



BlueCross BlueShield of Texas

Request for Group Coverage

GENERAL INFORMATION

Legal Account Name: American YouthWorks Account Number:
Primary Address: 216 E. 4th Street, Austin, TX, 78701
Physical Address, if Different from Primary: n/a
Primary Contact: Lynn Wilson Title: Senior Director of HR
Telephone Number: 512-236-6102 Fax Number: 512-236-6917 \*Email Address: lwilson@americanyouthworks.org
Billing Address: 216 E. 4th Street, Austin, TX, 78701
Billing Contact: Eliza Montana Title: Benefits Administrator
Telephone Number: 512-236-6148 Fax Number: 512-236-6917 \*Email Address: emontana@americanyouthworks.org
\*\*BAE Contact: Lynn Wilson Title: Senior Director of HR
Telephone Number: 512-236-6102 Fax Number: 512-236-6917 \*Email Address: lwilson@americanyouthworks.org
BAE Contact Address, if Different from Primary: n/a
Nature of Business: Alternate School SIC Code:
Is the Account Subject to ERISA? [X] Yes [ ] No If Yes, ERISA Plan Year: 05/01/2009 MM/DD/YYYY
Employer Identification Number (EIN): 74-2197942

\*Required fields for Electronic Issuance of Non-HMO Health and/or Dental Certificate Booklet(s)
\*\*BAE Contact must be an employee of the account. This individual will be the Delegated Administrator/Security Manger on BAE. Appropriately identifying the BAE Contact will allow the him/her to utilize the BAE on-line registration process for quicker access to the Employer's BAE Account.

ACCOUNT SET-UP INFORMATION

Requested Effective Date: 05/01/2009
Coverage Requested: [X] Health Plan Selected MH3, M26 and M06 [ ] Dental Plan Selected
[X] Prescription Drug Card [ ] Life & Disability (attach separate FDL application)
Network Selected: [X] BlueChoice® [ ] BlueChoice Solutions®
Associated Affiliate Companies to be Included:
Name of Company: Location: Number of Employees: Subsidiary or Affiliate?
n/a

If any employee locations outside of Texas, please specify the locations and the number of employees in each:
n/a

Billing Format: [X] Employees Listed Alphabetically [ ] Employees Listed by Location
If by location, list locations (including location numbers if applicable): n/a

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ID Cards Mailed To:  Participants' Homes  Account

Account Name: American YouthWorks

Account Number: \_\_\_\_\_

**HEALTH ELIGIBILITY INFORMATION**

Total Number of Eligible Employees on Payroll 75

Total Number of Employees on Approved Company Absence 0

Are any individuals currently covered under COBRA?  Yes  No

If Yes, please provide names, original COBRA effective dates and event types (e. g., termination, divorce, dependent age limit):

Kim Bookman, Cobra start 3/1/09, Cobra End 8/31/10, Layoff

Kelly Burnett, Cobra start 5/1/08, Cobra End 4/30/2011, Dependent No Longer Eligible

Julianna Crighton, Cobra start 12/1/07, Cobra end 5/31/09, Termination

Elaine Kistner, Cobra start 2/1/09, Cobra end 7/31/2010, Termination

Are retirees presently eligible?  Yes  No If yes, please indicate appropriate coverage:  Health  Dental

Are part-time employees eligible?  Yes  No

Total Number of Employees Serving New Hire Eligibility Period: 0

Total Number of Employees with Other Coverage (e.g., other group coverage, Medicare, Medicaid, Champus): \_\_\_\_\_

Are domestic partners considered eligible dependents under your company policy?  Yes  No

If Yes, are domestic partners eligible to continue coverage under COBRA?  Yes  No

Are any classes of employees to be excluded from coverage?  Yes  No

If yes, please identify the classes and describe the exclusion: \_\_\_\_\_

**ELIGIBILITY and WAITING PERIOD INFORMATION**

New Hire Eligibility Period:  30 Days  60 Days  90 Days  Other: \_\_\_\_\_

Is this requirement to be waived upon initial group enrollment?  Yes  No

Coverage Effective Date:  Coverage is effective the first of the month following the date eligibility is met  
 Coverage is effective the date eligibility is met

Coverage Termination Date:  Coverage ends on the last day of the month

**ACCOUNT EXPERIENCE**

Please answer the below questions to the best of your knowledge:

**NOTE: "Participant" means all Eligible Employees, Dependents, Retirees and COBRA Continuants**

Questions A & B: use \$10,000 for 51-100 employees or \$20,000 for 100 or more employees

A. Has any Participant received more than \$ 10,000 in medical benefits during the last 12 months?  Yes  No

B. Is any Participant expected to have claims in excess of \$ 10,000 during the next 12 months?  Yes  No

C. Is any Participant mentally or physically handicapped or disabled or not actively at work?  Yes  No

D. Has any Participant been diagnosed as having a high risk condition?  Yes  No

If any question is answered "yes," details *must* be provided below:

Participant Age	Diagnosis or Nature of the Disorder	Dates of Treatment	\$ Amount of Claims	Prognosis/Current Treatment
52	Neoplasms	06/08	116,676	

Account Name:

American YouthWorks

Account Number:

**EMPLOYER CONTRIBUTION INFORMATION**

The percentage of premium to be paid by the employer is:

Employee Health 100% % Dependent Health 0 % Other, describe: For Plan I Only

**AGENT OF RECORD INFORMATION**

1. \*Agent(s) or Agency(ies) to whom commissions are to be paid: Gallagher Benefit Services, Inc.

Tax ID Number (TIN) of  Agent or  Agency 36-4291971 Producer #:

Agency Address: Street: 221 W. 6<sup>th</sup> Street, # 1980 City: Austin Zip: 78701

Phone: 512.499.8005 Fax: 512.499.0412 Email: bruce\_romine@ajg.com

Is Agent/Agency appointed with BCBSTX?  Yes  No General Agent?  Yes  No

Affiliated with General Agent?  Yes  No

2. \*Agent(s) Agency(ies)\*\* to whom commissions are to be paid: n/a

Tax ID Number (TIN) of  Agent or  Agency \_\_\_\_\_ Producer #:

Agency Address: Street: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

Is Agent/Agency appointed with BCBSTX?  Yes  No General Agent?  Yes  No

Affiliated with General Agent?  Yes  No

If commission split, designate percentage for each agent/agency **Agent/Agency 1: 100** **Agent/Agency 2: 0**

Note: total commissions paid must equal 100%

3. **Multiple Location Agency(ies):** If servicing agency is not listed above as Item 1 or 2, specify location below:

\_\_\_\_\_

\* The agent or agency name(s) above to whom commissions are to be paid must exactly match the name(s) on the appointment application(s).

\*\* If commissions are split, please provide the information requested above on both agents or agencies. BOTH must be appointed to do business with BCBSTX.

**AGENT/BROKER'S STATEMENT**

I certify that I have reviewed all enrollment materials. I have also advised the Employer that I have no authority to bind these coverages, to alter the terms of the Contract(s)/Policy(ies), this Request for Coverage or enrollment material in any manner or to adjust any claims for benefits under the Contract(s)/Policy(ies).

Account Name: American YouthWorks

Account Number: \_\_\_\_\_

**I UNDERSTAND AND AGREE THAT:**

1. The proposed rates were developed based on the information supplied and the conditions stated. The final rates may vary in the event of any changes in the information or based on the actual enrollment results. The coverage and the effective date to be assigned are subject to final approval by Blue Cross and Blue Shield of Texas (BCBSTX) at its home office in Richardson, Texas. Notice of final approval and acceptance of the group and rates will be given in writing to the group by BCBSTX.
- 1a. Question 1a. to be Completed by Authorized Blue Cross and Blue Shield Representative:  
Quoted Rates will be effective for 12 months subject to contract provisions and minimum enrollment of 63 employees
2. Effective 05/01/2009, the above-named agent(s) or agency(ies) is/are recognized as Employer's Agent of Record (AOR), to act as representative in negotiations with and to receive commissions from Blue Cross and Blue Shield of Texas, a division of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company, and HCSC subsidiaries for our employee benefit programs. This statement rescinds any and all previous Agent of Record appointments for this company. This appointment will remain in effect until withdrawn or superseded in writing by our company.
3. The information given on this application is complete and accurate to the best of my knowledge. If this information is incomplete or inaccurate, BCBSTX may re-rate the plan, withdraw the proposal or cancel the contract.
4. Payment of the advance premium being submitted with this Request, completion of the enrollment forms and distribution of enrollment materials and literature do not alter statements 1. and 2., above, in any respect. Receipt by BCBSTX of the advance premium and completed enrollment forms does not constitute approval and acceptance by the BCBSTX home office.
5. Current group coverage options will be kept open until BCBSTX has at its home office in Richardson, Texas, approved this Request and written notification of approval and acceptance from my BCBSTX Representative has been received. In the event of approval and acceptance by BCBSTX, it will be my responsibility to coordinate with my current carrier if I decide to terminate my present group coverage and when to give notice of termination.
6. BCBSTX will report the value of all remuneration by BCBSTX to ERISA plans with 100 or more participants for use in preparation of ERISA Form 5500 schedules. Reporting will also be provided upon request to non-ERISA plans or plans with fewer than 100 participants. Reporting will include base commissions, bonuses, incentives, or other forms of remuneration for which your agent/consultant is eligible for the sale or renewal of insured products.
7. Notwithstanding anything to the contrary in this document, with respect to employer's employees who live in Massachusetts (if any) employer represents that it offers the health insurance benefits provided for herein to all full-time employees, and employer will not make a smaller premium contribution percentage to a full-time employee living in Massachusetts than to any other full-time employee living in Massachusetts who receive an equal or greater total hourly or annual salary. For purposes of this representation, a "full-time employee" is defined by Massachusetts law, generally an employee who is scheduled or expected to work at least the equivalent of an average of 35 hours per week.
8. **(Non-HMO Health and Dental Plans only)** The Certificate Booklet(s) provided by HCSC to me for delivery to each Insured will be received via an electronic file or access to an electronic file. I further agree that I am solely responsible for providing each Insured access, via the internet, intranet or otherwise, to the most current version of any electronic file provided by HCSC to me and, upon the Insured's request, a paper copy of the Certificate Booklet.  No, I Do Not Agree

Group Executive Name and Title Lynn Wilson, Senior Director of Human Resources

(Please print or type)

Group Executive's Signature Lynn P. Wilson Date 4/13/09

Acknowledged by: \_\_\_\_\_ 36-4291971  Yes  No  
Agent of Record Tax ID (TIN) Date Appointed with BCBSTX

Acknowledged by: \_\_\_\_\_  
Authorized Blue Cross and Blue Shield of Texas Representative R/D/T Date

TEXAS PROXY

Blue Cross and Blue Shield of Texas is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company. This means that policyholders are members of the corporation and mutually or in common have voting rights at all meetings of members on important issues such as the election of the Board of Directors. The "Reserve" part of the name refers to the financial reserves of the company, which help assure policyholders that the company has the ability to pay their claims. Health Care Service Corporation has reserves of more than \$1.2 billion, making us one of strongest health insurance companies in the nation.

As a Blue Cross and Blue Shield of Texas account, your company is now considered a policyholder of Health Care Service Corporation. The Proxy form on the bottom half of this page authorizes the Board of Directors of Health Care Service Corporation to act on your behalf, as a *policyholder*, at meetings. **Please complete the Proxy form below, sign and date it and return it with your Request for Group Coverage.**

*Blue Cross and Blue Shield of Texas is a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and an Independent Licensee of the Blue Cross and Blue Shield Association.*

PROXY

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the members not less than 30 nor more than 60 days prior to such meetings.

This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Group Number: TBD

By: Lynn R. Wilson  
Print Signer's Name Here

→ Lynn R. Wilson / Senior Director  
Signature and Title / of HR

Group Name & Address:

American YouthWorks

216 E. 4<sup>th</sup> Street

Austin, TX 78701

Dated this 13<sup>th</sup> day of April, 2009