Metropolitan Life Insurance Company
200 Park Avenue, New York, New York

APPLICATION FOR GROUP INSURANCE

The applicant named below is applying for Group Insurance to provide coverage for the class(es) of persons specified below.

APPLICANT DATA

1. Full legal name of Applicant: City Of Pflugerville (the "Policyholder")

2. Address: 100 East Main Street 300 P.O. Box 589 City Pflugerville State TX Zip 78660

EFFECTIVE DATE

The effective date of the applied for group insurance will be 01/01/2024, subject to MetLife's acceptance of this application and the applicant's payment of the Premium due on or before such date.

SITUS

Group Policy forms will be issued for delivery in and governed by the laws of **TEXAS**.

COVERAGE DATA

Employees / Members	Dependents
Dental	Dental

PREMIUM DATA ->

Premiums will be paid: ☒ Monthly ☐ Quarterly ☐ Annually ☐ Other

Attached is an advance payment of: $ 0

AGREEMENT

The Applicant signing below agrees to accept the terms and provisions of all Group Policy forms issued pursuant to this application; including all Exhibits, amendments and endorsements, if any.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Applicant's Authorized Representative

Signed at: City _____, State _____ Date: _____

Name of Authorized Representative _____

Title of Authorized Representative _____

Applicant's Signature _____

Signature of Licensed MetLife Agent or Resident Agent as required by law

Agent's State License No. _____

Date: 09/26/2023

Name of Agent: Andrew Clifton

Agent's Signature Andrew Clifton

HIPAA Request

If you wish to include in your booklet certificate the HIPAA privacy language shown on the specimen "Sample Dental and/or Vision Booklet Certificate/SPD Language" provided to you by MetLife, please answer the following questions, sign, and return this form to your MetLife Sales Office.

A. Are there employees of the Plan Sponsor that may access PHI (Protected Health Information) provided by the Plan? If there are, please provide their title(s) or other identifiers below.

PLEASE DO NOT PROVIDE THEIR NAMES; ONLY TITLE OR OTHER IDENTIFIER.

Title _____ Title _____ Title _____

Title _____ Title _____ Title _____

B. Should the term "Privacy Officer" be included in Section III. (c) "Sharing of PHI with the Plan Sponsor" of the Dental and/or Vision Plan Document?

☒ Yes ☐ No

C. Should Section IV. "Participant's Rights" be included in the Dental and/or Vision Plan Document? (This is an optional section.)

☒ Yes ☐ No

D. Should Section V. "Privacy Complaints/Issues" be included in the Dental and/or Vision Plan Document? (This is an optional section.)

☒ Yes ☐ No

As a duly authorized representative of the Customer named below and its group dental and/or vision plan, and consistent with such Customer's decision to amend its plan document to incorporate HIPAA privacy provisions, I hereby request that MetLife include in Customer's booklet certificate HIPAA privacy language reflecting Customer's choices on this form.

Customer Name **City Of Pflugerville**

Name of Authorized Representative _____

Title of Authorized Representative _____

Signature of Authorized Representative _____ Date _____

Group, Voluntary & Worksite Benefits
Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

MetLife

Statement of Responsibility

MetLife will be responsible to the group policyholder for the performance of its administrative obligations under the group policy(ies), this agreement and any other written agreement between MetLife and the group policyholder. If MetLife uses a third party in connection with any of MetLife's administrative obligations, MetLife will remain responsible to the group policyholder for the performance by the third party of those administrative obligations. The third party will work under the control and direction of MetLife and MetLife will be solely responsible for the acts, errors and omissions of the third party.

The group policyholder will be responsible to MetLife for the performance of its administrative obligations under the group policy(ies), this agreement and any other written agreement between MetLife and the group policyholder. If the group policyholder uses a third party in connection with any of the group policyholder's administrative obligations, the group policyholder will remain responsible to MetLife for the performance by the third party of those administrative obligations. The third party will work under the control and the direction of the group policyholder and the group policyholder will be solely responsible for the acts, errors and omissions of the third party.

To be completed by Policyholder:

_____ (Name of Authorized Representative)	_____ (Title of Authorized Representative)
_____ (Signature of Policyholder Authorized Representative)	City Of Pflugerville (Group Policyholder Name)

Signed at:

_____ (City)	_____ (State)	_____ Date(MM/DD/YYYY)

To be completed by Metropolitan Life Insurance Company:

Crystal McElroy
Vice President
Group Benefits Contracts & Compliance

_____ Date(MM/DD/YYYY)

Benefits provided by SafeGuard Health Plans, Inc.,
a Metlife company
200 Park Avenue, New York, New York 10166

APPLICATION FOR GROUP DENTAL BENEFITS

The applicant named below is applying for a Group Contract to provide dental benefits for the persons specified below.

APPLICANT DATA

1. Full legal name of Applicant: City Of Pflugerville

2. Address: 100 East Main Street 300 P.O. Box 589 City Pflugerville State TX Zip 78660

CONTRACT EFFECTIVE DATE

The Group Contract's effective date will be 01/01/2024, subject to MetLife's acceptance of this application.

CONTRACT SITUS

The Group Contract will be issued for delivery in and governed by the laws of **TEXAS**.

COVERAGE DATA

Employees / Members	Dependents
Dental Benefits	Dental Benefits

PREPAYMENT FEE DATA

Prepayment Fees will be paid: ☒ Monthly ☐ Quarterly ☐ Annually ☐ Other: _____

Attached is an advance payment of: $ 0.

AGREEMENT

The Applicant signing below agrees to accept the terms and provisions of the Group Contract, including its Exhibits, amendments and endorsements, if any.

Point-of-Service Option. MetLife does not offer a Point-of-Service Option in the state of Texas.

Fraud Warning. Any person who knowingly and with intent to defraud any insurance company or other person files an application or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Signature of Applicant's Legal Representative

Signed at: City _____, State _____ Date: _____

Name of Legal Representative _____

Title of Legal Representative _____

Applicant's Signature _____

Isaac Jones

(SafeGuard Representative) | Assistant Vice President (Representative's title) | Isaac Torres (Print Name of Representative)