RESOLUTION NO. 20151208-02

DENTAL BENEFITS RENEWAL WITH UNUM

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

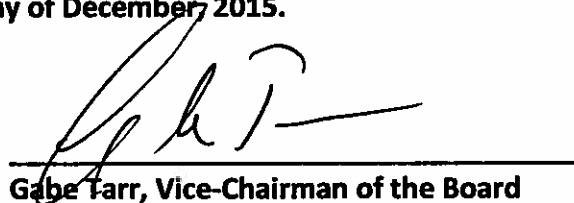
WHEREAS, TexAmericas Center adopted a Personnel Policy Manual by **Resolution # 20150922-24** on September 22, 2015; and

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

WHEREAS, UNUM has submitted a satisfactory proposal and can provide employee dental benefits starting January 1, 2016.

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

PASSED AND APPROVED THIS 8th day of December, 2015.



Gabe Farr, Vice-Chairman of the Board

ATTEST:

Boyd Sartin, Secretary-Treasurer

Attached: Employee Dental Insurance Plan Renewal

APPLICATION FOR PARTICIPATION IN THE SELECT GROUP INSURANCE TRUST
Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

To: The Trustees of The Select Group Insurance Trust and Unum Life Insurance Company of America

Name of Employer/Applicant TexAmericas Center

Address: 107 Chapel Lane

New Boston (City) Texas (State) 75570 (Zip)

requests approval to participate in the above named Group Insurance Trust and that

- ☑ Group Life Benefits
- ☐ Group Lifestyle Protection Life Benefits
- ☐ Group Universal Life Benefits
- ☑ Group Accidental Death & Dismemberment Benefits
- ☐ Group Lifestyle Protection Accidental Death & Dismemberment Benefits
- ☑ Group Short Term Disability Benefits
- ☑ Group Long Term Disability Benefits
- ☐ Group Long Term Care Benefits

be made available to its eligible employees under the terms of the Policy(ies) issued to the Trustee(s) of the Trust. The effective date of this insurance coverage is to be 01/01/2016 or such other date as the Insurance Company approves, whichever is later. If this request is approved, no insurance for which evidence of insurability is required will become effective until approved by the Insurance Company at its Home Office.

Is there any group life insurance plan in force or being applied for on some or all employees? ☑ Yes ☐ No

If yes, complete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates (mm/dd/yyyy)	Termination Dates (mm/dd/yyyy)
Active full time	$10,000	Guardian	01/01/2013	12/31/2015

By this application, the Employer/Applicant agrees and accepts the terms of the Trust Agreement for the Trust named above for so long as it elects to participate in the Trust. This includes all amendments to the Trust Agreement and any Rules and Regulations adopted by the Trustee(s) under the same Agreement.

The Employer/Applicant authorizes the Trustee(s) to act as its agent for the purposes set forth in the Trust Agreement. This includes functions relevant to the administration of Group Insurance; including but not limited to: (1) collection of premiums; (2) holding insurance policy(ies); and (3) delegation of agency to insurers. The Employer/Applicant also: (1) agrees to remit regularly the required premium payments; and (2) elects coverage as shown in the Summary of Benefits.

The Employer/Applicant acknowledges that the group policy(ies) under which insurance is provided contain(s) numerous optional provisions which are available in order to provide each employer with the ability to select provisions which meet its own needs. It is understood and agreed that only those provisions which appear in the Summary of Benefits provided to the Employer/Applicant apply to its insurance coverage.

Only approval of this request in writing by the Trustees shall permit the employer/applicant to participate in the above Trust. Insurance will become effective upon approval of the Insurance Company at its Home Office.

Signed at New Boston, TX (City and State) TexAmericas Center (Applicant)

on 12/10/2015 (mm/dd/yyyy) By: [signature] Executive Director/CEO (Signature and Title)

Producer Name: Matt Robertson (Please Print) Producer Signature: [signature]

SS# / Tax ID#: 75-2966965 State ID #: ________ Policy Effective Date: 01/01/2016 (mm/dd/yyyy)

PRODUCER INFORMATION: For Commission purposes, please list the producers for this application. Use full names, including complete business names. To ensure proper payment of commissions, include each producer's tax identification number (social security number or corporate tax id) and state identification number where applicable. If more than one producer, please be sure to specify the split %. For corporate producers, please specify the signing representative's name and ID #'s.

PLEASE PRINT ALL INFORMATION CLEARLY

	Producer Name (Please print full name)	SS# / Tax ID#	State ID# (where applicable)	Split % age (Must total 100%)	Unum Producer # (If known)
1.	Daines Insurance & Financial Svcs	75-29-66965		100%	
2.					
3.					

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

APPLICATION FOR GROUP INSURANCE
Unum Life Insurance Company of America
2211 Congress Street • Portland, Maine 04122

Name of Applicant TexAmericas Center

Address: 107 Chapel Lane
(Street)

New Boston (City) Texas (State) 75570 (Zip)

applies to the Unum Life Insurance Company of America, for:

- ☑ Group Life Benefits
- ☑ Group Accidental Death and Dismemberment Benefits
- ☐ Group Critical Illness Benefits
- ☐ Group Cancer Benefits
- ☐ Group Hospital Confinement Indemnity Benefits
- ☑ Group Short Term Disability Benefits
- ☐ Group Worksite Short Term Disability Benefits
- ☑ Group Long Term Disability Benefits
- ☐ Group Long Term Care Benefits
- ☐ Group Accident Benefits

Is there any group life insurance plan in force or being applied for on some or all employees? ☑ Yes ☐ No
If yes, complete the following or list the prior carriers:

Employee Class	Maximum Amounts	Name of Carrier	Effective Dates (mm/dd/yyyy)	Termination Dates (mm/dd/yyyy)
Active full time	$10,000	Guardian	01/01/2013	12/31/2015

If the Insurance Company approves this application, a policy will be issued. The applicant agrees that acceptance of the policy will be an approval of the policy terms. The policy specifications will be made a part of the policy along with a copy of this form.

By signing this Group Master Application, you acknowledge that you have received a copy of Unum's Disclosure Notice.

Signed at New Boston, TX (City and State) Tex Americas Center (Applicant)

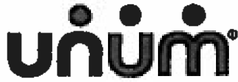
on 12/10/2015 (mm/dd/yyyy) By: [signature] Executive Director/CEO (Signature and Title)

Broker Name: Matt Robertson (Please Print) Broker Signature: [signature]

SS# / Tax ID# (last 4 digits): 75-2966965 Policy Effective Date: 01/01/2016 (mm/dd/yyyy)

Unum is a registered trademark and marketing brand of Unum Group and its insuring subsidiaries.

AE-1080 (11/14)



CLIENT INFORMATION – Existing Client
Unum Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122

Thank you for choosing Unum for your new line of insurance coverage. This information initiates Unum processing that ultimately produces your contract, employee booklets and bills. We thank you for completing this information accurately and promptly.

Company Legal Name TexAmericas Center   Policy Number 486541

Section 1: Contacts

Plan Administrator: Maria Byrd
Title: Executive Assistant
Phone: 903-223-9841
Fax: 903-223-8742
E-mail Address: maria.byrd@texamericascenter.com

Claims Contact: Same as plan administrator
Title:
Phone:
Fax:
E-mail Address:

Billing Contact: Holly Sleek
Title: Accountant
Phone: 903-223-9841
Fax: 903-223-8742
E-mail Address: holly.sleek@texamericascenter.com

DENTAL THIRD PARTY ADMINISTRATOR

Does your Company Utilize a Third Party Administrator for Cobra? ☑ Yes ☐ No

Third Party Administrator's Name: WageWorks
Third Party Administrator's Contact Name:

Email Address:
Phone Number: 1-800-488-8757

Your Third Party Administrator provides the following:

☐ Administration Only   ☑ Administration and Billing

Is the Third Party agreement provided? ☐ Yes ☑ No

Section 2: Eligibility

Description of Eligible Employees

All full time employees, working 30 or more hours per week

Are any employees excluded?	Is there anyone not actively at work?	Are any dependents disabled under Life plans?
☑ Yes ☐ No If Yes, who? Part time employees	☐ Yes ☑ No If Yes, who?	☐ Yes ☑ No If Yes, who?

Minimum Number of hours the employee must work to be covered 30 hours per week

Waiting Period: Present Employees:
Are all current employees covered as of the effective date?
☑ Yes ☐ No
If no, do they have the same waiting period as future hires?
☐ Yes ☐ No

Waiting Period: Future Employees:
1st of the month coinciding with or next following: (enter # of days or months)
30 days(s) of active employment OR
____ month(s) of active employment

The day following completion of: (enter # of days or months)
____ days(s) of active employment OR
____ month(s) of active employment

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Section 3: Type of Organization

- ☐ Regular C-Corporation (1120)
- ☐ Subchapter S-Corporation (1120S)
- ☐ Partnership (1065)
- ☐ Sole Proprietorship (Schedule C)
- ☐ Limited Liability Partnership (LLP)

Limited Liability Company (LLC) taxed as:

- ☐ C Corporation (1120)
- ☐ S Corporation (1120S)
- ☐ Partnership (1065)
- ☐ Sole Proprietorship (Schedule C)

- ☐ Trust
- ☐ School or Municipality
- ☐ Association
- ☐ Union
- ☑ Government Organization
- ☐ Non-Profit Organization
- ☐ Other (Please Specify) ____________________

Please attach a final census which includes the following:

Full Name	Date of Hire
Gender	Salary
Social Security Number	Occupation
Date of Birth	Class

Section 4: Insured Earnings Definition

- ☑ Salary Only
- ☐ Prior Year W-2
- ☐ Prior Year W-2 Without Bonuses
- ☐ Salary & Bonuses*
- ☐ Salary & Commissions
- ☐ Salary, Commissions & Bonuses
- ☐ Salary & Overtime
- ☐ Partners – Prior Year K-1
- ☐ Subchapter S Corporation
- ☐ Sole Proprietorship
- ☐ Teachers Contract (1/12th of annual contract salary)
- ☐ Teachers Contract (1/9th or 1/10th of contract salary)
- ☐ Other Insured Earnings Definition (please specify) ____________________

Owners Earnings Definition (if applicable) *(check all that apply)*

Owners included for: ☐ STD ☐ LTD ☐ Base Life ☐ Voluntary Life

Do the owners receive a W-2? .... ☐ Yes ☐ No

Do the owners receive a K-1? .... ☐ Yes ☐ No

Does the owner file a Schedule C? (Sole Proprietor) .... ☐ Yes ☐ No

Other Earnings (please specify) ____________________

Owner's total earnings should be calculated on the: ☐ Prior Year ☐ Prior 2 Year Average ☐ Prior 3 Year Average

Section 5: Contributions

- * Does your company (the employer) pay 100% of the plan premiums? please see note below ☐ Yes ☑ No

  If yes, are Owners covered under the plan? .... ☐ Yes ☐ No
- Do your employees pay 100% of the plan premiums? .... ☐ Yes ☐ No

  If yes, are the employee-paid premiums paid through a Section 125 plan? .... ☐ Yes ☐ No
- Do both the employer and the employees share the funding of the plan premiums? .... ☐ Yes ☐ No

  If yes, state the percentage of the contribution paid by the employer .... _____ %
- ***Life and/or Disability:*** Does your company (the employer) fund base plan with employee buy-ups? ☐ Yes ☑ No

  If yes, are employee-paid premiums through a Section 125 plan? .... ☐ Yes ☐ No

  If yes, state the percentage of the contribution paid by the employer: _____ % for employee coverage

  _____ % for dependent coverage
- ***Dental:*** Does your company (the employer) fund the dental plan for employees? .... ☑ Yes ☐ No

  If yes, which type of employer contributions? ☐ Dollar ☑ Percentage

  If yes, provide Dollar Amount Contribution: $________ or Percentage Amount Contribution 100 %
- ***Dental:*** Does your company (the employer) fund the dental plan for dependents? .... ☐ Yes ☑ No

  If yes, which type of employer contributions? ☐ Dollar ☐ Percentage

  If yes, provide Dollar Amount Contribution: $________ or Percentage Amount Contribution ______ %
- Is participation mandatory? .... ☑ Yes ☐ No

  If no, have participation requirements been met? .... ☑ Yes ☐ No

1. Employer pays 100% of employee only dental and 100% of group life only

Section 6: Prior Plan Information

If this Unum Plan is replacing current coverage, complete this section and attach a copy of the prior plan's contract or employee booklet.

Coverage	Effective Date	Termination Date	Prior Carrier Name
Long Term Disability	01/01/2013	12/31/2015	Guardian
Short Term Disability	01/01/2013	12/31/2015	Guardian
Life (and/or Life AD&D)	01/01/2013	12/31/2015	Guardian
Dental			

Section 7: STD

If purchasing STD, indicate if the company has employees who work in any of the following states*:

☐ New York ☐ New Jersey
☐ Hawaii ☐ California
☐ Rhode Island ☐ Puerto Rico

If yes, are these employees covered under this plan? ☐ Yes ☐ No
If yes, are these employees covered under the statutory plan? ☐ Yes ☐ No
* The states listed above have special requirements for disability coverage which your Unum contract may not satisfy.

Are any entities filed as a "Plan or Agreement"? If so, provide the DB-801 or DB-802 form as documentation for proper state filing.

Section 8 Acknowledgment

Anniversary Date for all lines of coverage (select a month)
January

Please Confirm Sold Rate(s)

STD $0.480 per $10 weekly benefit	LTD Age rated	Life VTL - Age rated CIL - $0.305 / $1,000
AD&D Included in life rate	Dependent Life $1.90 per $10,000	

Dental

Certificate Holder: $24.70 Certificate Holder and One Adult $52.48 Certificate Holder and Child(ren) $71.25

Certificate Holder and Family $99.02

Your Name Scott Norton Date 12/8/15

Signature [signature]