TexAmericas CENTER

RESOLUTION NO. 20121127-11

DENTAL/VISION/LIFE AND SUPPLEMENTAL BENEFITS CONTRACT WITH GUARDIAN

WHEREAS, TexAmericas Center is a political subdivision of the State of Texas with the powers and authorities specified in Chapter 3503 of the Special District Local Laws Code of the State of Texas; and

WHEREAS, TexAmericas Center has a health insurance policy for TexAmericas Center employees; and

WHEREAS, TexAmericas Center adopted a Personnel Policy Manual by **Resolution # 20110823-06** on August 23, 2011; and

WHEREAS, TexAmericas Center Interlocal Agreement with Bowie County is set to expire for employee dental, hearing, vision and life insurance on December 31, 2012; and

WHEREAS, TexAmericas Center has sought, though a competitive process, bids to provide employee dental, vision, life and supplemental benefits; and

WHEREAS, Guardian has submitted a satisfactory proposal and can provide employee dental, vision, life and supplemental benefits starting January 1, 2013.

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors that the Board of TexAmericas Center approves the dental, vision, life and supplemental benefits per the attached and the Executive Director/CEO shall be and are hereby authorized execute the attached documents.

PASSED AND APPROVED THIS 27th day of November, 2012.

Sign Here

Denis Washington, Chairman of the Board

ATTEST:

Wayne Cranfill, Secretary-Treasurer

Attached: Employee Dental/Vision/Life Insurance Plan Contract

Please print clearly to ensure accurate processing

GUARDIAN®

Your Insurance Broker is : **Jeff McGuire**
5124 Summerhill Road
Texarkana
TX 75505

Your Guardian Representative is :

The Guardian Life Insurance Company Of America | 7 Hanover Square, New York, NY 10004

APPLICATION FOR A PLAN OF GROUP INSURANCE

REQUESTED COVERAGE	
Applicant: TexAmericas Center 107 Chapel Lane New Boston , TX 75570 SIC Code: 9611	Coverage(s): **Dental** **Vision** **Short Term Disability** **Long Term Disability** **Basic Life** **Voluntary Life**

If information is incorrect, ask your insurance broker for an updated application.

BUSINESS INFORMATION

Types of Organization:
☐ Corporation ☐ Partnership ☐ Proprietorship
☐ S Corp ☒ Other: Special Purpose District of the State of Texas

Nature of Business Special Purpose District of the State of Texas - Econ. Development.

Tax ID Number: 75-2804233 | Date Established: 01/01/1998

☐ Yes ☒ No Has your company ever filed, or is it now in the process of filing, for bankruptcy (Chapter 7 or 11) ?

Complete below if your company or any of its affiliates has ever applied for group insurance with Guardian.

Company or Affiliate Name (If different from Section 1)	Plan Number	Cancellation Date MM/DD/YYYY

Worker's Compensation:
Present Carrier Name: Texas Mutual

List Owners/Partners NOT Covered by Workers' Compensation:

☐ Yes ☐ No ☒ N/A If present carrier provides life insurance, are extended benefits provided in case of disability?

Complete below if there are any COBRA or state continuation cases.

Employee/Dependent		Type	Reason	Continuation Dates	
	Date of Birth MM/DD/YYYY	☐ State ☐ Federal ☐ Extension of benefits	☐ Disability ☐ Non-Disability	Start MM/DD/YYYY	End MM/DD/YYYY

For additional names, please attach a separate sheet

HEALTH RELATED INFORMATION

Answer the following questions to the best of your knowledge for any members to be insured. The term "member" means eligible employees and their dependents and COBRA participants and their dependents. Provide details for any "Yes" response on a separate sheet. Do not disclose the name of any member.

☐ Yes ☒ No Are any employees currently not actively at work? If Yes, please complete the supplemental Actively at Work statement.

AGREEMENT

Conditions Of Agreement
It is understood that only full-time employees and dependents of such shall be eligible.

Full-time employee means one who regularly works the number of hours in the normal work week established by this applicant (but not less than 30 hours per week) at the applicant's normal place of business.

Insurance Broker Representation: It is further understood that no broker has power on behalf of The Guardian Life Insurance Company of America to make or modify any request or application for insurance, or to bind said Insurance Company by making any promise or representation or by giving and receiving any information.

Acceptance of Plan
It is further understood that no insurance will be effective until the plan is accepted in writing by the Insurance Company(-ies). No contract of insurance is to be implied in any way on the basis of the completion and submission of the application.
Upon acceptance, this application will be attached to and made part of the Group Insurance Policy.

Fraud Warning:
Any person, who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

The undersigned applicant certifies that to the best of his/her knowledge and belief, all of the responses given are true, correct and complete. The applicant understands that a false statement or misrepresentation in the application may result in loss of coverage in the policy, the rescission of the policy, or a revision of the rates quoted.

00010048284600160037578-05

SIGNATURES			
I have reviewed the statements made by me on this application, and they are true and complete to the best of my knowledge and belief. By my signature below, I acknowledge that TexAmericas Center endorses the Guardian plan of insurance.			
Officer, Partner or Proprietor Signature		Witness Signature	
X Will V Cook	Date 11/27/2012	X Cyd Collins	Date 11/27/2012
Title		Title	
Insurance Broker Signature		Additional Insurance Broker Signature	
X	Date / /	X	Date / /
Print Name		Print Name	
CMA2007			

Group Plan Number _____

Requested Effective Date / /

00010048284600160037578-05

GUARDIAN®

The Guardian Life Insurance Company Of America

ADDITIONAL INFORMATION QUESTIONNAIRE

Company Name (As it should appear on your bill and contract)	Plan Number	Requested Effective Date
TexAmericas Center	00482846	01/01/2013

Correspondent Name	Phone Number	Fax Number
Cyd Collins	903-223-9841	903-223-8742

Correspondent Title	Email Address
Office Mgr	Cyd.collins@texamericascenter.com

Company Address	Mailing Address (if different)
107 Chapel Lane	

City	State	Zip	City	State	Zip
New Boston	TX	75570			

Total Number of Employees	Total Number of Employees Eligible for Coverage
25	24

Are there any Additional Affiliate Locations? ☐ Yes (Please provide details, including name if different than company name)
☒ No (All out of state employees commute or work at home)

Guardian is able to arrange incidental group coverage for US-sitused corporations in most countries. Depending on the countries where your employees are located, there may be a certain set of restrictions or exclusions applicable to benefit plans.
Do you have any employees working outside the United States? ☐ Yes ☐ No

If Yes, please provide details regarding the number of employees, and locations.

1. Affiliate Name	Address		Total Employed	Eligible for Coverage
Correspondent Name	**Phone Number**	**Email Address**	**Fax Number**	

Please provide waiting period information.

Applies to:	☐(1) ☒(2)	Only employees hired after the effective date All employees including those hired before, on, or after effective date
Waiting Period:	☐(A) ☐(B) ☒(C) ☐(D) ☐(E)	_____ days (actual days counted) _____ month(s) first of the month following 30 days (actual days counted) first of the month following _____ month(s) first of the month following or coinciding with date hired
Coverage Ends:	First of the month effective dates give employees coverage until the end of the month for dental, medical and vision. Coverage ends immediately upon termination for life, disability, critical illness and when employees are not effective on the first of the month.	

Requested Class Definitions.

Class	Description	Waiting period: *If class specific, indicate letter and number from waiting period section*	Earnings and Benefit Redetermination
Class 1	☐ All eligible employees	Applies to: ☐ 1 ☒ 2 Waiting Period: ☐ A ☐ B ☒ C ☐ D ☐ E	☐ Immediate: notify Guardian every time an employee's salary changes ☐ Plan Anniversary: updated yearly on ***plan's*** anniversary date ☐ Other determined by employer as described here (i.e. W2) _____

Please indicate any classes to be excluded. _____
Final classes may be altered based on legal requirements or ease of administration.

Requested Class Definitions continued.

Class	Description	Waiting period: *If class specific, indicate letter and number from waiting period section*	Earnings and Benefit Redetermination

Are Retirees included? ☐ Yes ☒ No
Rates assume no retiree coverage. Coverage for retirees requires prior underwriting approval.

Coverage	Earnings Definition
Basic Life (if based on salary)	☐ Standard Excluding Bonus & Commission ☐ Standard Including Bonus ☐ Standard Including Commission ☐ Standard Including Bonus & Commission ☐ W-2 Preceding Calendar Yr. ☐ W-2 Preceding Tax Yr. ☐ Partnership/Subchapter S (Tax Year or Calendar Year) ☐ Sole Proprietorship ☐ Other_____
Optional Life (if based on salary)	☐ Standard Excluding Bonus & Commission ☐ Standard Including Bonus ☐ Standard Including Commission ☐ Standard Including Bonus & Commission ☐ W-2 Preceding Calendar Yr. ☐ W-2 Preceding Tax Yr. ☐ Partnership/Subchapter S (Tax Year or Calendar Year) ☐ Sole Proprietorship ☐ Other_____

Does the company offer coverage for Domestic Partners? ☐ Yes ☐ No
☐ children of domestic partner

Employer Contribution
Please complete this table listing the percentage of premium the employer pays.

STD	Employee	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none
LTD	Employee	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none
Basic Life	Employee	☒ Employer pays all	☐ Employer pays part ____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none
Voluntary Life	Employee	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none
Dental	Employee	☒ Employer pays all	☐ Employer pays part ____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none
Vision	Employee	☒ Employer pays all	☐ Employer pays part ____%	☐ Employer pays none
	Dependent	☐ Employer pays all	☐ Employer pays part ____%	☒ Employer pays none

What is the minimum hourly work requirement for employees to be eligible for benefits?
Minimum 30 Hours Per Week (All Classes / All Coverages)
☒ All employees work the required minimum number of hours
Explain if different by Class or Coverage_____

Please provide prior carrier information

	Insert carrier name or select 'none'		Termination Date
Dental	☒ Old Surety Life	☐ none	12/31/2012
Basic Life	☐ USable	☐ none	12/31/2012
Voluntary Life	☐	☒ none	__/__/____
Vision	☐ Old Surety	☐ none	12/31/2012
STD	☐	☒ none	__/__/____
LTD	☐	☒ none	__/__/____

Annual Open Enrollment ***(for dental, vision, and medical only)*** Check all that apply.

	Sign up period begins and ends		Change Effective	Type of open enrollment option			
	From Date	To Date	Transfer Date	Section 125	Buy-Up / Dual Choice	DHMO	None
Dental	___/___	___/___	___/___	☐	☐	☐	☐

Annual Open Enrollment ***(for dental, vision, and medical only)*** **continued.**

	Sign up period begins and ends		Change Effective	Type of open enrollment option			
	From Date	To Date	Transfer Date	Section 125	Buy-Up / Dual Choice	DHMO	None
Vision	___/___	___/___	___/___	☐	☐		☐

Billing Preferences

Guardian's standard billing method is electronic bills. You will receive e-bills for viewing and payment through our secure website www.GuardianAnytime.com. If you require a paper bill, please indicate below.

Billing frequency: ☒ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual
Payroll frequency: ☐ 12/year ☐ 24/year ☒ 26/year ☐ 48/year ☐ 52/year

Include Payroll Deduction Statements? ☒ Yes ☐ No
Bill delivery ☒ electronic (standard) ☐ paper with volumes ☐ paper without volumes
☒ Standard List Bill - alphabetically by employee
☐ Subtotal billing **Organize by (Check one):** ☐ Class
☐ Job title
☐ Department
☐ Location
☐ By these codes (Up to 4 characters):

___ ___ ___ ___ _____
___ ___ ___ ___ _____
___ ___ ___ ___ _____
___ ___ ___ ___ _____

☐ Division billing **Send bills to:** ☐ Individual Divisions
☒ Main Billing Office

NOTE: All checks must be submitted by the due date. Must have a minimum of 10 employees in each division. Any single missed payment may result in cancellation of the entire plan.

Main Billing Office/Division Name			Office/Division Contact Name
TexAmericas Center			Cyd Collins
Address (if other than page 1)			Telephone
107 Chapel Ln			903-223-9841
City	State	Zip	
New Boston	TX	75570	

☐ Self-Administered (Available for plans with over 250 covered employees.)

Would the company like to use Electronic Funds Transfer? ☐ Yes ☐ No

Delivery Preference of Plan Materials.

Administration Kit ***(select one)*****:**
☒ Mail to company ☐ Mail to insurance broker ☐ Mail to benefits advisor

ID Cards:

Electronic Member Level ID Cards or Electronic Plan Level ID Cards are available on Guardian Dental and Fully Insured Davis and VSP plans. These are accessible through our Guardian Anytime Website (www.guardiananytime.com)

Would you like Plan Level or Member Level Electronic Cards? ☐ Plan Level ☐ Member Level

☑ Electronic Cards

Claims

In case of a claim, send as follows (select one)
☐ Employee check / EOB to employee home
☐ Other_____

Master Application signed by: William V. Cork Title: Executive Director/CEO
printed name

Insurance Broker Information (Broker Use Only)

Insurance Broker Name:		License Number	
Address			
City		State	Zip Code
Tax ID Number	Guardian Broker Code	Guardian Agency	Agency Code
Fax		Phone Number	
Email			
Sub Producer:		Sub Producer Code, (if applicable):	
Sub Producer Address			
City		State	Zip Code
Fax		Phone Number	
Email			

Commissions: Split %

☐ Pay to Broker ☐ Pay to Agency

STD
- ☐ Standard M scale (for non-contributory and contributory)
- ☐ Standard Level 13% (for voluntary)
- ☐ Non-standard Percent _____%

Vol Life
- ☐ 13
- ☐ O (Net Commissions)

LTD
- ☐ Standard M scale (for non-contributory and contributory)
- ☐ Standard Level 13% (for voluntary)
- ☐ Non-standard Percent _____%

Dental
- ☐ Standard M Scale
- ☐ Percent _____%

Basic Life
- ☐ Standard M Scale
- ☐ Percent _____%

Vision
- ☐ Standard M Scale
- ☐ Percent _____%

Guardian Group Sales Use Only

Vision Access

If you have selected Vision, do you wish to also include Vision Access?

☒ Yes ☐ No

VSP Vision Plan Type G36

Tied Coverages

☐ Yes ☐ No

If yes, please indicate tied coverages and those tied to another carrier: _____

Grandfather Current Amounts

☐ Yes ☐ No

If yes, please include a copy of prior carrier bill, showing amounts to be grandfathered, and underwriter approval.

ID Cards

Your planholder cards are set up for electronic distribution (no print). If the planholder requires printed cards, please complete the information below.

*If no box is checked, we will process the card order as electronic.

Please provide details for printed cards: (Please select one: Plan level or Member level)

☐ Plan level Ship to: ☐ Company ☐ Division ☐ TPA ☐ Other_____

☐ Member level Ship to: ☐ Employee's home ☐ Company ☐ Division ☐ TPA ☐ Other_____

Were up-front printed cards already ordered by the RGO? ☐ Yes ☐ No

Split Compensation. If Split Compensation applies please complete the below.	
Rep #1	
Rep Name	
Telephone Number	Sales Rep Code
RGO Code	Percent of compensation to Rep #1
Percent of Production Credit lives & NPF for rep #1	
Rep #2	
Rep Name	
Telephone Number	Sales Rep Code
RGO Code	Percent of compensation to Rep #2
Percent of Production Credit lives & NPF for rep #2	
***Compensation and Production Credit percentage between reps should total 100%	

Remarks (Explain any non-standard benefits here)

GUARDIAN

The Guardian Life Insurance Company of America
The Guardian Insurance & Annuity Company, Inc.

☐ Midwest Regional Office
PO Box 8012
Appleton WI 54912-8012

☐ Northeast Regional Office
PO Box 26040
Lehigh Valley PA 18002-6040

☐ Western Regional Office
PO Box 2461
Spokane WA 99210-2461

Actively at Work Statement

Please complete this form and submit with the Master Application, if there are employees not active at work. **Please complete in Ink.** Erasures and changes invalidate this form.

Guardian Issues policies with an Actively at Work provision.
Employees must be Actively at Work in order to be considered eligible for coverage under this plan; exceptions require written approval by underwriting. Actively at work means an employee must be performing the normal duties of his or her occupation and working his or her regular number of hours on regularly scheduled workdays. All employees NOT Actively at Work must be reported on this statement. You may exclude employees who are off from work due to vacation.

Planholder Name (Company Name)	Group Plan No.	Proposed Effective Date

Employees who are NOT Actively at Work: The following employees will *not* be effective with Guardian on the proposed effective date unless approved by Underwriting

Name of Employee	Date of Birth	Date Last Worked	Reason for Absence	Anticipated Date to Return to Work	Insured with Prior Carrier for Life, CI, STD, LTD, ACC and/or CAN?	Indicate if claimant approved with prior carrier for waiver of premium, CI, STD, LTD, ACC and/or CAN benefits	Annual Salary
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$
					☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	☐Life ☐STD ☐LTD ☐CI ☐ACC ☐CAN	$

I hereby represent that the answers are, to the best of my knowledge and belief, full, complete and true. I understand they they will form the basis of any coverage under the Proposed Group Plan. Also, it is mutually understood and agreed that (1) the company will advise Guardian if the status on any employee(s) changes between the signature date below and the proposed effective date. (2) The rates, terms and conditions may vary if the actual data differs from data submitted. Underwriting approval is needed.

Signature of Employer X	Title	Date
Will L Cork	Executive Director / CEO	11/27/12

Please retain a photocopy for your records and submit this form to Guardian.

GUARDIAN®

Guardian Anytime Website
Pre-Registration Form & Consent to Delivery of Electronic Materials

Use this form to pre-register for the Guardian Anytime Benefits Administration Website. Pre-registration enables you to receive your first bill online and begin using the site to administer your benefits as soon as your plan information has been loaded into Guardian systems. Please include this form with the initial case submission package (enrollments, applications, etc.) If you prefer, you may register for the site yourself, once you receive your first bill.

PLAN INFORMATION

Company Name: TexAmericas Center

Group Number: _____ Effective Date: 1/1/2013

Division Number(s): ALL: ☐ Only Division Numbers: _____

PLAN ADMINISTRATOR(S) AUTHORIZED TO ADD, VIEW OR CHANGE ALL INFORMATION VIA GUARDIAN ANYTIME

Each individual pre-registered by Guardian will receive an e-mail with instructions on how to complete the registration process and access the Guardian Anytime website once your plan information is available. As part of Guardian's efforts to Go Green, billing statements will be available for viewing and, if you choose, payment through Guardian Anytime. If you require paper billing statements mailed to you, please log onto Guardian Anytime and select "Change Billing Options" under the "Billing" tab. Administrative fees for paper bills may apply. If you have questions about the pre-registration process, please call the Customer Response Unit at 800-627-4200.

Administrator(s) Names	Telephone Number(s)	Email Address(es) ~*Please print clearly*~
Cyp Collins	903-223-9841	Cyp.Collins@texamericascenter.com

GENERAL CONSENT TO ELECTRONIC DELIVERY OF PLAN MATERIALS

☒ I consent to receive all plan materials electronically

☐ I only consent to receive my company's policy and employee certificates electronically

With your consent, Guardian will make all plan materials and related documents available to you online at: www.GuardianAnytime.com

By signing below, you affirm that you are an authorized representative of the above referenced Group. Further, you acknowledge your consent to receiving electronic versions of Guardian plan materials and related documents, in lieu of paper copies, to the extent permitted by applicable law. You understand that you may change this election by providing Guardian thirty (30) days prior written notice

William V. Cork - Executive Director/CEO

Name and Title of Authorized Representative

Will V Cork

Signature, Authorized Representative