



RESOLUTION NO. 20171121-04

DENTAL BENEFITS APPLICATION WITH DENTAL SELECT

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 #20140923-20** on September 23, 2014 with a revision date of September 26, 2017 by **Resolution #20170926-21**; and

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

WHEREAS, Dental Select has submitted a satisfactory proposal and can provide employee dental benefits starting January 1, 2018.

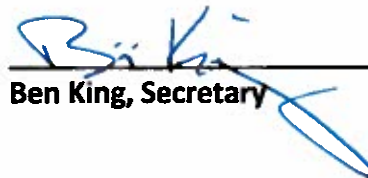
NOW, THEREFORE, BE IT RESOLVED by the Board of Directors that the Board of TexAmericas Center approves the dental benefits per the attached and the Executive Director/CEO shall be and are hereby authorized execute the attached documents.

PASSED AND APPROVED THIS 21st day of November 2017.



Boyd Sartin, Chairman of the Board

ATTEST:



Ben King, Secretary

Attached: Employee Dental Insurance Plan Application



Group Plan Application

Toll Free: 800-999-9789 Toll Free Fax: 888-998-8709 DentalSelect.com

Group Information

Group Name TexAmericas		Billing Address SAME AS MAILING	
Employer EIN 75-2804233	Requested Effective Date 01/01/2017	City	State Zip Code
Mailing Address 107 CHAPEL LANE		HR Contact & Title MARLA BYRD	
City NEW BOSTON	State TX	Zip Code 75570	Phone # 903-223-9841
Phone # 903-223-9841	Fax # 903-223-8742	Email marla.byrd@texamericascenter.com	
Nature of Business GOVERNMENT		Billing Contact & Title SAME AS ABOVE	
SIC Code or Industry 6512		Phone #	Email

Design Your Plan

Select Preferred Enrollment

Electronic Enrollment (834 File Format) For groups 50+ enrolled.
 Spreadsheet (Dental Select authorized form only)
 Paper Forms

Dental Only
 Dental & Vision
 Vision Only

Dental Plan Options - Utah & Texas Only

Funding: Contributory Plan Voluntary Plan
 Type: Classic Choice

Dental Plan: Discount - Silver Network* Co-Insurance PPO** EHB Child Only
 Network:** Gold Platinum

Co-Pay Co-Insurance Indemnity Certified Plans† Signature

AD&D Plan Option: Employee Employee & Family Contributory - Amount \$ _____ Voluntary

Beneficiary Designation Required - (Additional form available with Employee Enrollment) Principal Sums range from \$10,000 to \$250,000. Refer to plan flyer for specifications.

Dental Plan Options - All Other States

Funding: Contributory Plan Voluntary Plan
 Type: Choice

Dental Plan: Co-Insurance PPO/MAC Co-Insurance Passive PPO
 Network: Network availability listed by state in the Participation Guidelines.

Select a Vision Plan - All States

Funding: Contributory Plan Voluntary Plan

Plan: Vis 6z Vis 7z Vis 8z Other _____

Sold Rates - Based on plan design, complete rates below

	#1 DENTAL Sold Rates	#2 Sold Rates	#3 Sold Rates	Vision Sold Rates	AD&D Sold Rates
Single:	<u>23.82</u>	_____	_____	_____	_____
Employee/Spouse or EID:	<u>53.54</u>	_____	_____	_____	_____
Employee/Child(ren):	<u>63.36</u>	_____	_____	_____	_____
Family:	<u>89.73</u>	_____	_____	_____	_____
Child Only 1:	_____	_____	_____	_____	_____
Child Only 2:	_____	_____	_____	_____	_____
Child Only 3+:	_____	_____	_____	_____	_____
Monthly Administration Fee: \$	N/A				
(\$2.00 per employee; maximum \$20.00)					

First month's premium must be included with application.

*Discount plan is not underwritten by ACE Property and Casualty Insurance Company

** Where permitted by law

† Additional certified plan selection form required.



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Design Your Plan - (Continued)

General Participation

Number of Full Time (at least 30 hr. per week) Employees: 11 Number of Dental Employees Enrolling: 10 Number Waiving Due to Other Dental Coverage: 1
 Employer Contribution Percentage for Employees: 0 % Employer Contribution Percentage for Dependent: 0 % Number of Vision Employees Enrolling: _____

New Hire Waiting Periods

Employees will be eligible to enroll the first of the month following the required days of continuous full time employment with the group. Present employees who are eligible must enroll on the policy effective date, or within 31 days of group effective date. New employees must enroll within 31 days of the date they become eligible. (Please complete Employee Category below)

Employee Category

How long must a new hire be employed before being offered benefits? Benefits are available the first day of the month following:

- Date of Hire Exact date of hire
 30 Days Waive at initial enrollment only
 60 Days Other: _____
 90 Days

Is the new hire waiting period different for any class of Employees (i.e. hourly/salary/management/non-management)? If yes, please identify below. Minimum of 2 per class.

Class:	New Hire Waiting Period Days:
_____	_____
_____	_____
_____	_____
_____	_____

Comparable Dental Plans

Does the Group now have a comparable dental plan which has been in force for the past 12 consecutive months?

Yes No

If Yes:

Name of carrier: UNUM Length of coverage: 2+ YEARS

Waiting Period Waiver

Waiting Periods Orthodontic

Waiting Periods Waived for Prior Comparable Coverage:

With proof of coverage and Member's effective dates from the employer's prior dental carrier, the employee's waiting period, if any, will be reduced by the number of months the employee was covered by the prior plan. Proof of prior comparable coverage must accompany the application in order to reduce waiting periods.

The waiting periods for Basic, Major and Orthodontic services may be waived (in part or in their entirety) only for those Employees and Dependents covered on the Group's prior comparable plan.

To qualify for a waiver, the following documentation must accompany this application:

- Prior carrier's Summary of Benefits
- Most recent Billing Statement, listing the covered employees eligibility date

Take-over Provisions

Maximums & Deductibles

When take-over applies, both the maximum and deductible will be reviewed for take-over together. To qualify for a take-over, the following documentation must accompany this application:

- The total and any amount applied, per member for both maximum and deductibles

Terms & Conditions

By signing on the next page, company officer or authorized person:

- understands that the In-Network plan providers are not agents, representatives, nor employees of Dental Select.
- represents that all information on this application and any attachment is correct and complete to the best of his/her knowledge and belief.
- understands that no insurance will become effective until approved by the Insurance Company.
- understands that no agent has the authority to modify or waive any conditions of this application or the policy nor to bind the insurance company by making any promise of representation.
- agrees to maintain and furnish any records necessary to administer the policy.
- understands that only those employees who meet eligibility requirements are to be covered under the policy and that participation requirements must be met before the policy will become effective and that such requirements must be maintained while the policy is in force to prevent termination of the policy.
- understands that coverage under the policy can be terminated in accordance with its terms and conditions.
- understands that the employer is the plan sponsor and plan administrator and that neither Dental Select or ACE Property and Casualty Insurance Company, nor any insurance agent is a plan administrator nor fiduciary, as those terms are defined under the Employee Retirement Income Security Act of 1974 (ERISA) with respect to participating employer's plan of groups insurance, and the questions regarding the tax or legal effects of the plan are to be resolved by the employer with advice of their own counsel.

(Continued on next page)



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Terms & Conditions (continued)

(Continued from previous page)

The applicant hereby requests insurance for eligible persons based on the above statements and representations, and where applicable, agrees to be bound by the terms and conditions of any trust agreement establishing a trustee as policyholder. Insurance will not go into effect until the required premium is paid for the plan of benefits selected by the Applicant.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF FRAUDULATING 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.

Fraud Warning for Kentucky Applicants:

WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE 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.


Signature - Company Officer or Authorized Person

Scott Norton
Printed Name

11/21/17
Date

AH-38026

How To Submit Your Information

The first month's premium must accompany the application. Thereafter, Dental Select must receive the premium by the first day of each month to the P.O. Box address listed in the administrative guide.

1. Complete group plan application. Retain a copy for your files.
2. Have each employee complete and sign an employee enrollment form.
3. Submit electronic enrollment (834 file format) for groups 50+ employees enrolled (ongoing).
4. Send the original group plan application, completed employee enrollment forms and the first month of premium payable to Dental Select to:

Dental Select
5373 South Green Street, 4th Floor
Salt Lake City, UT 84123
Toll Free Fax: 888-998-8704

Please Select Payment Option:

- EFT Electronic Funds Transfer -- Groups must enroll for recurring EFT on Web Portal.
Initial premium MUST be submitted as a Binder Check.
- Monthly BILLING Invoice

Any questions? Call 800-999-9789.

Agent / Broker Information

Agent Name	MATT ROBERTSON		Email	MPRITCHETT@DAINESINSURANCE.COM			
Agency Name	DAINES INSURANCE		Agent Phone #	903793-3034			
GA (if applicable)			Agent ID #				
Agent Signature			Date				
Agent Address	5806 SUMMERFIELD DRIVE	City	TEXARKANA	State	TX	Zip Code	75503

NOTE: Please make a copy of this form for your records before submitting.

Dental Select Office Use Only

Approved by	Date Approved	Title			
Effective Date	Group #	Subgroup #			



5373 South Green St. 4th Floor
Salt Lake City, UT 84123
801-495-3000 800-999-9789
Fax 888-998-8709



ACE USA is the U.S. domestic operating division of ACE Limited. Insurance products and services are provided by the U.S. insurance underwriting companies and not by ACE Limited. This plan of insurance is underwritten by ACE American Insurance Company.

ace usa



Portal User Account Request

TOLL FREE PHONE: 800-999-9789 TOLL FREE FAX: 888-673-5328 DENTALSELECT.COM

User Type	
<input checked="" type="checkbox"/> Group	<input type="checkbox"/> Member
<input checked="" type="checkbox"/> Agent/Broker (If the user type is Agent/Broker, you MUST attach the group's authorization email.)	

Administrator Information	
Group Name:	TEXAMERICAS
Group Number:	
SE for Group:	
Group Type:	<input checked="" type="checkbox"/> Fully - Insured <input type="checkbox"/> Self - Funded*

User Information	
User First Name:	MARLA
User Last Name:	BYRD
Is this proposed user a Dental Select member? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
User's Date of Birth:	9/28/1959
User Email Address:	marla.byrd@texamericascenter.com

* Special Notes or Exceptions: