble employees/members th	Life Insurance Company, our authorize ne opportunity to purchase insurance co	ed agents or verage as d	our enrolle escribed in	ers (collect this form	tively refer . This auth	rred to as norization	we, us, or our) to offer each of is based upon the following	
	customarily conduct an anr ermine proper enrollment eli	nual enrollment program for your eligible igibility.	e employees.	/members	. You will	provide us	s with cen	sus data if needed for us to	
	initial enrollment shall take	place from 10/21/24 to 10/31/2 etings and individual interviews in a suita		•			-	mployees/members to obtain	
from Unle with rem busi inclu	n the enrollment and cancel ess otherwise agreed upon in 15 days after you receive ains in force and for two yea iness hours. If premium cor uding attorney fees and exp	you and us. Participation in your group any applications already obtained if the by you and us, you will collect premiums the monthly bill. You will maintain recorars after it terminates. During this period atributions collected by you, your employenses incurred in collection, to the externass?	se condition s from your p rds of all prer , you will ma yees, or you nt permitted	s are not s participatir miums col ke these r vendors a	atisfied.  g employ lected from ecords average misap	rees/memi m your em railable for propriated	bers. You ployees/r inspectio	will forward the premiums to us members while this agreement n and audit by us during normal	
	Definition of Class 1:	Full Time Benefit Eligible							
	Definition of Class 2:	Part Time Benefit Eligible							
	Definition of Class 3:								
	Definition of Class 4:								
	ibility for insurance: Employer Groups - eligible	employees are defined as those who we	ork at least	Class 1	Class 2	Class 3	Class 4	hours per week for you,	
		and have been so employe	ed for at leas	0	730			days,	
6. Isda 7. Isc If"ya	ependent coverage being o	nembers are defined as members of an offered? ☑ Yes ☐ No or ngh a Section 125 plan? ☐ Yes ☑ No	eligible class	s of memb	ers, who	are in goo	d standing	in accordance with your by-laws	
Plar	Start Date: 01/01/2024	Plan Anniversary Date							
lf"ye	overage being offered repla es", which product(s): Vhole Life 13	cing existing coverage? Yes No	······································						
aterial surand nderst imed a	ly false information or co ce act which is a crime. and and agree that this app	vith intent to defraud any insurance of nceals, for the purpose of misleading dication will be made part of each group group master policy. I agree that no insurance that the last of (Month/Year	g, any information of the master police of the master police of the master will be a second of the master police o	mation co	onceming as a result	g any fact t of this ap	material	thereto, commits a fraudulent  The Group listed above will be	
Signature	of Officer	4.0	Email Add	Iress					
	Tena	a) Sorton)							
rint Nan	ne and Title of Officer		English Mark		0.000				
1	n		benji@	bimgroup	J.US				

Benji Mars

Signature of Licensed Agent/Producer

Print Name of Licensed Agent/Producer

Email Address TR020362

Agent/Producer Number

License Number

## Billing Information

		,				
Billing Name (if other than group name): LEXINGTON-	FAYETTE URBAN CO	UNTY GOVERNMENT				
Billing Address: 200 E. Main Street		City: Lexington	State:	Zip Code: 40507		
Billing Contact Name: Winona Embry		Email Address: wembry@lexingtonky.	Phone #: 859-258-3034	Fax#: 859-425-2277		
Billing Address is: ☑ Group Policyholder ☐ Third Party /	Administrator 🔲 Premium	Collection Agency (Requires a	Premium Collection Agr	eement)		
Pay periods per year: 26	Payments will be ren	nitted: ion Monthly Other				
Payroll deductions per year: 26	Premium amount on bill should reflect: ☐ Levelized amount over 12 months ☑ Actual amount of deductions					
First payroll deduction date: 01/03/2025	Preferred billing sequ ☑ Alphabetical ☐ S	Preferred billing sequence: ☑ Alphabetical ☐ Social Security Number ☐ Employee ID				
First bill due date: 2.1.2025	Preferred Billing Met  ☑ Paper ☐ Website		Multiple Billing Locations: ☑ No ☐ Yes (attach listing)			

## **Insurance Selections**

(Product and Rider availability subject to state approval)

**Participation Requirement:** Each group master policy requires a minimum of 2 covered lives or the state minimum, whichever is greater in order to be issued and remain in force. Any group master that falls below this requirement may be terminated, subject to the notice requirements in the master policy. Special underwriting offers may require higher participation in order to continue receiving the special underwriting offer for new insureds.

Group Interest Sensitive Whole Life Insurance WL13	Group Contribution? ☐ Yes ☑ No	Requested Effective Date 2.1.2025	
	If yes, list amount or %:		
	Plan Option 1		
Accelerated Death Benefit for Terminal Condition Rider	Included		
Waiver of Premium for Layoff or Strike Rider	Included		
Accelerated Death Benefit for Chronic Condition Rider	Included		
Extension of Benefits Rider	Included		
Child Level Term Insurance Rider	Included		

# **TEB eServices Information & Authorization Form**

Transamerica Employee Benefits – Online Administration tools

# Simple

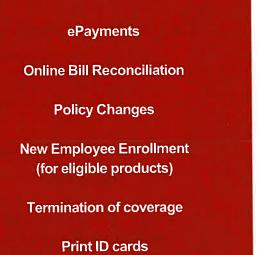
Simplify your administrative tasks with the tools and functionality available on our Employer Website. We provide secure, streamlined and easy-to-use processes for Policy and Group administration, Bill reconciliation and ePayment capability.

# **Fast**

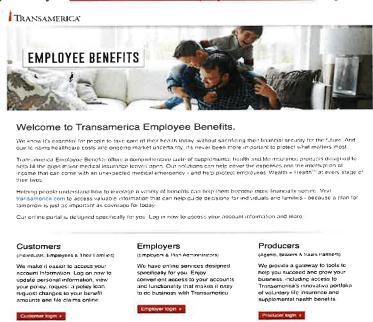
Complete policy and billing changes online, reconcile and submit your payment online; be on your way to the next item on your busy schedule.

# **Flexible**

Use one, some or all of the website tools as needed. Flexibility to meet your needs is our goal. Our site is available on your schedule; research policy data, view paid and current bills, use our handy reference section to view a demo or print employee forms.



Log in today at www.transamericaemployeebenefits.com to get started!



We also provide you, the Employer, with the option to designate an agent to have access to these tools on your behalf. To authorize such access, please complete the back of this form.

TEB-AgentAuth-0712

Instructions to Transamerica Life Insurance Company (Trans	nsamerica)
--	------------

_	ed Employer can perform certain administrative functions relating to its group insurance at ericaemployeebenefits.com ("Website"). The Employer hereby directs Transamerica to
also allow the A	Authorized Agent designated below, and such Agent's authorized designees, access to is needed to perform on behalf of the Employer the function(s) selected below.
Emp	oloyee Administration functions
	Add/Enroll new employees (for eligible products) Change/Terminate employee status Change/Updated employee information Request policy change/cancellation
Grou	up Administration functions
	Bill reconciliation
through th	r understands and agrees that (1) Employer is responsible for the transactions performed he access granted in these instructions; (2) and Employer will notify Transamerica immediately ming of any errors in these transactions or upon any change to these instructions.
•	on executing this document on behalf of the Employer represents and warrants that he or she zed to do so.
Employer N	lame:Employer Number/Group Number
	signature of Employer representative Date
Name of Au	uthorized Agent (please print)

Return completed forms to the TEB Home Office along with new case submission documents or return individually via mail, fax or email to your Client Relationship Manager.

TEB-AgentAuth-0712

4 of 6

☐ Electronic System ☐ Self-Admin ☐ Simplified Issue						Issue			
Spreadsheet	☐ Paper	Billing	Billing & Enrollment Worksheet				☐ Guarantee Issue		
Employer Name Lexington Fayette Urban County Government Date Billing Information Completed									
Billing Address is: 200 Eas	st Main Street, Lexin	igton, KY 40 🗖 🗖 Grot	up 🔲 Bill	ling Administra	itor Pre	mium Collection Ag	jency		
Billing Name:				- (	include Premi	ium Collection Agre	ement)		
Billing Address:									
		= "	5'4	D	Payment	Premium	Past Due		
Billing Contact	Name:	Email Address:	Phone #	Payments	Detail	Discrepancies	Notification		
1) Winona Embry		wembry@lexing	859-258-36	☑	V	☑	<b>•</b>		
2) Kashene Horton			859-258-3						
3) Desi Norquist		desi.norquist@s	606-878-27		-61	Ø			
Billing Options									
Payroll Schedule	Number of pay pe	eriods per year: 26	F	First deduction	date: 01/03/2	2025			
	Number of deduc	ctions per year: 26							
Bill Schedule:	✓ Arrears		□ A	dvance					
Bill Delivery:	☐ Website			elf-Bill		☐ Paper			
Billed premium amount:	Levelized	d over 12 month	☑ A	ctual amount o	of deduction				
Employee ID:	Social Se	ecurity Number	☑ A	Iternate Emplo	yee ID				
Billing Sort:	■ Name		<b>☑</b> E	mployee ID					
Multiple Billing Locations:	☑ No		□ Y <sub>1</sub>						
	If yes, will Will empl	II each location remit ployees need to be liste	payment sepa ed by separate	ırately? (attach e division on th	listing with lo	cation name and adment?	ddress)		
Payments and Remittance	e								
Payments remitted:	After each	h deduction		Monthly		Other			
Payment Method:	■ Website	<u> </u>				Check			
Payment Detail Remitted:	☐ Website			Electronic via e	email	Paper Statemen	1 <b>t</b>		
Select one:	☑ Credits			Refunds					
		ct from payment (self-	·bill)	Refund overpayments to:					
	☐ Bill Cr		1	Pre-tax Post-tax					
	Sun	-		Employee					
	☑ Det	.ail				Employer Billing Administrator			
Employee Management						<u>g</u>			
Missed Deductions	☐ Bill empl	loyee at home		Rebill group	р	Other			
Employee Request to									
Cancellation/Change:									
				E	Email:				
				F	Phone:				
					TION O				
Domicile State:		Othe	er Enrollment	States:					
Enrollment Start Date:				Enrollment E	nd Date:				
Enrollment Platform:	Enrollment Platform: Will a Census be provided: Yes No						No		
Enrollment Method:		☐ Self Service	Call Center Face to Face						
Product Selection:		Accident		Life Insurar					
		Disability		TransConn					
		Critical Illness		☐ TransChoid	се				
		☐ Hospital Indemni	ity						
Eligibility:		Waiting Period:							
	_								
		Min Hours Worked:							
		Domestic Partner Co	verage:	Yes	No				

KY

# **Self Admin Billing Worksheet**

<b>Employer Name:</b>	
Group Name:	
Group Number: L	0000
Contact Type:	Group Billing Administrator Premium Collection Agency
	(PCA Agreement Required)
Billing Address:	
Billing Contact Name:	Email Address: Phone# Prem Summary Premium Audit Past Due Notification
Billing Options:	
Bill Schedule:	Arrears Advance
Division Setup:	Monthly (Only)
Payroll Schedule:	
Number of pay period	s per year:
Number of deductions	
First Deduction Date:	, p
First Bill Due Date:	
Delivery Method:	
Self Administered-Bill	
The employer is respon	nsible for calculating and remitting premium to Transamerica directly.
Davis anta Danitta di	Manual In (Out )
Payments Remitted: Payment Method:	Monthly (Only)
ACH/Wire	
Check	
Payment Summary:	
Electronic	
Print/Mail with Check	
D (   111 )   1	
Ketunas Will not be iss	ued. Credits should be deducted from payment.
Products Sold:	
Floudets Sold.	
<b>Employee Manageme</b>	nt:
· ·	should be remitted to Transamerica.
	employees of the option to convert. If they have an employee who wants to continue the coverage
they should contact th	e call center within 31 days of their termination.

C-PH-02-00 6 of 6 KY