



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

**DENTAL EMPLOYER APPLICATION**  
Blues Enroll

Renewal APPLICATION by: CITY OF CONWAY	
(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.	
<b>GROUP INFORMATION</b>	
Legal Name of Business: CITY OF CONWAY	
D/B/A: CITY OF CONWAY	
Street Address: 1201 OAK ST	
City, State, Zip: Conway , AR , 72032	County: Faulkner
Mailing Address: (if different from Street) 1201 OAK STREET	
City, State, Zip: Conway , AR , 72032	
Telephone #: 501-450-7087	
Fax #: 501-513-3505 <b>3</b>	
Fed. Tax I.D #: 71-6001898	
Exec. Contact:	E-Mail:
Group Administrator: TAB TOWNSELL	E-Mail:
Primary SIC Code: 9111	SIC Description: Executive Offices
Business Type: N/A	
Agent:	Agent's Lic #:
Agent's Company:	Agent's Tax Id:
<b>POLICYHOLDER AS PLAN ADMINISTRATOR</b>	
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.	
<b>COBRA ADMINISTRATION</b>	
Our records indicate you are subject to the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, commonly known as COBRA. Your COBRA Administrator is Ceridian	
The Policyholder agrees to indemnify ABCBS for any damage, claim or loss ABCBS may suffer by any action, litigation, suit, or claim brought by any individual arising out of the Policyholder's failure or Policyholder's COBRA administrator's failure to perform duties under COBRA	

BENEFIT SELECTION			
<b>DENTAL BLUE PLAN: Stand Alone - Dental Blue Plan IV-E - 1</b>			
<b>REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2011</b>			
<b>Waiting Period Note:</b> Effective Date is first of the month following the Waiting Period.			
Date of Open Enrollment <b>December</b> <i>If a month is not specified, the Group's Open Enrollment will be the month prior to the Group's renewal date.</i>			
Class	Class Description	Waiting Period	Contribution
3	Low Option	1 Month	Employee 79 %    Dependent 71 %
4	High Option	1 Month	Employee 70 %    Dependent 64 %
Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.			
<b>Maximum Dependent Age 26</b>			
<b>Deductible: \$50</b>			
<b>Annual Maximum: \$1000</b>			
<b>Diagnostic &amp; Preventive Services: 100%</b>		<b>Basic Services: 80%</b>	
<b>Major Services: 50%</b>		<b>Orthodontic Service: 50%</b>	
<b>Orthodontic Lifetime Maximum: \$1000</b>			
<b>Optional Benefit: Posterior Resins:    No</b>			
<b>Basic Services Waiting Period: None</b>		<b>Major Services Waiting Period: None</b>	

RATES - Dental Blue Plan IV-E - 1	
<b>Four Tier Composite</b>	<b>Total Premium</b>
Employee	\$22.40
Employee & Spouse	\$46.30
Employee & Child(ren)	\$54.70
Family	\$66.90
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.	

**BENEFIT SELECTION****DENTAL BLUE PLAN: Stand Alone - Dental Blue Plan IV-C - 1****REQUESTED EFFECTIVE DATE, PENDING APPROVAL IS: 1/1/2011****Waiting Period Note:** Effective Date is first 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	
3	Low Option	1 Month	Employee 79 %	Dependent 71 %
4	High Option	1 Month	Employee 70 %	Dependent 64 %

*Note: The Employer must pay a minimum of 50% of the Employee premium. This Policy may be terminated by the company if the Policyholder fails to contribute the percentage or fixed amount of Employees' premium specified above.*

**Maximum Dependent Age 26****Deductible: \$25****Annual Maximum: \$1500****Diagnostic & Preventive Services: 100%****Basic Services: 80%****Major Services: 50%****Orthodontic Service: 50%****Orthodontic Lifetime Maximum: \$1000****Optional Benefit: Posterior Resins: No****Basic Services Waiting Period: None****Major Services Waiting Period: None****RATES - Dental Blue Plan IV-C - 1**

Four Tier Composite	Total Premium
Employee	\$24.90
Employee & Spouse	\$51.30
Employee & Child(ren)	\$60.90
Family	\$74.40

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):	438		438
Full-Time Employees waiving (including those satisfying their waiting period within 3 months after the effective date):	24	0	24
COBRA Continuees (Enrolling):			2
Total Enrolling and Waiving:			464
Part Time/Seasonal/Temporary Employees :			26
Total # of Employees:			490

**Minimum Number of Insured Employees.** To meet large group enrollment guidelines a group must have at least fifty-one full-time enrolled employees. Groups whose enrollment subsequently drops below fifty-one enrolled must be rated as a small group upon renewal.

**Minimum Participation Requirements.** If an employer pays 100% of the employee-only premium, 100% of all full-time employees must be insured. If an employer pays less than 100% of the premium, employees covered through other dental coverage may be waived from the eligibility count. 75% of all eligible employees without waivers must be insured, and no less than 50% of the full-time employees must enroll.

**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 CONWAY, ARKANSAS, this 28<sup>th</sup> day of DECEMBER 2010  
(City, State)

[full legal name of Policyholder]

By: *Tab Townsell*  
Authorized Signature

TAB TOWNSELL  
Printed Name

MAYOR, CITY OF CONWAY  
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.

*Bentley Pew*  
Agent Signature

C20/320  
Insurance License # / Agency Fed. Tax ID #

James Bentley Pew  
Agent Printed Name

1/4/11  
Date