Payroll deductions

Arizona Fireplaces 3/1/2021 to 2/28/2022

Co.

Plan 1 - CIGNA Local Plus Network H.S.A. $4,000 100%/70%

	Monthly Rate	Employer Paid Monthly Amount	Employee Paid Monthly Amount	Employee Paid Per Paycheck (52 Pay Periods)
Medical EE	$349.54	$300.00	$49.54	$11.43
Medical EE & SP	$699.12	$400.00	$299.12	$69.03
Medical EE & CHILD	$681.62	$400.00	$281.62	$64.99
Medical FAMILY	$1,153.50	$600.00	$553.50	$127.73

Plan 2 - CIGNA Open Access Network PPO - $2,000 80%/50% $30/$45 Office Visit Co-Pays

Medical EE	$517.64	$300.00	$217.64	$50.22
Medical EE & SP	$1,035.29	$400.00	$635.29	$146.61
Medical EE & CHILD	$1,009.42	$400.00	$609.42	$140.64
Medical FAMILY	$1,708.22	$600.00	$1,108.22	$255.74

Plan 3 - CIGNA Open Access Network PPO - $500 100%/70% $25/$40 Office Visit Co-Pays

Medical EE	$595.87	$300.00	$295.87	$68.28
Medical EE & SP	$1,191.74	$400.00	$791.74	$182.71
Medical EE & CHILD	$1,161.94	$400.00	$761.94	$175.83
Medical FAMILY	$1,966.38	$600.00	$1,366.38	$315.32

Waiving Medical Coverage - Indicate reason for waiving coverage (circle reason if waiving)

I wish to decline medical coverage and not participate on the plan for the following reason:

A) Do not wish to be covered - no other coverage

B) Covered by spouse's or parent's employer group plan

C) Covered by TRICARE

D) Covered by AHCCCS

E) Covered by I.H.S. (Indian Health Services)

F) Covered by Medicare

G) Married and covered by fellow Arizona Fireplaces employee

H) Individual coverage purchased directly from carrier

I) Individual coverage purchased on Healthcare Marketplace

CIGNA DHMO - Low Option Dental

dental EE	$8.11	$0.00	$8.11	$1.87
dental EE & SP	$13.57	$0.00	$13.57	$3.13
dental EE & CHILD	$17.01	$0.00	$17.01	$3.93
dental FAMILY	$24.01	$0.00	$24.01	$5.54

CIGNA PPO High Option Dental Plan

dental EE	$35.58	$0.00	$35.58	$8.21
dental EE & SP	$74.73	$0.00	$74.73	$17.25
dental EE & CHILD	$77.29	$0.00	$77.29	$17.84
dental FAMILY	$121.45	$0.00	$121.45	$28.03

Waving Dental Coverage - (circle if waiving dental coverage)

I wish to decline dental coverage and not participate on the plan.

CIGNA Vision Plan

vision EE	$7.43	$0.00	$7.43	$1.71
vision EE & SP	$13.19	$0.00	$13.19	$3.04
vision EE & CHILD	$13.32	$0.00	$13.32	$3.07
vision FAMILY	$20.25	$0.00	$20.25	$4.67

Waving Vision Coverage - (circle if waiving vision coverage)

I wish to decline vision coverage and not participate on the plan.

Please circle appropriate payroll deduction then sign, date and return to the HR Department.

Employee Name (Print)

Employee Signature Date

MEDICAL BENEFITS

Triple-Option … In-Network Benefits Stated
Group #0629276

Benefits	Plan 1 H.S.A. $4,000 100%/70% Local Plus	Plan 2 $2,000 80%/50% $30/$45 OAP PPO	Plan 3 $500 100%/70% $25/$40 OAP PPO
Calendar Year Deductible *January 1st – December 31st*	$4,000 individual $8,000 family	$2,000 individual $4,000 family	$500 individual $1,000 family
Coinsurance after Deductible	CIGNA pays 100% You pay 0%	CIGNA pays 80% You pay 20%	CIGNA pays 100% You pay 0%
Out of Pocket Maximum *Includes Ded & Co-Pays*	$4,000 individual $8,000 family	$4,000 individual $8,000 family	$4,000 individual $8,000 family
Primary Care Office Visit	**Ded then 0%**	**$30 copay**	**$25 copay**
Specialist Office Visit	**Ded then 0%**	**$45 copay**	**$40 copay**
Radiology Services	Ded then 0%	Ded then 20%	Ded then 0%
Preventive Services *Certain Screenings, Routine Physicals,*	Member pays 0% (Ded waived)	Member pays 0% (Ded waived)	Member pays 0% (Ded waived)
Outpatient Surgery	Ded then 0%	Ded then 20%	Ded then 0%
Inpatient Hospital/Surgery	Ded then 0%	Ded then 20%	Ded then 0%
Maternity	Ded then 0%	Ded then 20%	Ded then 0%
Urgent Care	Ded then 0%	$100 copay	$100 copay
Emergency Room	Ded then 0%	$350 copay	$350 copay
Prescriptions	**Ded then 0%**	**$10/$40/$70**	**$10/$30/$50**

Vision Plan

Group #0629276

Eye Exam	(One every 12 Months) – $10 Co-pay	
Frames	(One every 24 Months) – $25 Co-pay	
	Up to a $150 Allowance	
Lenses	(One Every 12 Months)	
	Single Vision	$25 Co-pay
	Bifocal	$25 Co-pay
	Trifocal	$25 Co-pay
Contact Lenses	(In lieu of Frame and Spectacle) $150 Allowance	

DENTAL BENEFITS

PPO w/ Orthodontia
Group #0629276

	PPO Plan	DHMO Plan
Calendar Year Deductible *January 1st – December 31st* *(waived for –preventive services)*	**$25 In-Network $50 Out-of-Network**	**None**
Annual Maximum *January 1st – December 31st*	**$2,000**	**Unlimited**
Preventative *No deductible* • Oral Exams • Cleanings • Bitewings	**100% In-Network 100% Out-of-Network**	**See Schedule**
Basic *After meeting deductible* • Sealants • Fillings • Simple extractions • Space Maintainers (through age 14)	**80% In-Network 80% Out-of-Network**	**See Schedule**
Major *After meeting deductible* • Endo (including Root Canal Treatment) • Periodontal (Surgery & non-surgical therapy) • Crowns, Inlays, Onlays, Bridges • Dentures • Surgical extractions • Oral Surgery	**50% In-Network 50% Out-of-Network**	**See Schedule**
Ortho (Adults & Child) – Lifetime Max	**Not Covered**	**Unlimited**
• *Treatment*	**Not Covered**	**Copays – See Schedule**

ARIZONA FIREPLACES

PAYROLL DEDUCTIONS
52 pay periods

PER PAYCHECK (Weekly)	***Medical Plan 1 H.S.A. $4000 Local Plus***	***Medical Plan 2 PPO $2000 OAP Network***	***Medical Plan 3 PPO $500 OAP***	***Dental Low Plan***	***Dental High Plan***
Employee Only	*11.43*	*50.22*	*68.28*	*1.87*	*8.21*
Employee + Spouse	*69.03*	*146.61*	*182.71*	*3.13*	*17.25*
Employee + Child(ren)	*64.99*	*140.64*	*175.83*	*3.93*	*17.84*
Family	*127.73*	*255.74*	*315.32*	*5.54*	*28.03*

Voluntary LIFE/AD&D

Group #0629276

Plan Design	*- $10,000 Increments up to $300,000 for EE or up to $100,000 for Spouse*
Guaranteed Issue	*-$100,000 for EE, $30,000 for Spouse*
Child Coverage Option	*$10,000 or $20,000*

IMPORTANT!

This is a brief summary of the benefit plans. Refer to full Benefit Certificate Booklets. If terms of this summary differ from the Certificate Booklet, the terms of Certificate Booklet control and apply. Benefits listed above are in-network benefits. Services received from non-contracted providers will be processed at a lesser and separate amount.

CIGNA **Medical -** *Group #0629276* **866.494.2111** *www.mycigna.com* **CIGNA Dental & Vision** **Dental** *Group #0629276* **Vision** *Group #0629276* **800.244.6224** www.mycigna.com	**Marreel Slater Insurance** Kurt Kumetat **602.476.0077** *Kurt@MSInsuranceLLC.com*	**CIGNA** **Life/AD&D, Voluntary Life/AD&D** *Group #0629276* **800.362.4462** www.mycigna.com **Arizona Fireplaces** Andrew Yenney **602.243.6423**

ARIZONA FIREPLACES

MEDICAL •LIFE/AD&D • Voluntary Dental, Voluntary Vision, Voluntary Life/AD&D

March 1, 2021 – February 28, 2022

MARREEL SLATER Insurance

Offered by Life Insurance Company of North America, a Cigna company

Employer-Paid
TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Arizona Fasteners Corp.

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-time Employees of the Employer who are United States citizens or permanent resident aliens regularly working a minimum of 20 hours per week in the United States.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	$15,000	$15,000	$15,000

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Continuation of Disability – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.

Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.

Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.

Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:

Employee: 75% of your Term Life Insurance coverage amount or $11,250, whichever is less.

Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits will reduce to 65% at age 65 and 50% at age 70.

Limitations - The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. **Waiver of Premium** – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. SGM 611044. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

Offered by Life Insurance Company of North America, a Cigna company

Employee-Paid

TERM LIFE INSURANCE

SUMMARY OF BENEFITS

Prepared for: Arizona Fasteners Corp.

Term Life insurance can help protect your loved ones' financial health if you are no longer there to support them.

Who Is Eligible For Coverage?:

You: All active, Full-time Employees of the Employer who are United States citizens or permanent resident aliens regularly working a minimum of 20 hours per week in the United States.
Your Spouse*: Is eligible as long as you apply for and are approved for coverage yourself.
Your Child(ren): Birth to 26, as long as you apply for and are approved for coverage yourself.

*Domestic Partner is defined in the Group Policy. For purposes of this brochure, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your Benefit Services Representative.

Available Coverage:

	Benefit Amount	Maximum	Guaranteed Issue Amount
Employee	Units of $10,000	Lesser of 5 times salary or $300,000	$100,000
Spouse	Units of $5,000	$100,000 not to exceed 100% of the employees benefit	$30,000
Children	Units of $10,000	$20,000; under 6 Months old $1,000	All amounts

Guaranteed Issue means that you may be able to purchase coverage without medical exams or health questions. See "Guaranteed Issue" below for more information.

Additional Features:

Continuation of Disability – If your active service ends due to disability, at age 60 or over, your life insurance coverage will continue while you are disabled. Benefits will remain in force until the earliest of: the date you are no longer disabled, the date the policy terminates, the date you are Disabled for 12 consecutive months, or the day after the last period for which premiums are paid. You are considered disabled if, because of injury or sickness, you are unable to perform all the material duties of your Regular Occupation, or you are receiving disability benefits under your Employer's plan.
Extended Death Benefit with Waiver of Premium – The extended death benefit continues your coverage without payment of premium, before you're eligible to qualify for Waiver of Premium, if you are continuously Disabled for 9 months prior to age 60. "Disabled" means, because of injury or sickness, you are unable to perform all the material duties of your regular occupation, or you are receiving disability benefits under a program sponsored by your Employer. Regular Occupation means the occupation you routinely performed at the time your Disability began. We/the insurance company will consider the duties of your occupations as those that are normally performed in the general labor market in the national economy. If you qualify for this benefit and have insured your spouse or children, the insurance company will also extend their coverage if applicable.
Waiver of Premium – If you become Disabled prior to age 60, and you remain Disabled continuously for a 9 month period and thereafter, you won't need to pay premiums for your life insurance coverage, provided we/the Insurance Company determine(s) you are Disabled. "Disabled" for this coverage means, because of injury or sickness, you are unable to perform the material duties of your regular occupation, or are receiving disability benefits under a program sponsored by your employer, for the first 12 months after your Disability began. Thereafter, you must be unable to perform the material duties of any occupation that you are or may reasonably become qualified based on your education, training or experience. If you qualify for this coverage and have insured your spouse or children, the insurance company will also waive their premium if applicable.
Accelerated Death Benefit – Terminal Illness – if two unaffiliated doctors diagnose you or your spouse as terminally ill while the coverage is active, with a life expectancy of 12 months or less, the benefit for Terminal Illness provides up to:
Employee: 75% of your Term Life Insurance coverage amount or $225,000, whichever is less.
Spouse: 75% of your Term Life Insurance coverage amount or $225,000, whichever is less.

Portability – If your employment is terminated, you can continue your life insurance on a direct-bill basis. Coverage may also be continued for your spouse/children. Premiums will increase at this time. Coverage can be continued to age 70, unless the insurance company terminates portability for all insured persons. Refer to your certificate for details.
Conversion – To convert, you must apply for the conversion policy and pay the first premium payment within 31 days after your group coverage ends.

Employee's Monthly Cost of Coverage:

Age	Employee Cost Per $10,000 Unit	Spouse Cost Per $5,000 Unit
0-19	$0.800	$0.400
20-24	$0.800	$0.400
25-29	$0.800	$0.400
30-34	$0.880	$0.440
35-39	$1.320	$0.660
40-44	$2.130	$1.065
45-49	$3.280	$1.640
50-54	$5.350	$2.675
55-59	$8.400	$4.200
60-64	$11.670	$5.835
65-69	$20.530	$10.265
70+	$35.170	$17.585

Child Cost Per $10,000 Unit = $2.000

Actual per pay period premiums may differ slightly due to rounding. Rates vary by age and may be subject to change in the future. Benefits will reduce based on age (see Benefits Reduction Schedule for details).

How to Calculate Your Monthly Cost:

Step 1: Use the chart above to find your **Monthly** rate based on your age as of your effective date.
Step 2: Multiply this rate by your desired coverage amount, in units. Reference the table above to find the appropriate unit amounts for employee and/or dependents.
Step 3: The result is the **Monthly** cost.

Important Definitions and Policy Provisions:

When Your Coverage Begins and Ends – Coverage becomes effective on the later of the program's effective date, the date you become eligible, the date your enrollment elections are received if applicable, or the date you authorize any necessary payroll deductions if applicable. Your coverage will not begin unless you are actively at work on the effective date. Dependent coverage, if applicable, will not begin for any spouse or child who on the effective date is an inpatient in a facility or is home confined and under the care of a physician. Coverage will end on the earliest of the date you are eligible for coverage under a plan intended to replace this coverage, you or your dependents if applicable, are no longer eligible, the group policy is no longer in force, or required premiums are not paid.

Benefit Reductions, Exclusions and Limitations:

Benefit Reduction Schedule - If you are still employed, your benefits will reduce to 65% at age 65 and 50% at age 70.
Exclusions - Voluntary life insurance will not be paid if you commit suicide, while sane or insane, within the first two years of coverage.
Limitations - The Accelerated Death Benefit is payable only once. Using this benefit reduces the life insurance death benefit. The amount payable under the Accelerated Death Benefit may be reduced by the amount of other benefits already paid to the insured under the policy. See your certificate for details. Benefits will be extended without premium payment until the earlier of the date you are no longer disabled, or the date you fail to qualify for Waiver of Premium or fail to provide proof of Disability. **Waiver of Premium** – After premiums have been waived for 12 months, they will be waived for future periods of 12 months if you remain Disabled. This benefit will remain active until age 65 subject to proof of continuing disability each year.

Guaranteed Issue:

If you are a new hire and you apply within 31 days after you are eligible to elect coverage for yourself, you are entitled to choose any coverage offered up to the Guaranteed Issue Amount, without providing proof of good health. If you apply for an amount of coverage greater than the Guaranteed Issue Amount, coverage in excess of the Guaranteed Issue Amount will not be issued until the insurance company approves acceptable proof of good health. If you apply for coverage for yourself more than 31 days from the date you become eligible to elect coverage under this plan, the Guaranteed Issue Amount will not apply, unless Guaranteed Issue has been approved by your employer for a specific period of time. Coverage will not be issued until the insurance company approves acceptable proof of good health.

These are summarized definitions only. To be eligible for coverage, the covered illness or event must meet the definitions and other terms and conditions set forth in the group policy.

THIS POLICY PROVIDES LIMITED COVERAGE. IT PAYS A FIXED BENEFIT AND DOES NOT COVER MEDICAL EXPENSES AS INCURRED. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE OR MAJOR MEDICAL HEALTH INSURANCE. THIS COVERAGE DOES NOT SATISFY THE INDIVIDUAL MANDATE OF THE AFFORDABLE CARE ACT BECAUSE THE COVERAGE DOES NOT MEET THE REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Terms and conditions of coverage for Term Life insurance are set forth in Group Policy No. SGM 611044. This is not intended as a complete description of the insurance coverage offered. This is not a contract. Complete coverage details, including premiums, eligible conditions, their respective payments and policy exclusions and limitations are contained in the Policy. Please see your Plan Sponsor to obtain a copy of the Policy. If there are any differences between this summary and the group policy, the information in the group policy takes precedence. Product availability, costs, benefits, riders, covered conditions and/or features may vary by state. Please keep this material as a reference. Insurance coverage is issued on group policy form number: Policy Form TL-004700. Coverage is underwritten by Life Insurance Company of North America, 1601 Chestnut St. Philadelphia, PA 19192.

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

Return completed form to Cigna Group Insurance
P.O. Box 20310
Lehigh Valley, PA 18003-9924
Phone: 1-800-732-1603

Cigna

Life Insurance Company of North America

Employer: Arizona Fasteners Corp.

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____
Address _____ City _____ State _____ Zip _____
Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: _____ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information Name _____ **Social Security #** _____
Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # SGM 611044

Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Benefit: Units of $10,000 up to the lesser of 5 times your salary, or $300,000. Guaranteed Coverage: $100,000	❑ $10,000 ❑ $100,000* ❑ $300,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Benefit: Units of $5,000 up to $100,000. Guaranteed Coverage: $30,000	❑ $5,000 ❑ $30,000* ❑ $100,000** ❑ Other _____ *Amount must be a multiple of $5,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
Child	Benefit: Units of $10,000 up to $20,000.	❑ $10,000 ❑ $20,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance Policy # SOK 608217		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Benefit: Units of $10,000 up to the lesser of 5 times your salary, or $300,000.	❑ $10,000 ❑ $130,000 ❑ $300,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Benefit: Units of $5,000 up to $100,000.	❑ $5,000 ❑ $45,000 ❑ $100,000** ❑ Other _____ *Amount must be a multiple of $5,000 and cannot exceed $100,000.* ❑ Decline Coverage

**This is the Guaranteed Coverage amount. You may choose this amount, or less, without answering medical questions during your enrollment period.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latter of 03/01/2020 or the date the insurance company approves your application.

SIGN HERE TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to Cigna's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Please Sign Here ☛ Signature _____ Date _____

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren) unless you specify otherwise. If there is not enough room to specify all beneficiaries, attach, sign and date a separate page using the format below.

Voluntary Term Life Insurance Policy# SGM 611044					
Insured	**Beneficiary Name**	**Relationship**	**Social Security #**	**Date of Birth**	**Percentage** *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					
Child(ren)					

Voluntary Accidental Death & Dismemberment Insurance Policy# SOK 608217					
Insured	**Beneficiary Name**	**Relationship**	**Social Security #**	**Date of Birth**	**Percentage** *(must equal 100% for each insured)*
Employee	1.				
	2.				
Spouse					

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse also signs the beneficiary designation.

Spouse Signature _____ Date _____

Employee Signature _____ Date _____

Be sure to make a copy for your records.

ARIZONA FIREPLACES

Aflac

Group Accident Policy – 24 hour Coverage

Cash benefits paid directly to you for situations resulting from an accident/injury

$200 Per Accident visit to ER/Urgent Care (within 7 days of injury) / $50 additional if with X-rays
$100 Per Accident visit to Dr. Office / $50 additional if with X-rays
$1,250 Benefit Hospital Admission as a patient in a room (does not apply to observation)
$300 Per day Hospital Confinement as a patient in a room (does not apply to observation)
$200 Major Diagnostic Testing
$40 Cane, Ankle Brace / $400 Wheel Chair / $100 Crutches / $400 Knee Scooter
$50 Follow up visits (6 per injury) / $50 Physical Therapy visits (10 per injury)
$25 Health Screening Benefit once per year per person covered 1st year / $50 2nd year

Fractures, Dislocations, Burns, Concussion, Eye injuries, Surgery, Dismemberment, Paralysis.

Employee Rates	Weekly Cost	Semi Monthly Cost
Employee Only	$4.57	$9.90
Employee + Spouse	$7.39	$16.02
Employee + Child(ren)	$9.95	$21.56
Employee, Spouse, Child(ren)	$12.78	$27.68

Group Hospital Indemnity Policy

Cash benefits paid directly to you for hospital admission due to an injury or an illness:

$1,000 benefit hospital admission as a patient in a room
$150 per day confinement up to 31 days
$150 per day for ICU confinement up to 10 days
$75 per day ICU step down unit up to 10 days

(Does not pay a benefit for ER visits, outpatient surgeries or observation rooms)

Pre existing condition exclusions have been waived for this enrollment and new hires

Employee Rates	Weekly Cost	Semi Monthly Cost
Employee Only	$5.18	$11.22
Employee + Spouse	$9.88	$21.41
Employee + Child(ren)	$7.97	$17.24
Employee, Spouse, Child(ren)	$12.67	$27.46

Group Critical Illness Policy

Cash benefits paid directly to you for a covered critical illness:

$20,000 Lump Sum Benefit for Employee – Guarantee issue amount for newly enrolled employees

$10,000 Lump Sum Benefit for Spouse/Children

Dependent children are automatically covered, if the employee is enrolled, for no additional cost.
Dependent child benefit is $10,000.

$50 Health Screening once per year for employee and spouse

100% Benefit amount paid upon occurrence of Heart Attack, Sudden Cardiac Arrest, Major Organ Transplant, Kidney Failure, Stroke, Bone Marrow Transplant, Internal or Invasive Cancer.

Pre existing condition exclusions have been waived for this enrollment and new hires

Non Tobacco

Age 18-29	**Weekly**	**Semi Monthly**
Employee	$2.46	$5.34
$10,000 Spouse	$1.41	$3.05
Age 30-39		
Employee	$3.97	$8.60
$10,000 Spouse	$2.16	$4.68
Age 40-49		
Employee	$7.66	$16.59
$10,000 Spouse	$4.00	$8.68
Age 50-59		
Employee	$14.80	$32.07
$10,000 Spouse	$7.57	$16.41
Age 60+		
Employee	$28.30	$61.33
$10,000 Spouse	$14.33	$31.04

Tobacco

Age 18-29	**Weekly**	**Semi Monthly**
Employee	$3.44	$7.46
$10,000 Spouse	$1.90	$4.11
Age 30-39		
Employee	$6.17	$13.37
$10,000 Spouse	$3.26	$7.06
Age 40-49		
Employee	$12.04	$26.09
$10,000 Spouse	$6.20	$13.43
Age 50-59		
Employee	$23.97	$51.94
$10,000 Spouse	$12.16	$26.35
Age 60+		
Employee	$44.33	$96.06
$10,000 Spouse	$23.34	$48.41

MUST COMPLETE AFLAC APPLICATON FORM TO ENROLL

Deanna Lujan | Insurance Advisor
office 602.343.6236 | fax 480.378.3903 | cell 480.231.9588
deanna@msinsurancellc.com

MARREEL SLATER Insurance

CONTINENTAL AMERICAN INSURANCE COMPANY

EMPLOYEE APPLICATION
Please Mail: PO Box 84078,
Columbus, GA 31993
800.433.3036

FOR HOME OFFICE USE ONLY		
PLAN	***PLAN CODE***	***ID NUMBER***
Accident		
Critical Illness		
Hospital Indemnity		
Endorsement:		
EFFECTIVE DATE:		

FOR AGENT USE ONLY				
☐ **Initial Enrollment**	☐ **New Hire**	☐ **Re-Enrollment**	☐ **New Eligible**	☐ **Re-Submission**

Deduction start date _____

Applicant Name (First, MI, Last)		Social Security # or ID #	Gender	Date of Birth
Street Address	City		State	ZIP
Group Policyholder **Arizona Fireplaces #25286**	Class/Occupation	Location	Date of Hire	
E-mail address (optional)	Hours Worked per Week	Daytime Phone No.		
Spouse's Name (if coverage is requested)		Spouse's Gender	Spouse's Date of Birth	

	Applicant	**Spouse**
Are you actively at work?	☐ **YES** ☐ **NO**	
Have you used tobacco products in the last 12 months?	☐ **YES** ☐ **NO**	☐ **YES** ☐ **NO**

LIST ALL ELIGIBLE CHILDREN FOR WHOM YOU ARE PROPOSING COVERAGE (FROM YOUNGEST TO OLDEST):

Name	**Gender**	**Date of Birth**	**Name**	**Gender**	**Date of Birth**

Beneficiary Information – Employee's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

Beneficiary Information – Spouse's Beneficiary

Name	Relationship	Address	Date of Birth	Social Security #	Telephone #	Percent
						%
						%

Total: 100%

GROUP ACCIDENT INSURANCE

☐ New Coverage ☐ Change in Coverage ☐Increase/Buy-Up

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost per pay period: $_____

GROUP CRITICAL ILLNESS INSURANCE ☐ Applicant ☐ Applicant and Spouse

❑ New Coverage ❑ Change in Coverage ☐Increase/Buy-Up

Applicant Face Amount: $	Applicant cost per pay period: $
Spouse Face Amount: $	Spouse cost per pay period: $
	TOTAL cost per pay period: $

STATEMENT OF INSURABILITY

COMPLETE FOR GROUP CRITICAL ILLNESS INSURANCE AMOUNTS REQUESTED ABOVE GUARANTEE ISSUE AMOUNT

		Applicant	Spouse
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐YES ☐NO	☐YES ☐NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma of the skin.	☐YES ☐ NO	☐YES ☐NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatment?	☐YES ☐NO	☐YES ☐NO

GROUP HOSPITAL INDEMNITY INSURANCE

☐ New Coverage ☐ Change in Coverage ☐ Increase/Buy-Up

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family

Cost Per Pay Period : _____

If <u>NOT</u> Guaranteed Issue, answer the following questions:

		Applicant	Spouse	Children
1	Have you ever been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3	Have you ever been treated for, or diagnosed with, any of the following: a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatment?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
4	In the last 5 years, have you sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

HEALTH COVERAGES:

- Does this coverage replace or change any existing insurance? ☐ **YES** ☐ **NO**
  If yes, provide carrier: _____
- Are you currently covered under, or does this coverage replace, an Aflac individual policy? ☐ **YES** ☐ **NO**
  If yes and if it is the same type of coverage you are applying for on this application, please identify which individual policy(ies) you already have: ☐ Critical Illness ☐ Accident ☐ Hospital Indemnity

If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.

I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance coverage.

ALL COVERAGES:

If a covered child reaches a limiting age as specified in the certificate or a rider, it is your responsibility to notify the company.

To the best of my knowledge and belief, my answers to the questions are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued. I realize any false statement or misrepresentation in the application may result in loss of coverage under the certificate. I understand that no insurance will be in effect unless I am actively at work on the effective date of coverage, and until my application is approved and the necessary premium is paid. If I am not actively at work on the effective date of coverage, coverage will become effective on the date I return to an active work status.

I understand and agree that the coverage I am applying for may have a pre-existing condition limitation.

I authorize the Group Policyholder to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.

Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Date_____ Signature of Applicant_____

Date_____ Signature of Agent_____

Agent's Printed Name_____

Agent No._____ State of Enrollment_____

This form is not complete unless signed and dated as indicated.

Instructions

1. Your employer will complete section A.
2. Complete sections B through G.
3. If you are electing dental coverage, complete the section entitled “DENTAL OPTIONS.”
4. If you are electing medical, complete the section entitled “MEDICAL OPTIONS.”
5. Read the information on the back of the enrollment/change form.
6. Sign and date the enrollment/change.

We look forward to having you as our customer.

Administered by Cigna Health and Life Insurance Company

Cigna

Employer: Complete Section A **Employee:** Complete Section B-G

Enrollment/Change Form

A						
☐ OPEN ENROLL ☐ CHANGE ☐ NEW ENROLL ☐ REINSTATE	EFFECTIVE DATE OF CHANGE ADD/CHANGE/CANCELLATION (MM/DD/CCYY) _____/_____/_____	EMPLOYER NAME Arizona Fasteners Corp.	DATE OF HIRE (MM/DD/CCYY) _____/_____/_____	PLAN NUMBER 629276	SUBGROUP 0001	CLASS A001

B

☐ SINGLE ☐ MARRIED _____/_____/_____
☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

TYPE OF CHANGE ☐ Add Dependent(s) * ☐ Demographics ☐ PCP Change ☐ Retirement
* List Name(s) in Section C ☐ COBRA Continuation ☐ Other ___________________________
Qualifying Event Date: _____/_____/_____

C

EMPLOYEE NAME *(Last)*	*(First)*	SOCIAL SECURITY NUMBER - -
EMPLOYEE DATE OF BIRTH (MM/DD/CCYY) _______/_______/_______	HOME PHONE (________)	EMAIL ADDRESS
ADDRESS *(Street)* *(City)*	*(State)*	*(Zip Code)*

☐ YES, I WOULD LIKE COVERAGE FOR MYSELF AND MY DEPENDENTS. (Specify last name if different from yours) Last Name First Name	Dependent Social Security Number	Date of Birth (MM/DD/CCYY)	Gender	Height	Weight	Coverage Selection	Full-Time Student?	Dental Late Entrant?
Employee	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No	☐ Yes ☐ No
Dependent Relationship	- -	/ /	☐M ☐F			☐Med ☐Den ☐Vis	☐ Yes ☐ No	☐ Yes ☐ No

ADDITIONAL INFORMATION- * DEPENDENTS – If totally disabled prior to age 26, attach proof of disability for eligibility review. Dependents are covered under the medical plan to age 26. Proof of student status may be required for dental and/or vision coverage. **PCP ID is required when the Medical Option selected below is Cigna SureFit®. If a PCP is not selected during enrollment one will be assigned. Otherwise PCP is optional.

D

MEDICAL OPTIONS:

☐ HSA (without Banking)/ HDHP LocalPlus
☐ Open Access Plus/ OAP Buy Up
☐ Open Access Plus/ OAP Base
☐ Decline Coverage

E

DENTAL OPTIONS:

☐ Cigna Dental PPO/ DPPO
☐ Decline Coverage

VISION OPTIONS:

☐ Cigna Vision/Vision
☐ Decline Coverage

F

OTHER HEALTHCARE COVERAGE: Do you or your dependents have other health insurance under a group plan, HMO, or Medicare? ☐ Yes ☐ No If yes, please provide the following:

NAME OF PERSON COVERED	SOCIAL SECURITY NUMBER	EFFECTIVE DATE	MEDICARE Part A	MEDICARE Part B	MEDICAID	OTHER INSURANCE CARRIER
	- -	_____/_____/_____	☐	☐	☐	
	- -	_____/_____/_____	☐	☐	☐	

G	The information provided above is true and correct to the best of my knowledge, and I accept the provisions on the reverse side of this form which I have read and understand. By my signature below, I acknowledge that I have read and understand the disclosure in this Enrollment/Change Form. I authorize the required payroll deduction for contributory benefits. I also represent that all information shown on this Enrollment/Change Form is correct. I understand that I will not be individually denied coverage or be individually charged different rates as a result of my answers. However, if I knowingly provide false information on this Questionnaire, I understand and agree that it may affect the payment of claims or result in termination of my/or my dependent(s) coverage.
	EMPLOYEE SIGNATURE / DATE

PROVISIONS

- Cigna Dental PPO plans are administered by CHLIC, with network management services provided by Cigna Dental Health, Inc. and certain of its subsidiaries.
- I agree, for myself and my covered dependents, that, in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act or omission of another person, I will fully inform the health plan and will execute such assignments, liens or other documents which may be necessary to enable the health plan to recover the value of the services provided. I further agree that in the event I or any of my covered dependents collect benefits or damages from any other party who has primary responsibility for services provided by the health plan, I will immediately reimburse the health plan to the extent permitted by state law.

FRAUD WARNING

Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

AUTHORIZATION TO DEDUCT CONTRIBUTIONS

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. This authorization applies only if employee contributions are required.

SPECIAL PROVISIONS FOR EMPLOYERS WITH SECTION 125 PLANS

By allowing an individual to enroll in the health plan, other than during the open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not waive any terms of its contract. Further, by allowing an individual to enroll in the health plan, other than during an open enrollment period, Cigna Health and Life Insurance Company and its affiliates do not thereby express any opinion regarding the appropriateness of the change under Section 125 of the Internal Revenue Code or the terms of the employer's Section 125 Plan.