



ACE American Insurance Company
436 Walnut Street
Philadelphia, PA 19106
800-352-4462 (inquiries/customerservice)

Application for Group Supplemental Medical Expense Insurance

The Applicant requests Group Supplemental Medical Expense Insurance for eligible persons listed below based on the following statements and representations. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the Applicant and agreed to in writing by the Insurance Company.

APPLICANT INFORMATION

Note: There must be an underlying Major Medical Plan in place.

Applicant (Full Legal Name): Muskogee County	Requested Effective Date: 01/01/2026
Address: 400 W Broadway St	City, State, Zip Code: Muskogee, OK 74401
Nature of Business: County Government	Taxpayer ID # 73-6006395
Contact Person: Polly Irving	Title: County Clerk
Phone: 918-682-2169 Fax:	E-Mail: polly.clerk@gmail.com
Billing Contact Person: Sheila Harrison	Title: Deputy Clerk
Billing Address: P.O. Box 1008	City, State, Zip Code: Muskogee OK 74402
Phone: 918-682-2169 Fax:	E-Mail: sheilamuskogeecounty@gmail.com
Number Eligible for Coverage:	Open Enrollment Period: from 10/15 to 12/01
Number Enrolling for Coverage:	On-Line Enrollment: ☐ Yes ☐ No
Number Waiving Coverage:	
Deposit Premium Amount: \$ <u>N/A</u>	
If any subsidiary or affiliated companies are to be insured or any employees are working at a location other than the address shown above, please explain: N/A	
Number of persons on COBRA or State Continuation: Employees: None Dependents: None (Please list names, qualifying event and date on a separate page and attach the page to this Application)	
This request is for: ☒ New Coverage ☐ Replacement Coverage	
If replacing existing coverage, indicate: Name of Carrier: Coverage Type: Policy Number(s):	
Date(s) of Replacement:	



6th day of Oct 2025
Chairman _____
Member Keith Harrison
Member _____
Attest Polly Irving
County Clerk

Class(es) of Employees (please describe):

Class I: All employees of the Policyholder who are working 30 or more hours per week and are enrolled in the Policyholder's Major Medical Plan.

Eligibility Waiting Period: Same as Major Medical Plan

These Benefits are available to all employees in an eligible class who are actively at work for the employer. Employees may enroll their spouse and eligible dependent children to age 26 who are engaging in the usual activities of a person in good health of like age and sex and not confined in a hospital or other facility.

COBRA Administration:

In the event the employer deems the Group Supplemental Medical Expense Insurance applied for herein is subject to the requirements of the Consolidated Omnibus Reconciliation Act (COBRA), the Insurance Company has arranged for the administration of this program through the services of its administrator. Please indicate whether COBRA Administration services will be selected: ☒ Yes ☐ No

SELECTION OF COVERAGE

SEE ATTACHED NAS SIGNED PLAN & RATE SELECTION FORM, AND/OR CHUBB PROPOSAL FOR SELECTED PLAN DESIGN & CORRESPONDING RATES

We reserve the right to modify the rates or plan benefits or to decline to bind coverage if participation requirements are not met by initial enrollment.

For any insurance paid in part, or wholly, by individual covered persons, the Applicant will support enrollment activities and allow all eligible persons an opportunity to enroll. No brochures or any material referencing the requested insurance will be published without the prior written approval of the Insurance Company.

The Applicant represents the information contained in this Application is true and correct and forms the basis of the requested insurance. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the Applicant.

I understand this Application is for a Supplemental Medical Expense Insurance Plan. The insurance provided is not Major Medical or Comprehensive Medical coverage, and does not satisfy an individual's obligation to secure the requirement of minimum essential coverage under the Affordable Care Act (ACA).

I understand and acknowledge that no coverage will take effect for any person who is not also covered by a Major Medical Plan in effect at the time of the proposed Effective Date for this coverage. This underlying Major Medical Plan must include Coinsurance and/or Deductible amounts.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Signature and Title

Date

Signed by Licensed Resident Agent
(Where Required by Law)

21215593

License Number

AGENT / BROKER INFORMATION

Name: Dylan Lucht	Company Name: Lucht Insurance Service	
Address: 101 W Broadway St, Muskogee, OK, 74401		
Phone: 918-856-6774	Fax: 918-948-8559	E-mail: dylan@lucht-ok.com



Group Supplemental Medical Expense Insurance

Oklahoma | Non-Voluntary | 5-99 Eligible | Effective 08/01/2025 to 06/30/2026

For Groups with 100+ Eligible Employees, please request a quote.

Please refer to the Ineligible SIC List.

Group Name: Muskogee County

Effective Date: 01/01/2026

Monthly Rates | \$1,000 Deductible

PLAN	Inpatient/ Outpatient Benefit Amounts	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
☐	\$500	\$15.44	\$26.75	\$28.68	\$40.00
☐	\$600	\$18.15	\$31.46	\$33.73	\$47.04
☐	\$700	\$20.87	\$36.17	\$38.78	\$54.08
☐	\$800	\$23.59	\$40.88	\$43.83	\$61.12
☐	\$900	\$26.31	\$45.59	\$48.88	\$68.16
☐	\$1,000	\$29.03	\$50.30	\$53.93	\$75.20
☐	\$1,100	\$30.99	\$53.70	\$57.56	\$80.28
☐	\$1,200	\$32.95	\$57.10	\$61.20	\$85.35
☐	\$1,300	\$34.92	\$60.50	\$64.84	\$90.43
☐	\$1,400	\$36.88	\$63.90	\$68.47	\$95.50
☐	\$1,500	\$38.84	\$67.30	\$72.11	\$100.58
☐	\$1,600	\$40.14	\$69.55	\$74.51	\$103.93
☐	\$1,700	\$41.44	\$71.80	\$76.92	\$107.29
☐	\$1,800	\$42.74	\$74.05	\$79.32	\$110.64
☐	\$1,900	\$44.04	\$76.29	\$81.73	\$114.00
☐	\$2,000	\$45.33	\$78.54	\$84.13	\$117.35
☐	\$2,100	\$46.15	\$79.95	\$85.64	\$119.46
☐	\$2,200	\$46.96	\$81.37	\$87.15	\$121.56
☐	\$2,300	\$47.78	\$82.78	\$88.66	\$123.66
☐	\$2,400	\$48.59	\$84.19	\$90.17	\$125.77
☐	\$2,500	\$49.41	\$85.60	\$91.67	\$127.87
☐	\$2,600	\$49.92	\$86.48	\$92.61	\$129.18
☐	\$2,700	\$50.43	\$87.35	\$93.55	\$130.48
☐	\$2,800	\$50.93	\$88.23	\$94.48	\$131.78
☐	\$2,900	\$51.44	\$89.11	\$95.42	\$133.08
☐	\$3,000	\$51.95	\$89.98	\$96.35	\$134.39
☐	\$3,100	\$52.45	\$90.86	\$97.29	\$135.69
☐	\$3,200	\$52.96	\$91.73	\$98.22	\$136.99
☐	\$3,300	\$53.47	\$92.61	\$99.15	\$138.30
☐	\$3,400	\$53.97	\$93.48	\$100.08	\$139.60
☐	\$3,500	\$54.48	\$94.36	\$101.02	\$140.90
☐	\$3,600	\$55.03	\$95.32	\$102.04	\$142.33
☐	\$3,700	\$55.59	\$96.27	\$103.06	\$143.76

PLAN	Inpatient/ Outpatient Benefit Amounts	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
☐	\$3,800	\$56.14	\$97.23	\$104.09	\$145.19
☐	\$3,900	\$56.69	\$98.19	\$105.11	\$146.61
☒	\$4,000	\$57.25	\$99.15	\$106.14	\$148.04
☐	\$4,100	\$59.55	\$103.15	\$110.42	\$154.01
☐	\$4,200	\$61.85	\$107.14	\$114.70	\$159.98
☐	\$4,300	\$64.16	\$111.13	\$118.98	\$165.95
☐	\$4,400	\$66.46	\$115.12	\$123.27	\$171.92
☐	\$4,500	\$68.76	\$119.12	\$127.55	\$177.89
☐	\$4,600	\$69.31	\$120.07	\$128.57	\$179.33
☐	\$4,700	\$69.87	\$121.03	\$129.60	\$180.76
☐	\$4,800	\$70.42	\$121.99	\$130.62	\$182.19
☐	\$4,900	\$70.98	\$122.95	\$131.64	\$183.62
☐	\$5,000	\$71.53	\$123.91	\$132.67	\$185.05
☐	\$5,100	\$72.10	\$124.89	\$133.71	\$186.50
☐	\$5,200	\$72.66	\$125.86	\$134.75	\$187.95
☐	\$5,300	\$73.22	\$126.83	\$135.78	\$189.40
☒	\$5,400	\$73.79	\$127.81	\$136.82	\$190.85
☐	\$5,500	\$74.35	\$128.78	\$137.86	\$192.29
☐	\$5,600	\$76.53	\$132.57	\$141.92	\$197.96
☐	\$5,700	\$78.72	\$136.35	\$145.98	\$203.62
☐	\$5,800	\$80.90	\$140.14	\$150.04	\$209.28
☐	\$5,900	\$83.08	\$143.92	\$154.11	\$214.95
☐	\$6,000	\$85.27	\$147.71	\$158.17	\$220.61
☐	\$6,100	\$85.77	\$148.57	\$159.09	\$221.90
☐	\$6,200	\$86.27	\$149.44	\$160.01	\$223.18
☐	\$6,300	\$86.77	\$150.31	\$160.94	\$224.47
☐	\$6,400	\$87.27	\$151.17	\$161.86	\$225.76
☐	\$6,500	\$87.77	\$152.04	\$162.78	\$227.04
☐	\$6,600	\$88.24	\$152.86	\$163.66	\$228.26
☐	\$6,700	\$88.71	\$153.68	\$164.53	\$229.48
☐	\$6,800	\$89.19	\$154.49	\$165.40	\$230.70
☐	\$6,900	\$89.66	\$155.31	\$166.28	\$231.92
☐	\$7,000	\$90.14	\$156.13	\$167.15	\$233.15

Agent Signature:

Agent Name: Dylan Lucht

Date: 10/06/2025

For Agent Use Only. Not for Public Distribution. A qualified major medical plan must be in place during the period of coverage and the insured must be enrolled in such coverage. This information is a brief description of the important features of the proposed insurance plan underwritten by ACE American Insurance Company. It is not a contract of insurance. Coverage may not be available in all states or certain terms may be different if required by state law. Administered by 90 Degree Benefits and distributed by National Agency Solutions. Brochure AGT-GAP-OK-2024-NAS04 for use with Form AH-40504-OK. Revision Date 09/12/2025.



Group Supplemental Medical Expense Insurance

Oklahoma | Non-Voluntary | 5-99 Eligible | Effective 08/01/2025 to 06/30/2026

For Groups with 100+ Eligible Employees, please request a quote.

Please refer to the Ineligible SIC List.

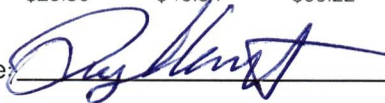
Group Name: Muskogee County

Effective Date: 01/01/2026

Monthly Rates | \$2,500 Deductible

PLAN	Inpatient/ Outpatient Benefit Amounts	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
☐	\$500	\$7.13	\$12.34	\$13.19	\$18.40
☐	\$600	\$8.39	\$14.52	\$15.52	\$21.65
☐	\$700	\$9.65	\$16.70	\$17.85	\$24.90
☐	\$800	\$10.91	\$18.88	\$20.18	\$28.15
☐	\$900	\$12.17	\$21.07	\$22.51	\$31.41
☐	\$1,000	\$13.43	\$23.25	\$24.84	\$34.66
☐	\$1,100	\$14.41	\$24.96	\$26.66	\$37.20
☐	\$1,200	\$15.40	\$26.66	\$28.48	\$39.75
☐	\$1,300	\$16.39	\$28.37	\$30.30	\$42.29
☐	\$1,400	\$17.37	\$30.08	\$32.13	\$44.83
☐	\$1,500	\$18.36	\$31.79	\$33.95	\$47.38
☐	\$1,600	\$19.09	\$33.04	\$35.29	\$49.25
☐	\$1,700	\$19.81	\$34.30	\$36.63	\$51.12
☐	\$1,800	\$20.54	\$35.55	\$37.97	\$52.99
☐	\$1,900	\$21.27	\$36.81	\$39.31	\$54.86
☐	\$2,000	\$22.00	\$38.06	\$40.65	\$56.73
☐	\$2,100	\$22.49	\$38.92	\$41.57	\$58.01
☐	\$2,200	\$22.99	\$39.78	\$42.49	\$59.28
☐	\$2,300	\$23.48	\$40.64	\$43.40	\$60.56
☐	\$2,400	\$23.98	\$41.50	\$44.32	\$61.84
☐	\$2,500	\$24.47	\$42.35	\$45.23	\$63.12
☐	\$2,600	\$24.83	\$42.97	\$45.89	\$64.03
☐	\$2,700	\$25.18	\$43.58	\$46.54	\$64.94
☐	\$2,800	\$25.53	\$44.19	\$47.19	\$65.85
☐	\$2,900	\$25.89	\$44.80	\$47.85	\$66.77
☐	\$3,000	\$26.24	\$45.41	\$48.50	\$67.68
☐	\$3,100	\$26.60	\$46.03	\$49.16	\$68.60
☐	\$3,200	\$26.96	\$46.65	\$49.82	\$69.52
☐	\$3,300	\$27.31	\$47.27	\$50.48	\$70.44
☐	\$3,400	\$27.67	\$47.88	\$51.14	\$71.36
☐	\$3,500	\$28.03	\$48.50	\$51.80	\$72.28
☐	\$3,600	\$28.41	\$49.17	\$52.51	\$73.27
☐	\$3,700	\$28.80	\$49.84	\$53.22	\$74.26

PLAN	Inpatient/ Outpatient Benefit Amounts	EMPLOYEE	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	FAMILY
☐	\$3,800	\$29.18	\$50.50	\$53.93	\$75.25
☒	\$3,900	\$29.57	\$51.17	\$54.65	\$76.25
☐	\$4,000	\$29.95	\$51.84	\$55.36	\$77.24
☐	\$4,100	\$31.41	\$54.37	\$58.06	\$81.01
☐	\$4,200	\$32.87	\$56.89	\$60.76	\$84.78
☐	\$4,300	\$34.33	\$59.42	\$63.46	\$88.55
☐	\$4,400	\$35.78	\$61.94	\$66.17	\$92.31
☐	\$4,500	\$37.24	\$64.47	\$68.87	\$96.08
☐	\$4,600	\$37.62	\$65.11	\$69.56	\$97.05
☐	\$4,700	\$37.99	\$65.76	\$70.25	\$98.01
☐	\$4,800	\$38.37	\$66.41	\$70.94	\$98.97
☐	\$4,900	\$38.74	\$67.05	\$71.63	\$99.94
☐	\$5,000	\$39.11	\$67.70	\$72.32	\$100.90
☐	\$5,100	\$39.48	\$68.34	\$73.00	\$101.85
☐	\$5,200	\$39.85	\$68.97	\$73.68	\$102.80
☐	\$5,300	\$40.22	\$69.61	\$74.36	\$103.74
☐	\$5,400	\$40.59	\$70.25	\$75.04	\$104.69
☐	\$5,500	\$40.96	\$70.88	\$75.72	\$105.64
☐	\$5,600	\$42.86	\$74.18	\$79.25	\$110.57
☐	\$5,700	\$44.76	\$77.48	\$82.78	\$115.49
☐	\$5,800	\$46.67	\$80.78	\$86.31	\$120.42
☐	\$5,900	\$48.57	\$84.07	\$89.84	\$125.34
☐	\$6,000	\$50.47	\$87.37	\$93.38	\$130.27
☐	\$6,100	\$50.79	\$87.93	\$93.97	\$131.09
☐	\$6,200	\$51.12	\$88.48	\$94.56	\$131.92
☐	\$6,300	\$51.44	\$89.04	\$95.15	\$132.75
☐	\$6,400	\$51.76	\$89.60	\$95.74	\$133.58
☐	\$6,500	\$52.08	\$90.15	\$96.34	\$134.41
☐	\$6,600	\$52.40	\$90.71	\$96.93	\$135.23
☐	\$6,700	\$52.72	\$91.27	\$97.52	\$136.06
☐	\$6,800	\$53.04	\$91.82	\$98.12	\$136.89
☐	\$6,900	\$53.36	\$92.38	\$98.71	\$137.72
☐	\$7,000	\$53.69	\$92.93	\$99.31	\$138.55

Agent Signature:  Agent Name: Dylan Lucht

Date: 10/06/2025

For Agent Use Only. Not for Public Distribution. A qualified major medical plan must be in place during the period of coverage and the insured must be enrolled in such coverage. This information is a brief description of the important features of the proposed insurance plan underwritten by ACE American Insurance Company. It is not a contract of insurance. Coverage may not be available in all states or certain terms may be different if required by state law. Administered by 90 Degree Benefits and distributed by National Agency Solutions. Brochure AGT-GAP-OK-2024-NAS04 for use with Form AH-40504-OK. Revision Date 09/12/2025.

Employer ACH Debit Authorization Agreement



The undersigned Employer (the "RECEIVER") hereby (1) authorizes 90 Degree Benefits ("90DB", "ORIGINATOR") to debit the account below by electronic funds transfer (EFT) through the Automated Clearing House (ACH) network pursuant to the terms of this Agreement and the Rules (the "Rules") of the National Automated Clearing House Association, (2) certifies that it has selected the following depository financial institution ("DEPOSITORY"), and (3) directs that all such electronic funds transfers be made as provided below.

Depository Institution (Bank) Name: _____

Routing/Transit Number: _____ Account Number: _____

Account Type: ☐ Checking ☐ Savings

Please include a voided check with this agreement.

Please contact your financial institution to make sure that there are no ACH debit blocks or transaction limits.

PLEASE READ

IT IS THE RECEIVER'S RESPONSIBILITY TO ENSURE THAT EACH INVOICE DETAIL IS CORRECT BEFORE THE ACH AUTO DEBIT COMMENCES. CREDITS ARISING FROM INVOICE DISCREPANCIES WILL NOT BE HONORED AFTER 60 (SIXTY) DAYS.

- RECEIVER acknowledges that the origination of ACH transactions must comply with the provisions of U.S. law.
- RECEIVER acknowledges 90DB will use the account information listed above to fund participant contribution invoices and will only debit the amount you authorize.
- RECEIVER shall comply with and be bound by the Rules, as amended from time to time. Any reference to the Rules shall include any amendment to the Rules in effect on the date of the ACH Entry.
- This authority is to remain in full force and effect until BBA has received written notification from RECEIVER of its termination in such a time and in such manner as to afford BBA a reasonable opportunity to act on it.

Authorization Signature: _____ Date: _____

Name/Title: _____

Employer Name: Muskogee County EIN: 73-6006395

Employer Address: 400 W Broadway St, Muskogee, OK 74401

Contact Name: Polly Irving Contact Phone: 918-682-2169

Please complete, sign, and return this agreement with a voided check to us via one of the following Options:

Email: nasbilling.t5@90DegreeBenefits.com

Fax: 678-258-8299

Mail: 2810 Premiere Pkwy Suite 400, Duluth, GA 30097