Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

EMPLOYER APPLICATION
Blues Enroll

Renewal APPLICATION by CITY OF JONESBORO ARKANSAS
(hereinafter called "Policyholder")

For a Group Policy covering the employees of the Policyholder and the eligible dependents of such employees. The Policyholder intends hereby to establish and maintain an employee benefit plan (the "Plan") for the Policyholder's employees and eligible dependents, to contribute to the cost of the Plan, and to actively promote the Plan to the Policyholder's employees.

GROUP INFORMATION

Legal Name Of Business: CITY OF JONESBORO ARKANSAS
D/B/A : CITY OF JONESBORO ARKANSAS
Street Address: 515 W WASHIGTON
City,State,Zip: Jonesboro,AR,72401 | County :Craighead
Mailing Address : (if different from street) P O BOX 1845
City,State,Zip: Jonesboro,AR,72403
Telephone # - 870-933-4640
Fax # -
Fed. Tax I.D # 71-6013749

Exec. Contact :HAROLD PERRIN	E-Mail : HPERRIN@JONESBORO.ORG
Group Administrator : REBEKAH RODDY	E-Mail : RRODDY@JONESBORO.ORG
Primary SIC Code : 9199	SIC Description:General Government, NEC
Business Type : Government	
Agent :	Agent's Lic # :
Agent's Company :	Agent's Tax ID :

POLICYHOLDER AS PLAN ADMINISTRATOR

The Policyholder, as Plan Administrator, assumes responsibility for the accuracy of information presented to Arkansas Blue Cross and Blue Shield ("ABCBS"), including all information on the employment status and eligibility of individuals to be covered under the Plan, as well as medical information provided with respect to each such individual.The Policyholder agrees that if misrepresentations are made in any of the information provided for rating or in this Group Application or any of the materials submitted with it, including, but not limited to, individual applications and medical information, then ABCBS may cancel or rescind this Group Policy. The Policyholder further agrees that if misrepresentations or false or misleading information is presented in filing of any claims hereunder ("improper claims"), ABCBS may cancel or rescind the coverage of any individual involved in presenting such a claim. Further, ABCBS may cancel or rescind the entire Group Policy if the Policyholder or any representative of the Policyholder knew or should have known of the improper claims, or if the Policyholder's action or inaction contributed to presentation of improper claims.

COBRA ADMINISTRATION

COBRA - Group vision plans for employers with 20 or more employees on more than 50% of the business days in the previous calendar year are subject to Cobra. Employers are required to provide qualified beneficiaries an election period during which the beneficiary can elect to continue coverage under the guidelines.We offer the services of a vendor, "WageWorks", to assist you in administering Cobra (no additional cost).Both full time and part time employees are counted to determine if a plan is subject to Cobra.Each part-time employee counts as a fraction of an employee, with the fraction equal to the number of hours worked divided by the number of hours used to determine full time status.

(Yes✓) (No__)As an employer, are you currently obligated by law to comply with COBRA?

(Yes✓)(No__) Do you want to use the services of WageWorks?

(Yes__)(No✓) If yes, are you currently contracting directly with WageWorks?

BENEFIT SELECTION

VOLUNTARY VISION VOLUNTARY VSP CHOICE PLAN GOLD

Customized Plan : No

Requested Effective Date,Pending approval is : 01/01/2017

Waiting Period Note :Effective Date is the first day of the month following the Waiting Period.

Date of Open Enrollment: December

If a month is not specified, the Group's open enrollment will be the month prior to the Group's renewal date.

Class	Class Description	Waiting Period	Contribution	
1	ALL FULL TIME EMPLOYEES	1 Month	Employee 0% Dependent 0%	
2	RETIREES	0 Days	Employee 0% Dependent 0%	

Note: *Employer contribution is 0% to 49%.*

Eye Health Examination inclusive of Dialation: 12 Months

Spectacle Lens: 12 Months | **Frames:** 24 Months

Contact Lens Evaluation,Fitting & Follow-up Care: 12 Months

Contact Lens(in lieu of eyeglasses): 12 Months

Eye Health Examination Copayment: $10 | **Spectacle Lens Copayment:** $20

Contact Lens Evaluation, Fitting & Follow-Up Care Copayment: 15% discount/$60 max

Elective Contact Lenses :$150

Out-Of-Network Coverage

Eye Examination: Once every 12 Months, $45 | **Frames:** Once every 24 Months, $70

Spectacle Lens:

Single Vision Lens: Once every 12 Months , $30 | **Bifocal/Progressive Lens:** Once every 12 Months, $50

Trifocal Lens: Once every 12 Months, $65 | **Lenticular Lens:** Once every 12 Months, $100

Elective Contact Lens: Once every 12 Months, $105

Medically Necessary Contact Lens(with prior approval): $210

Minimum Participation Requirements and Minimum Number of Insured Employees: This policy may be terminated by the Company if the number of insured Employees falls below five (5) insured Employees.

RATES - VOLUNTARY VSP CHOICE PLAN GOLD

Two Tier Composite	Total Premium
Employee	$9.00
Family	$21.06

If there is an agent or broker involved in this coverage transaction they may receive compensation from Arkansas Blue Cross and Blue Shield, or one of its affiliates, for his or her services related to the placement of this coverage. Any such compensation is included in the premium paid by the covered person. For more information on the compensation involved in this transaction, please direct your inquiry to the agent or broker.

EMPLOYEE INFORMATION
MINIMUM NUMBER OF INSURED EMPLOYEES & MINIMUM PARTICIPATION REQUIREMENTS

Full-Time= means an active employee with a minimum of 30 hrs/week & 48 weeks/year.

	In State	Out Of State	Total
Full-Time Employees enrolling (including those satisfying their waiting period within 3 months after the effective date):			
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):			
COBRA Continuees (Enrolling):			
Total Enrolling and Waiving:			
Part Time/Seasonal/Temporary Employees :			
Total # of Employees:			

This Policy may be terminated by the Company if the number of insured Employees falls below the minimum number of insured Employees specified above or if the percentage of eligible Employees of the Policyholder covered by the Policy becomes less than the percentage of Employee participation specified above.

PROXY

"The Policyholder hereby appoints the Board of Directors ("Board") of Arkansas Blue Cross and Blue Shield ("ABCBS"), as its proxy to act on its behalf at all meetings of members of ABCBS. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for the Policyholder on all matters that may be voted upon at any meeting.The annual meeting of Members is held each year at the home office of ABCBS located at 601 S. Gaines Street, Little Rock, Arkansas, on the third Monday of March, at 1:00 p.m. If the third Monday of March is a legal holiday, then the meeting will be at the same time and place on the next day after, which is not a legal holiday. A special meeting may be called upon notice mailed not less than ten (10) or more than sixty (60) days prior to such meeting.This proxy, unless revoked, shall remain in effect during the Policyholder's membership in ABCBS. The Policyholder may revoke this proxy in writing by advising ABCBS, attention Legal Division, of such at least five (5) days prior to any meeting. The Policyholder may also revoke its proxy by attending and voting in person at any Member's meeting."

SIGNATURES

This Application is made and delivered in the State of Arkansas and is governed by the laws of Arkansas and the United States of America. This Application is incorporated in and made a part of the Group Policy and Benefit Certificate.

I hereby renew the above referenced coverage and agree the group insurance, subject to the terms and conditions of the policies renewed, will take effect as of the renewal date, provided this application is approved and the premium is received by the home office of Arkansas Blue Cross and Blue Shield. **I also understand that my signature below represents my agreement and acceptance of the premium rate schedule**.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in connection with an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

1. Policyholder

Signed at _____, this _____ day of _____ 20___
(City, State)

_____ [full legal name of Policyholder]

By: _____ _____
Authorized Signature Printed Name

_____
Title or Position

2. Agent

I hereby certify that all of the information contained in this employer application is correct to the best of my knowledge, and I know nothing unfavorable about this firm or any individual proposed for coverage (except as noted on the employee applications). I have complied with the underwriting rules and regulations and have explained in detail the coverage to the member firm and its employees including the preexisting condition limitations and the qualifications of the effective date provisions. I understand that Arkansas Blue Cross and Blue Shield will have no liability until this application has been approved and the premium is received.

✓ I will provide the applicant with a signed copy of this application.

_____ I have emailed the applicant a signed copy of this application.

_____ #23908
Agent Signature Insurance License # / Agency Fed. TaxID #

David C. Ferguson 11-2-2016
Agent Printed Name Date