



**RESOLUTION NO. 20151208-03**

**LIFE AND SUPPLEMENTAL BENEFITS 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

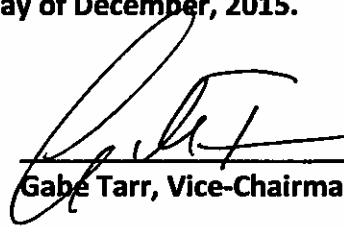
**WHEREAS**, TexAmericas Center adopted a Personnel Policy Manual by **Resolution # 20150922-24** on September 22, 2015; and

**WHEREAS**, TexAmericas Center has sought, through a competitive process, bids to provide employee life and supplemental benefits; and

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

**NOW, THEREFORE, BE IT RESOLVED** by the Board of Directors that the Board of TexAmericas Center approves the 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 8<sup>th</sup> day of December, 2015.**

  
\_\_\_\_\_  
Gabe Tarr, Vice-Chairman of the Board

**ATTEST:**

  
\_\_\_\_\_  
Boyd Sartin, Secretary-Treasurer

Attached: Life & Supplemental Benefits Plan



**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

Texas

75570

(City)

(State)

(Zip)

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

- Group Life Benefits     
  Group Accidental Death & Dismemberment Benefits     
  Group Short Term Disability Benefits  
 Group Lifestyle Protection Life Benefits     
  Group Lifestyle Protection Accidental Death & Dismemberment Benefits     
  Group Long Term Disability Benefits  
 Group Universal Life 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 TexAmericas Center  
(City and State) (Applicant)

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

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

SS# / Tax ID#: 75-294965 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.	Dalnes 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.



**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 Texas 75570  
 (City) (State) (Zip)

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

- |   |  |
|---|--|
| <input checked="" type="checkbox"/> Group Life Benefits                               | <input checked="" type="checkbox"/> Group Short Term Disability Benefits |
| <input checked="" type="checkbox"/> Group Accidental Death and Dismemberment Benefits | <input type="checkbox"/> Group Worksite Short Term Disability Benefits   |
| <input type="checkbox"/> Group Critical Illness Benefits                              | <input checked="" type="checkbox"/> Group Long Term Disability Benefits  |
| <input type="checkbox"/> Group Cancer Benefits  | <input type="checkbox"/> Group Long Term Care Benefits                   |
| <input type="checkbox"/> Group Hospital Confinement Indemnity Benefits                | <input type="checkbox"/> 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 TexAmericas Center  
 (City and State) (Applicant)

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

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

SS# / Tax ID# (last 4 digits): 75-29469105 Policy Effective Date: 01/01/2016  
 (mm/dd/yyyy)

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



**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 Marla Byrd		Title Executive Assistant
Phone 903-223-9841	Fax 903-223-8742	E-mail Address marla.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? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, who? Part time employees	Is there anyone not actively at work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, who?	Are any dependents disabled under Life plans? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, who?
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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

**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? *plans are not active*  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 with dental and 100% of group life only

