Application Checklist

Name:_____ D.O.H_____

Branch Name:_____ NMLS #:_____

Email Address:_____

1. New Hire Authorization Form:_____
2. System Access Request Form:_____
3. Application:_____
4. W-4:_____
5. I-9:_____
6. 2 forms of government issued ID (see pg 3 of I-9):_____
7. Criminal History/Credit Report Authorization:_____
8. Loan Fraud Prevention Policy:_____
9. Wage Deduction Authorization Form:_____
10. Employee Policy Manual Acknowledgement:_____
11. Special Notice - HUD:_____
12. 2012/2012 Medical Benefits Summary:_____
13. 2012/2012 Dental Benefits Summary:_____
14. Medical Enrollment/Declination Form(if enrolling):_____
15. NMLS Compliance Notice (**LO Only**):_____
16. Loan Officer Compensation Agreement (**LO Only**):_____

HR Only	
NMLS appr.	
AccuPro	
HUD LDP / ASA EPLS	
SARMA	
PR	
IT	
Marketing	
LORS	
Contacts	
Welcome Email	
AGO	

EMPLOYEE REQUISITION FORM / NEW HIRE AUTHORIZATION

Request Date: _____
Proposed Start Date: _____
Job Title: _____
If employee identified, Employee Name: _____
Hiring Manager: _____
Cost Center/Branch: _____

Is this position replacing a current position? ☐ Yes ☐ No
If new position for branch/cost center, please provide business justification for addition of employee:

_____

Terms of Employment:

☐ Salaried ☐ Hourly
☐ Full-time ☐ Part-time
☐ Permanent ☐ Temporary

Salary Rate: $_____ Per: ☐ Hour ☐ Month ☐ Year
Will the position pay a production bonus? ☐ Yes ☐ No
Describe terms of bonus plan: _____

_____

If above is yes, must provide executed bonus plan agreement with new hire documents.

Will the position pay commission? ☐ Yes ☐ No
Describe terms of commission agreement plan: _____

_____

If above is yes, must provide executed compensation plan with new hire documents.

Additional compensation terms to be considered: _____

_____

Hiring Manager Signature: _____ Date: _____

Regional Manager Approval: _____ Date: _____

Human Resources:: _____ Date: _____

* *New hire processing will not commence without this fully completed and approved form.*

2943 Mossrock
San Antonio, TX 78230

Phone 210-366-1070

APPLICATION FOR PROFESSIONAL EMPLOYMENT

I. PERSONAL

A. Name: _____
Last First Middle

B. Street Address: _____

C. City, State, Zip _____

D. Telephone Numbers _____

E. Social Security Number: _____

F. Permanent Address & Phone Number _____

G. Name used on records (if different) _____

II. POSITION DATA

Position for which you are applying: _____

Credentials included with application:

- ☐ Resume
- ☐ All professional certificates (front and back, if appropriate)

Date Available for Employment _____

III. CERTIFICATION

List valid certificates currently held. Enclose a copy of all certification.

_____

_____

_____

IV. OTHER WORK EXPERIENCE

Please provide a complete listing of all other jobs or administrative positions you have held in the past 10 years. Attach additional sheets if necessary. **Or, attach resume, if available**.

Firm Name	Position/Title	Dates Employed	Reason for Leaving

V. GENERAL INFORMATION

- Are you aware of any reasons you would not be able to perform the duties of the position for which you are applying? ☐ Yes ☐ No

  If yes, please explain: _____

  _____

  _____

- Do you have a relative who is an employee of AmCap Mortgage, Ltd.? ☐Yes ☐No

  If yes, please give the name of relative and relationship:

  _____

  _____

- Have you ever been convicted of a felony or offense involving moral turpitude (including, but not limited to, theft, attempted theft, rape, murder, swindling, and indecency with a minor) and/or received probation or deferred adjudication?

  ☐ Yes ☐ No

  If yes, please explain: _____

  _____

  _____

  (Conviction of a felony is not an automatic bar to employment. This office will consider the nature, date, and relationship between the offense and the position for which you are applying.)

VI. REFERENCES

Please list below references that may be contacted regarding your work history. Please include all managers/supervisors at the last two employing organizations who evaluated or supervised your performance.

Full Name of Reference	Firm Name	Mailing Address	Position/Title	Area Code/ Phone #

I hereby affirm that all information provided in this application is true and accurate to the best of my knowledge, and understand that any deliberate falsifications, misrepresentations, or omissions of fact may be grounds for rejection of my application or dismissal from subsequent employment.

I authorize the references listed above to give you any and all information concerning my previous employment and any pertinent information they may have, personal or otherwise, and release all parties from all liability for any damage that may result from furnishing same to you.

I understand that Gold Financial Services, a division ofAmCap Mortgage, Ltd. will obtain a criminal history record and a credit report on all applicants for employment.

This application becomes the property of the AmCap Mortgage, Ltd. The AmCap Mortgage, Ltd. reserves the right to accept or reject it. This application shall be considered active for a period of time not to exceed 360 days. Any applicant wishing to be considered for employment beyond this time period may inquire as to whether or not applications are being accepted at that time.

Date _____ Signature _____

It is the policy of AmCap Mortgage, Ltd. not to discriminate on the basis of sex, handicap, race, color, and national origin in employment . Amcap Mortgage, LTD is an equal opportunity employer.

2943 Mossrock
San Antonio, TX

Phone 210-366-1070

Gold Financial Services

CRIMINAL HISTORY RECORD AND CREDIT REPORT

(THIS INFORMATION OBTAINED WILL BE KEPT STRICTLY CONFIDENTIAL)

The information requested below is necessary to obtain criminal history record and credit report.

FULL NAME _____
Print Last First Middle

SOCIAL SECURITY NO: _____

DATE OF BIRTH _____ SEX M _____ F_____

ETHNICITY: Black _____ White/Other _____

I understand the information I am providing about age, sex, and ethnicity will not be used to determine eligibility for employment, but will be used solely for the purpose of obtaining criminal history record information.

_____
Signature

RETURN TO: **Gold Financial Services a division of AmCap Mortgage, Ltd.**

This form will be removed from the application and filed separately in the personnel office.

Office Use: _____ Credit Report Received

_____ Criminal Record Report Received

Form W-4 (2012)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2012 expires February 18, 2013. See Pub. 505, Tax Withholding and Estimated Tax.

Note. If another person can claim you as a dependent on his or her tax return, you cannot claim exemption from withholding if your income exceeds $950 and includes more than $300 of unearned income (for example, interest and dividends).

Basic instructions. If you are not exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2012. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. The IRS has created a page on IRS.gov for information about Form W-4, at *www.irs.gov/w4*. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted on that page.

Personal Allowances Worksheet (Keep for your records.)

A	Enter "1" for **yourself** if no one else can claim you as a dependent	**A** _____
B	Enter "1" if: • You are single and have only one job; or • You are married, have only one job, and your spouse does not work; or • Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.	**B** _____
C	Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.)	**C** _____
D	Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return	**D** _____
E	Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above)	**E** _____
F	Enter "1" if you have at least $1,900 of **child or dependent care expenses** for which you plan to claim a credit (**Note.** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)	**F** _____
G	**Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information. • If your total income will be less than $61,000 ($90,000 if married), enter "2" for each eligible child; then **less** "1" if you have three to seven eligible children or **less** "2" if you have eight or more eligible children. • If your total income will be between $61,000 and $84,000 ($90,000 and $119,000 if married), enter "1" for each eligible child	**G** _____
H	Add lines A through G and enter total here. (**Note.** This may be different from the number of exemptions you claim on your tax return.) ►	**H** _____

For accuracy, complete all worksheets that apply.

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $40,000 ($10,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

► **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2012

1	Your first name and middle initial	Last name	**2** **Your social security number**
	Home address (number and street or rural route)	**3** ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note.** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
	City or town, state, and ZIP code	**4** **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ► ☐	
5	Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2)		**5**
6	Additional amount, if any, you want withheld from each paycheck		**6** $
7	I claim exemption from withholding for 2012, and I certify that I meet **both** of the following conditions for exemption. • Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and** • This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability. If you meet both conditions, write "Exempt" here ►		**7**

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ► **Date** ►

8	Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	**9** Office code (optional)	**10** Employer identification number (EIN)

Deductions and Adjustments Worksheet

Note. Use this worksheet *only* if you plan to itemize deductions or claim certain credits or adjustments to income.

1	Enter an estimate of your 2012 itemized deductions. These include qualifying home mortgage interest, charitable contributions, state and local taxes, medical expenses in excess of 7.5% of your income, and miscellaneous deductions	1	$
2	Enter: { $11,900 if married filing jointly or qualifying widow(er); $8,700 if head of household; $5,950 if single or married filing separately }	2	$
3	**Subtract** line 2 from line 1. If zero or less, enter "-0-"	3	$
4	Enter an estimate of your 2012 adjustments to income and any additional standard deduction (see Pub. 505)	4	$
5	**Add** lines 3 and 4 and enter the total. (Include any amount for credits from the *Converting Credits to Withholding Allowances for 2012 Form W-4* worksheet in Pub. 505.)	5	$
6	Enter an estimate of your 2012 nonwage income (such as dividends or interest)	6	$
7	**Subtract** line 6 from line 5. If zero or less, enter "-0-"	7	$
8	**Divide** the amount on line 7 by $3,800 and enter the result here. Drop any fraction	8	
9	Enter the number from the **Personal Allowances Worksheet,** line H, page 1	9	
10	**Add** lines 8 and 9 and enter the total here. If you plan to use the **Two-Earners/Multiple Jobs Worksheet,** also enter this total on line 1 below. Otherwise, **stop here** and enter this total on Form W-4, line 5, page 1	10	

Two-Earners/Multiple Jobs Worksheet (See *Two earners or multiple jobs* on page 1.)

Note. Use this worksheet *only* if the instructions under line H on page 1 direct you here.

1	Enter the number from line H, page 1 (or from line 10 above if you used the **Deductions and Adjustments Worksheet**)	1	
2	Find the number in **Table 1** below that applies to the **LOWEST** paying job and enter it here. **However,** if you are married filing jointly and wages from the highest paying job are $65,000 or less, do not enter more than "3"	2	
3	If line 1 is **more than or equal to** line 2, subtract line 2 from line 1. Enter the result here (if zero, enter "-0-") and on Form W-4, line 5, page 1. **Do not** use the rest of this worksheet	3	

Note. If line 1 is **less than** line 2, enter "-0-" on Form W-4, line 5, page 1. Complete lines 4 through 9 below to figure the additional withholding amount necessary to avoid a year-end tax bill.

4	Enter the number from line 2 of this worksheet	4	
5	Enter the number from line 1 of this worksheet	5	
6	**Subtract** line 5 from line 4	6	
7	Find the amount in **Table 2** below that applies to the **HIGHEST** paying job and enter it here	7	$
8	**Multiply** line 7 by line 6 and enter the result here. This is the additional annual withholding needed	8	$
9	Divide line 8 by the number of pay periods remaining in 2012. For example, divide by 26 if you are paid every two weeks and you complete this form in December 2011. Enter the result here and on Form W-4, line 6, page 1. This is the additional amount to be withheld from each paycheck	9	$

Table 1

Married Filing Jointly		All Others	
If wages from **LOWEST** paying job are—	Enter on line 2 above	If wages from **LOWEST** paying job are—	Enter on line 2 above
$0 - $5,000	0	$0 - $8,000	0
5,001 - 12,000	1	8,001 - 15,000	1
12,001 - 22,000	2	15,001 - 25,000	2
22,001 - 25,000	3	25,001 - 30,000	3
25,001 - 30,000	4	30,001 - 40,000	4
30,001 - 40,000	5	40,001 - 50,000	5
40,001 - 48,000	6	50,001 - 65,000	6
48,001 - 55,000	7	65,001 - 80,000	7
55,001 - 65,000	8	80,001 - 95,000	8
65,001 - 72,000	9	95,001 - 120,000	9
72,001 - 85,000	10	120,001 and over	10
85,001 - 97,000	11		
97,001 - 110,000	12		
110,001 - 120,000	13		
120,001 - 135,000	14		
135,001 and over	15		

Table 2

Married Filing Jointly		All Others	
If wages from **HIGHEST** paying job are—	Enter on line 7 above	If wages from **HIGHEST** paying job are—	Enter on line 7 above
$0 - $70,000	$570	$0 - $35,000	$570
70,001 - 125,000	950	35,001 - 90,000	950
125,001 - 190,000	1,060	90,001 - 170,000	1,060
190,001 - 340,000	1,250	170,001 - 375,000	1,250
340,001 and over	1,330	375,001 and over	1,330

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to carry out the Internal Revenue laws of the United States. Internal Revenue Code sections 3402(f)(2) and 6109 and their regulations require you to provide this information; your employer uses it to determine your federal income tax withholding. Failure to provide a properly completed form will result in your being treated as a single person who claims no withholding allowances; providing fraudulent information may subject you to penalties. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation; to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws; and to the Department of Health and Human Services for use in the National Directory of New Hires. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by Code section 6103.

The average time and expenses required to complete and file this form will vary depending on individual circumstances. For estimated averages, see the instructions for your income tax return.

If you have suggestions for making this form simpler, we would be happy to hear from you. See the instructions for your income tax return.

OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Instructions

Read all instructions carefully before completing this form.

Anti-Discrimination Notice. It is illegal to discriminate against any individual (other than an alien not authorized to work in the United States) in hiring, discharging, or recruiting or referring for a fee because of that individual's national origin or citizenship status. It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents presented have a future expiration date may also constitute illegal discrimination. For more information, call the Office of Special Counsel for Immigration Related Unfair Employment Practices at 1-800-255-8155.

What Is the Purpose of This Form?

The purpose of this form is to document that each new employee (both citizen and noncitizen) hired after November 6, 1986, is authorized to work in the United States.

When Should Form I-9 Be Used?

All employees (citizens and noncitizens) hired after November 6, 1986, and working in the United States must complete Form I-9.

Filling Out Form I-9

Section 1, Employee

This part of the form must be completed no later than the time of hire, which is the actual beginning of employment. Providing the Social Security Number is voluntary, except for employees hired by employers participating in the USCIS Electronic Employment Eligibility Verification Program (E-Verify). **The employer is responsible for ensuring that Section 1 is timely and properly completed.**

Noncitizen nationals of the United States are persons born in American Samoa, certain former citizens of the former Trust Territory of the Pacific Islands, and certain children of noncitizen nationals born abroad.

Employers should note the work authorization expiration date (if any) shown in **Section 1**. For employees who indicate an employment authorization expiration date in **Section 1**, employers are required to reverify employment authorization for employment on or before the date shown. Note that some employees may leave the expiration date blank if they are aliens whose work authorization does not expire (e.g., asylees, refugees, certain citizens of the Federated States of Micronesia or the Republic of the Marshall Islands). For such employees, reverification does not apply unless they choose to present in Section 2 evidence of employment authorization that contains an expiration date (e.g., Employment Authorization Document (Form I-766)).

Preparer/Translator Certification

The Preparer/Translator Certification must be completed if **Section 1** is prepared by a person other than the employee. A preparer/translator may be used only when the employee is unable to complete **Section 1** on his or her own. However, the employee must still sign **Section 1** personally.

Section 2, Employer

For the purpose of completing this form, the term "employer" means all employers including those recruiters and referrers for a fee who are agricultural associations, agricultural employers, or farm labor contractors. Employers must complete **Section 2** by examining evidence of identity and employment authorization within three business days of the date employment begins. However, if an employer hires an individual for less than three business days, **Section 2** must be completed at the time employment begins. Employers cannot specify which document(s) listed on the last page of Form I-9 employees present to establish identity and employment authorization. Employees may present any List A document **OR** a combination of a List B and a List C document.

If an employee is unable to present a required document (or documents), the employee must present an acceptable receipt in lieu of a document listed on the last page of this form. Receipts showing that a person has applied for an initial grant of employment authorization, or for renewal of employment authorization, are not acceptable. Employees must present receipts within three business days of the date employment begins and must present valid replacement documents within 90 days or other specified time.

Employers must record in Section 2:

1. Document title;
2. Issuing authority;
3. Document number;
4. Expiration date, if any; and
5. The date employment begins.

Employers must sign and date the certification in **Section 2**. Employees must present original documents. Employers may, but are not required to, photocopy the document(s) presented. If photocopies are made, they must be made for all new hires. Photocopies may only be used for the verification process and must be retained with Form I-9. **Employers are still responsible for completing and retaining Form I-9.**

For more detailed information, you may refer to the *USCIS Handbook for Employers* (Form M-274). You may obtain the handbook using the contact information found under the header "USCIS Forms and Information."

Section 3, Updating and Reverification

Employers must complete **Section 3** when updating and/or reverifying Form I-9. Employers must reverify employment authorization of their employees on or before the work authorization expiration date recorded in **Section 1** (if any). Employers **CANNOT** specify which document(s) they will accept from an employee.

A. If an employee's name has changed at the time this form is being updated/reverified, complete Block A.

B. If an employee is rehired within three years of the date this form was originally completed and the employee is still authorized to be employed on the same basis as previously indicated on this form (updating), complete Block B and the signature block.

C. If an employee is rehired within three years of the date this form was originally completed and the employee's work authorization has expired **or** if a current employee's work authorization is about to expire (reverification), complete Block B; and:

1. Examine any document that reflects the employee is authorized to work in the United States (see List A **or** C);
2. Record the document title, document number, and expiration date (if any) in Block C; and
3. Complete the signature block.

Note that for reverification purposes, employers have the option of completing a new Form I-9 instead of completing **Section 3.**

What Is the Filing Fee?

There is no associated filing fee for completing Form I-9. This form is not filed with USCIS or any government agency. Form I-9 must be retained by the employer and made available for inspection by U.S. Government officials as specified in the Privacy Act Notice below.

USCIS Forms and Information

To order USCIS forms, you can download them from our website at www.uscis.gov/forms or call our toll-free number at 1-800-870-3676. You can obtain information about Form I-9 from our website at www.uscis.gov or by calling 1-888-464-4218.

Information about E-Verify, a free and voluntary program that allows participating employers to electronically verify the employment eligibility of their newly hired employees, can be obtained from our website at www.uscis.gov/e-verify or by calling 1-888-464-4218.

General information on immigration laws, regulations, and procedures can be obtained by telephoning our National Customer Service Center at 1-800-375-5283 or visiting our Internet website at www.uscis.gov.

Photocopying and Retaining Form I-9

A blank Form I-9 may be reproduced, provided both sides are copied. The Instructions must be available to all employees completing this form. Employers must retain completed Form I-9s for three years after the date of hire or one year after the date employment ends, whichever is later.

Form I-9 may be signed and retained electronically, as authorized in Department of Homeland Security regulations at 8 CFR 274a.2.

Privacy Act Notice

The authority for collecting this information is the Immigration Reform and Control Act of 1986, Pub. L. 99-603 (8 USC 1324a).

This information is for employers to verify the eligibility of individuals for employment to preclude the unlawful hiring, or recruiting or referring for a fee, of aliens who are not authorized to work in the United States.

This information will be used by employers as a record of their basis for determining eligibility of an employee to work in the United States. The form will be kept by the employer and made available for inspection by authorized officials of the Department of Homeland Security, Department of Labor, and Office of Special Counsel for Immigration-Related Unfair Employment Practices.

Submission of the information required in this form is voluntary. However, an individual may not begin employment unless this form is completed, since employers are subject to civil or criminal penalties if they do not comply with the Immigration Reform and Control Act of 1986.

Paperwork Reduction Act

An agency may not conduct or sponsor an information collection and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The public reporting burden for this collection of information is estimated at 12 minutes per response, including the time for reviewing instructions and completing and submitting the form. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: U.S. Citizenship and Immigration Services, Regulatory Management Division, 111 Massachusetts Avenue, N.W., 3rd Floor, Suite 3008, Washington, DC 20529-2210. OMB No. 1615-0047. **Do not mail your completed Form I-9 to this address.**

OMB No. 1615-0047; Expires 08/31/12

Department of Homeland Security
U.S. Citizenship and Immigration Services

Form I-9, Employment Eligibility Verification

Read instructions carefully before completing this form. The instructions must be available during completion of this form.

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers CANNOT specify which document(s) they will accept from an employee. The refusal to hire an individual because the documents have a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Verification *(To be completed and signed by employee at the time employment begins.)*

Print Name: Last	First	Middle Initial	Maiden Name

Address *(Street Name and Number)*	Apt. #	Date of Birth *(month/day/year)*

City	State	Zip Code	Social Security #

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

- ☐ A citizen of the United States
- ☐ A noncitizen national of the United States (see instructions)
- ☐ A lawful permanent resident (Alien #) _____
- ☐ An alien authorized to work (Alien # or Admission #) _____ until (expiration date, if applicable - *month/day/year*)

Employee's Signature — Date *(month/day/year)*

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.) I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.*

Preparer's/Translator's Signature	Print Name

Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 2. Employer Review and Verification *(To be completed and signed by employer. Examine one document from List A OR examine one document from List B and one from List C, as listed on the reverse of this form, and record the title, number, and expiration date, if any, of the document(s).)*

	List A	OR	List B	AND	List C
Document title:					
Issuing authority:					
Document #:					
Expiration Date *(if any)*:					
Document #:					
Expiration Date *(if any)*:					

CERTIFICATION: I attest, under penalty of perjury, that I have examined the document(s) presented by the above-named employee, that the above-listed document(s) appear to be genuine and to relate to the employee named, that the employee began employment on *(month/day/year)* _____ **and that to the best of my knowledge the employee is authorized to work in the United States. (State employment agencies may omit the date the employee began employment.)**

Signature of Employer or Authorized Representative	Print Name	Title

Business or Organization Name and Address *(Street Name and Number, City, State, Zip Code)*	Date *(month/day/year)*

Section 3. Updating and Reverification *(To be completed and signed by employer.)*

A. New Name *(if applicable)*	B. Date of Rehire *(month/day/year) (if applicable)*

C. If employee's previous grant of work authorization has expired, provide the information below for the document that establishes current employment authorization.

Document Title: _____ Document #: _____ Expiration Date *(if any)*: _____

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative	Date *(month/day/year)*

LISTS OF ACCEPTABLE DOCUMENTS

All documents must be unexpired

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** Social Security Account Number card other than one that specifies on the face that the issuance of the card does not authorize employment in the United States
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)				**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph		
		4. Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. In the case of a nonimmigrant alien authorized to work for a specific employer incident to status, a foreign passport with Form I-94 or Form I-94A bearing the same name as the passport and containing an endorsement of the alien's nonimmigrant status, as long as the period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form		**5.** U.S. Military card or draft record		
		6. Military dependent's ID card		
		7. U.S. Coast Guard Merchant Mariner Card		**5.** Native American tribal document
		8. Native American tribal document		**6.** U.S. Citizen ID Card (Form I-197)
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card		**8.** Employment authorization document issued by the Department of Homeland Security
		11. Clinic, doctor, or hospital record		
		12. Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274)

Exhibit A
Loan Fraud Prevention Policy

It is the policy and intent of Gold Financial Services a division of AmCap Mortgage, LTD to support the elimination of mortgage loan fraud and misrepresentation within the residential lending industry. The submission of a loan application containing false or misrepresented information is a FEDERAL CRIME.

Although fraud or negligent misrepresentation may be perpetrated in many ways, some of the most common examples are provided below:

- Submission of inaccurate information, including false statements on loan applications and falsification of documentation relating to all the information provided on loan applications.
- Forgery or misrepresentation of partially or predominately accurate information.
- Misrepresentation of occupancy or intent to maintain required occupancy as agreed in the security instrument.
- Lack of due diligence or concern by the Broker, loan officer, interviewer or processor including failure to obtain or divulge all information required by the application and/or failure to request further information as dictated by the applicant's response to other inquires or documentation.
- Failure of the Broker to disclose any relevant or pertinent information regarding the loan application.

The consequences of loan fraud are wide ranging and costly. AmCap Mortgage, LTD warrants the quality of our loan production to our investors. Fraudulent loans may not be sold in the secondary mortgage market. If a loan is found to be fraudulent after its sale, AmCap Mortgage LTD could be obligated to repurchase the loan from our investor. Fraudulent loans harm our reputation and jeopardize our relationships with investors and insurers.

The consequences to those who participate in loan fraud are even more severe. Such consequences include, but are not limited to:

To the Loan Officer, Processor or Broker:

- Criminal prosecution which may result in fines and imprisonment.
- Revocation of Broker's license
- Inability to access lenders caused by legally permissible exchange of information between lenders, mortgage insurance companies, Agencies and Federal and State regulatory agencies including the Department of Real Estate.
- Civil Action by AmCap Mortgage, LTD.
- Civil Action by applicant and/or other parties to the transaction.
- Termination of employment.
- Immediate loss of approved broker status with AmCap Mortgage, LTD.

To the Borrower:

- Acceleration of debt as mandated by the security instrument (Deed of Trust or Mortgage)
- Criminal prosecution which may result in fines and imprisonment.

- Civil Action by AmCap Mortgage, LTD
- Civil Action by other parties to the transaction such as the seller or real estate agent
- Forfeiture of and professional license

to the Borrower: cont.

- Adverse, long term effect on credit history. Findings may be reported to Government/Licensing Agencies.

AmCap Mortgage Ltd will consider and pursue any and all remedies available to it in the event of mortgage loan fraud or misrepresentation regardless of whether the discovery is prior to, of after, loan closing and funding.

I have read the foregoing. I understand and accept AmCap Mortgage, LTD's Loan Fraud Prevention Policy.

Signature: _____ Company Name: _____

Printed Name/Title: _____ Date: _____

2943 Mossrock
San Antonio, TX 78230

Phone: 210-366-1070

Gold Financial Services

Wage Deduction Authorization Agreement

I _____understand and agree that my employer, Gold Financial Services a division of AmCap Mortgage Ltd., may deduct money from my compensation from time to time for reasons that fall into the following categories:

1. My share of the premiums for AmCap's group medical/dental plan, life insurance/disability if eligible;

2. Any contributions I may make into a retirement or pension plan sponsored, controlled or managed by AmCap;

3. Installment payments on loans or wage advances given to me by AmCap, and if there is a balance remaining which I leave Amcap, the balance of such loans or advances;

4. If I receive an overpayment of wages for any reason, repayment of such overpayments to AmCap;

5. The cost to AmCap for personal long distance and local calls I make on AmCap phones and AmCap cell phones, personal faxes sent by me using AmCap equipment, or any postage, courier, or overnight express services used for personal use;

6. The cost of repairing or replacing any AmCap supplies, materials, equipment, cell phones, keys or other property that I may damage (other than normal wear and tear), lose, fail to return or take without appropriate authorization from AmCap during my employment.

7. If I take paid vacation or sick leave in advance of the date I would normally be entitled to it and if I separate from AmCap before accruing time to cover such advance leave. The value of such leave taken in advance that is not so covered.

I agree that AmCap Mortgage Ltd. may deduct money from my pay under the above circumstances.

_____ _____

Employee Name **Date**

_____

Gold Financial Services Representative

This agreement can only be amended by a separately signed agreement.
April 17, 2003

SPECIAL NOTICE:

Gold Financial Services a division of Amcap Mortgage, Ltd is a designated mortgage bank that is licensed by the U.S. Department of Housing and Urban Development. As such, it is the intent of management that all employees of AmCap remain in full compliance of all H.U.D. rules and regulations at all times.

H.U.D. specifically stipulates that all mortgage bank employees whether full-time or part-time may have other employment, but any outside employment MAY NOT be in the mortgage lending (e.g. Mortgage broker), real estate (e.g. real estate agent), or a related field. All such forms of activities are explicitly prohibited under HUD/FHA guidelines. (Reference: HUD Handbook 4060.1 Rev 2, Paragraph 2-9G)

I have read and understand the above information and will comply to the fullest.

_____ _____

Signature: Print:

_____

Date:

ACKNOWLEDGEMENT OF RECEIPT
OF
EMPLOYEE POLICY HANDBOOK

I, _____ DO HEREBY ACKNOWLEDGE THAT I HAVE RECEIVED AND READ A COPY OF THE GOLD FINANCIAL SERVICES A DIVISION OF AMCAP MORTGAGE LIMITED EMPLOYEE POLICY HANDBOOK.

_____ _____

Signature Date

2943 Mossrock
San Antonio, TX 78230

Phone: 210-366-1070

Gold Financial Services

National Mortgage Licensing System (NMLS)

(Initial Access Request)

In conjunction with the employment background check please provide Gold Financial Services a division AmCap Mortgage with Access to your NMLS report.

Logon to the NMLS website http://mortgage.nationwidelicensingsystem.org/Pages/default.aspx

Please logon and under the "Filing" tab, click "Company Access" and search for Amcap (NMLS # 129122) to grant us access to your record.

By signing this form you are confirming access to AmCap Mortgage thru NMLS for record review.

Print Name: _____ NMLS #: _____

Signature: _____ Date: _____

(To view your personal status and confirm access)

Logon to the NMLS website http://mortgage.nationwidelicensingsystem.org/Pages/default.aspx

Go to the "Composite View" tab

Click "View Individual"

Click "View Relationships" on the left side of the screen

If you do not see Amcap Mortgage under "Active Company Relationships", you are not in good standing with Amcap and need to grant company access.

If you do see Amcap Mortgage under "Active Company Relationships", click the little piece of paper icon next to "Amcap". It should show your sponsorship status and "Amcap" should be listed if we have been able to sponsor you.

If you have any questions please email humanresources@amcap1.com

ENROLLMENT APPLICATION /CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION / CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

Please Note: If your group offers a Consumer Choice health plan you have the option to choose a Consumer Choice of Benefits Health Insurance Plan or Consumer Choice of Benefits Health Maintenance Organization health care plan that, either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies or evidences of coverage in Texas. This standard health benefit plan may provide a more affordable health insurance policy or health plan for you, although, at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies or evidences of coverage in Texas. If you choose this standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in this policy or evidence of coverage (Certificate of Coverage).

SECTION 1

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all Sections where applicable.

Add Dependent: Complete all Sections where applicable.

- If you are adding or enrolling a dependent due to court order, you must submit a copy of the court order or decree AND a completed Dependent Addition and Change Form for Court-Mandated Health Coverage.
- If student dependent coverage is part of your employer's plan and you are adding or enrolling a dependent child age 26 or over who is a student, you may be required to submit a completed Student Certification form.
- If you are applying for coverage for a disabled dependent child over the dependent age limit of your employer's plan, you are required to submit a completed Dependent Child's Statement of Disability form. A disabled dependent over the dependent age limit of your employer's plan must be certified by medical underwriting.

Cancel Enrollee: Complete Sections 1, 2, 4, and 11. In Section 4 include name, social security number, and date of birth of individual(s) cancelling.

Cancel Dependent: Complete Sections 1, 2, 4, and 11. In Section 4 include name and date of birth of individual(s) cancelling.

Declining Coverage: Complete Sections 2, 10, and 11.

SECTIONS 2 & 3

Complete all areas that apply to you.

SECTION 4

Complete all areas that apply to you and each dependent.

For HMO and POS only: Those applying for HMO or POS coverage should select a PCP for each individual to be covered. List the name of the physician and the provider number from the provider directory or Provider Finder at **www.bcbstx.com**. Be sure to check the appropriate box for a new patient.

ATTENTION FEMALE MEMBERS: In selecting your PCP, remember that your PCP's network may affect your choice of an OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your PCP. However, for HMO members, the OB/GYN from whom you receive services must belong to the same physician practice group or independent practice association (IPA) as your PCP. This is another reason to make certain that your PCP's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your PCP.

Change Primary Care Physician (PCP): In Section 1, check the "Other Change(s)" box, then complete sections 2, 3, 4, and 11. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, and name and number of the new PCP.

Change Address / Name: In Section 1, check the "Other Change(s)" box, then complete sections 1, 2, and 11.

SECTION 5

Complete this section if your employer is offering life insurance coverage.

SECTION 6

Complete this section if you are applying for coverage for a disabled dependent child over the dependent child age limit of your employer's plan. A disabled dependent must be certified by medical underwriting and a completed Dependent Child's Statement of Disability form must be submitted with this enrollment application.

SECTION 7

Complete this section unless you are applying for HMO or In-Hospital Indemnity coverage.

The health coverage for which you are applying may have a preexisting condition waiting period. On your group's first contract date or contract anniversary date on or after September 23, 2010, a preexisting condition waiting period will not apply for individuals under the age of 19. Check with your employer if you have questions regarding preexisting condition waiting period applicability for individuals under the age of 19.

SECTION 8

Complete this section if you or any dependent have other health care coverage through an employer (group coverage) that will not be cancelled when the coverage under this application becomes effective.

SECTION 9

Complete this section if you or any of your dependents are covered by Medicare.

SECTION 10

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 10, not just those declining because of other coverage.

IMPORTANT NOTICE – DECLINATION OF HEALTH COVERAGE
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, birth, adoption or becoming a party in a suit for adoption, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption or suit for adoption.

SECTION 11

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form to: **Group Accounts Dept. • P. O. Box 655730 • Dallas, TX 75265-5730**

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

Forms referenced above may be obtained by accessing the BCBSTX website at www.bcbstx.com, from your Marketing Service Representative, or from your employer. If you have any questions, please contact your Marketing Service Representative.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Texas

Dearborn National

Group No.	Section No.	Dept No.	Social Security No.
Group No.	Section No.	Dept No.	Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 10, & 11 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Change(s)**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ Marriage ☐ Birth

☐ Adoption or Suit for Adoption (Provide Legal Documents)

☐ Court Order (Provide Court Order or decree)

☐ Loss of Other Coverage (Provide Certificate of Creditable Coverage)

☐ Other (Explain): ____________________

NOTE: Declination of Coverage (Complete Sections 2, 10, & 11)

Add Coverage:

☐ Health

☐ Dental

☐ Term Life

☐ Dependent Life

☐ Short Term Disability (STD)

☐ Long Term Disability (LTD)

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental ☐ Term Life ☐ Dependent Life ☐ STD ☐ LTD

List names of those cancelling in Section 4 below

Event: ☐ Divorce ☐ Death

☐ Terminated Employment

☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security No. – –

Mailing Address - Street - Apt No.	City	State	Zip

E-Mail Address	☐ Male ☐ Female	Home/Cell Phone No.

Name of Employer	Job Title	Business Phone No.	Employment Date (MM/DD/YYYY)	Do you usually work at least 30 hours a week for this employer? ☐ Yes ☐ No

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ____________ ☐ COBRA Continuation

☐ State Continuation of Group Coverage (insured plans only) ☐ Dependent State Continuation of Group Coverage (insured plans only)

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Health Coverage (select one)

☐ PPO ☐ HMO

☐ Blue Options ☐ BlueEdge HCA ☐ BlueEdge HSA

☐ HMO Consumer Choice Plan (small group only)

☐ PPO Consumer Choice Plan (small group only)

☐ EPO

☐ Other: ____________

Plan #, if known: ____________

Health Enrollees (select one)

☐ Employee Only

☐ Employee /Spouse

☐ Employee /Child(ren)

☐ Family

☐ I am not applying for Health coverage

Dental Coverage

☐ Yes

☐ No

Plan No., if known: ____________

Dental Enrollees (select one)

☐ Employee Only

☐ Employee /Spouse

☐ Employee /Child(ren)

☐ Family

☐ I am not applying for Dental coverage

Complete only if you are applying for HMO coverage: Primary Language: ____________ ☐ Check here to request a Spanish Member Handbook

Do you have a disability affecting your ability to communicate or read? ☐ Yes ☐ No

If "Yes", describe special communication materials needed: ____________

SECTION 4 — COVERAGE OPTIONS

SELECT A PCP FOR HMO OR POS ONLY

Employee/Enrollee's Name	PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Dependent's Name ☐ Husband ☐ Wife	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N

Dependent's Social Security No. – –	Birth Date (MM/DD/YYYY)	Address (if different) - No. and Street Address	City	State	Zip

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐ Y ☐ N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐ Y ☐ N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent ____________	Dependent's Social Security No. – –	Dependent's PCP Name	PCP No.	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address, if different — No. and Street Name/City/State/Zip	Is this dependent a natural child, stepchild, adopted child, or a child in Suit for Adoption? ☐ Y ☐ N	If not your natural child, stepchild, adopted child or child in Suit for Adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	

SECTION 5 — GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), AND DISABILITY INSURANCE COVERAGES

Employee Occupation/Job Title: ____________ Wage Rate $____________ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life & AD&D ☐ I do not apply ☐ I do apply Amount $____________

Group Dependents' Life ☐ I do not apply ☐ I do apply

Group Supplemental Life ☐ I do not apply ☐ I do apply

Employee Election: $____________ Spouse Election: $____________ Child Election: $____________

Short Term Disability (STD) ☐ I do not apply ☐ I do apply

Long Term Disability (LTD) ☐ I do not apply ☐ I do apply

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security No.
Primary Beneficiary						– –
Contingent Beneficiary						– –

Last Name: Social Security No.: — — Group #

SECTION 6 — DISABLED DEPENDENT

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form.

SECTION 7 — PREVIOUS HEALTH COVERAGE INFORMATION

DO NOT COMPLETE IF APPLYING FOR HMO OR IN-HOSPITAL INDEMNITY COVERAGE

In order to receive credit for preexisting condition waiting periods, you must provide information about the last 12 months of coverage (18 months if new/current coverage is self-funded) for you and any dependents listed. If you have a Certificate of Creditable Coverage, please attach a copy to this enrollment application. (If more than one plan was in effect, or if information is different for dependents, attach additional pages.) If Medicare, please complete the Medicare Coverage Information in Section 9. Please see instruction page for more information.

List names of every individual covered:

Previous Coverage Policyholder Name	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent	Group or Policy No.	ID Number

Name of Previous Insurance Company, TPA, HMO:	Effective Date (MM/DD/YYYY)	Type of Coverage ☐ Health ☐ Dental	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Employer's Name:	Employment Date under Previous Coverage (MM/DD/YYYY)	Will Coverage be Continued? ☐ Health ☐ Dental If No, Expected Cancel Date (MM/DD/YYYY) _____

SECTION 8 — OTHER COVERAGE INFORMATION

Complete this section only if you or any of your dependents have other health and / or dental coverage **that will not be cancelled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Yes ☐ No	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group No.	Health ID No.	Dental Group No.	Dental ID No.

SECTION 9 — MEDICARE COVERAGE INFORMATION

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

Name of person covered:	Medicare A (Hospital) Effective Date: _____ End Date: _____ Medicare B (Medical) Effective Date: _____ End Date: _____ Medicare D (Drug) Effective Date: _____ End Date: _____ Medicare D (Drug) Carrier: _____	Medicare HIC No. (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 10 — DECLINATION OF COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage as well as a preexisting condition waiting period.

Name ☐ Employee	Reason for Declining Health: ☐ Other Group Health Coverage; Carrier: _____ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage; Carrier: _____ ☐ Other, Explain: _____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Employee	Reason for Declining Dental: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Dental insurance plan, but do not want this coverage.
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.
Name ☐ Child	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other, Explain:_____ ☐ I am not enrolled in any Health insurance plan, but do not want this coverage.

SECTION 11 — COVERAGE CONDITIONS

- I am an employee of the Employer named in this Enrollment Application. I am eligible to participate in the coverage(s) afforded by my Employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Texas (BCBSTX) or Fort Dearborn Life Insurance Company (FDL). On behalf of myself and any dependents listed on this Enrollment Application, I apply for those coverage(s) for which I am eligible. I state that the information given on this Enrollment Application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this Enrollment Application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contracts(s)/Plan(s).
- For individuals age 19 and over, I understand that the Health coverage for which I am applying may have a preexisting condition exclusion waiting period. (Does not apply to HMO or In-Hospital Indemnity coverage.)
- I agree that my Employer acts as my agent. I authorize necessary payroll deduction by my Employer, if any, to cover the cost of my coverage(s). As applies to HMO coverage, I will accept an electronic copy of my coverage documents (whether certificate of coverage or benefit booklet) if my Employer requests that BCBSTX deliver the information electronically. I understand that a hard copy is available to me upon request.
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my Employer are applicable to me.

Applicant's Signature _____ Date _____

YOUR RETIREMENT.

PLAN FOR LIFE.[SM]

GET A HEAD START ON SAVING FOR YOUR FUTURE.

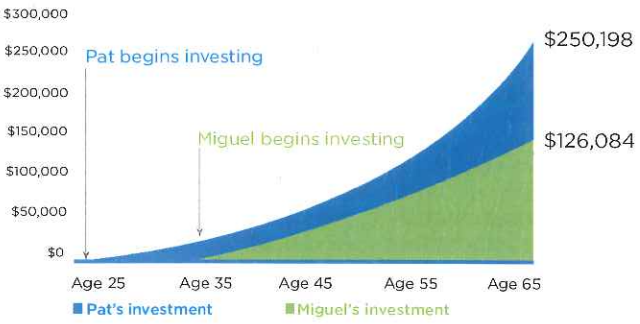
When you start saving for retirement could make a huge difference in the choices you have later on.

Did you know that if you begin saving at age 25 — instead of age 35 — you could potentially have *nearly twice as much* money in your account by the time you retire?

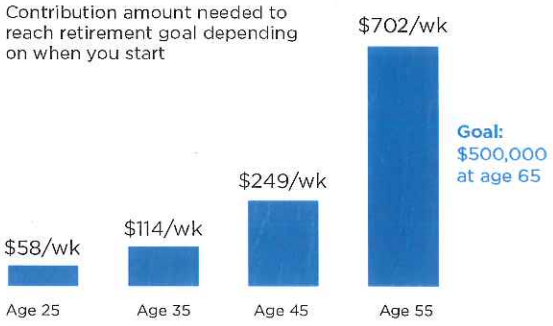
THE HIGH COST OF WAITING.

In the example below left, Pat and Miguel both saved about $29 a week until retiring at age 65. Pat started at age 25, but Miguel waited until age 35. As you can see, those 10 years of waiting cost Miguel almost $125,000.*

WAITING COULD MEAN HAVING A LOT LESS*...



OR HAVING TO SAVE MUCH MORE.*



SMART SAVING STARTS EARLY.

As you can see in the example above right, if you wait another ten years until you're 45, you would have to ***more than double*** your contribution at age 35 to potentially achieve the same balance. At 55, you would have to contribute ***more than six times as much*** just to end up in the same place at age 65.

TIME IS ON YOUR SIDE.

The longer you wait to start saving, the more you'll need to contribute just to play catch-up. So be smart about your future — join your plan today.

To enroll in your plan, contact your benefits administrator, call your Hartford representative, or visit our website.

*Example is hypothetical and does not predict the performance of any investment option in your employer's plan. Example assumes weekly before-tax contributions of $28.85 earning a hypothetical 6% annual rate of return. Actual returns and principal values will fluctuate.

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YOUR RETIREMENT.

PLAN FOR LIFE.[SM]

THINK YOU CAN'T AFFORD TO SAVE FOR RETIREMENT? MAYBE YOU CAN'T AFFORD NOT TO.

Times are tough for many people. You might even be asking yourself if you can afford to contribute to your employer's retirement plan right now. After all, when you're facing immediate expenses, retirement can seem a long way off. But it's important to make your contributions a priority — in good economic times and bad.

RETIREMENT IS CLOSER THAN YOU THINK.

That's because your savings need time to grow. With the power of long-term tax-deferred growth, even small contributions can increase significantly over time. So don't sell your future short for a few more dollars in your paycheck now.

THREE GREAT REASONS TO START OR KEEP CONTRIBUTING TO YOUR PLAN:

1. **It couldn't be easier.** Your contribution is deducted automatically every pay period.
2. **It may cost less than you think.** Before-tax contributions lower your taxable income, so you take home more pay than you might expect.
3. **It goes where you go.** If you leave your employer, the contributions you make are always yours.

You may be able to find a little more money for savings by making some minor adjustments in your everyday activities.

DRIVING	FOOD	UTILITIES	EXTRAS
• *Meet your neighbors.* Take public transit or carpool a couple of times a week. • *Take the high road.* Aggressive driving wastes gas. Slow down and avoid rapid starts.	• *Avoid temptation.* Stick to your list when you go food shopping. • *Revive home cooking.* Resist take-out by keeping pre-cooked family favorites in the freezer.	• *Keep out of hot water.* Lower the temperature on your hot water heater. • *Clean up.* Wash full loads of clothes and dishes. • *Lighten up.* Use compact florescent bulbs.	• *Get mellow.* Cut down on coffee and soda. • *Bank on it.* Pay bills online to save on postage. • *Perk up.* Take advantage of employee discounts.

For more information about your plan, contact your benefits administrator, call your Hartford representative, or visit our website.

YOUR RETIREMENT.

PLAN FOR LIFE.[SM]

A LITTLE MORE NOW COULD MEAN A LOT MORE LATER.

Every extra dollar you contribute to your employer's retirement plan today has the potential to grow over time through the power of tax-deferred earnings. That's why even a small increase to your contributions today could have a big impact on your account balance in retirement.

JUST 2% CAN JUMPSTART YOUR SAVINGS.

If you're already contributing 5% of your annual salary to your retirement plan, that's approximately $24 a week on a $25,000 salary. By putting aside only 2% more — about $9 a week (or less than the price of a movie ticket) — you could save another $500 a year. At a hypothetical 6% annual rate of return for 30 years, that could mean over $42,000 more for your retirement.

SAVING MORE COULD COST YOU LESS.

Because before-tax contributions reduce your taxable income, you could end up with more take-home pay than you expect. In this example, a 2% increase means an annual contribution increase of $500, but the impact to annual spendable pay is only $425 — or only $8.17 more a week.

For more information or to enroll in your plan, contact your benefits administrator, call your Hartford representative, or visit our website.

Take your savings to the next level with an increase of just 2%. It could make a significant difference in your account balance and only a small difference in your take-home pay.

THE 2% DIFFERENCE = $42,028[1]

IT ONLY COSTS $425 TO SAVE $500 MORE.[2]

	5% contribution	7% contribution	The 2% difference
Gross annual income	$25,000	$25,000	
Before-tax contributions	1,250	1,750	**$500**
Taxable income	23,750	23,250	
Federal tax withheld	3,563	3,488	
Spendable annual pay	20,188	19,763	**$425**
Spendable weekly pay	388.22	380.05	**$8.17**

[1] Example is hypothetical and does not represent the future performance of any investment option available in your employer's plan. Numbers assume before-tax weekly contributions of 5% and 7% of a $25,000 annual salary, or $24.03 and $33.65 per week, earning a hypothetical 6% annual rate of return over 30 years.

[2] Example is hypothetical and assumes a 15% tax bracket. Additional FICA and state taxes may be withheld.

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Many tax planning strategies emphasize the deferral of current income taxes, on the basis that your federal income tax rate may be lower at retirement. Please keep in mind that federal income tax rates are unpredictable and may be higher when you take a distribution than at the time of deferral. Other factors, including state tax rates and your income, may also affect your overall tax rate upon distribution. Please consult with your tax advisor for individual tax planning strategy and advice. The Hartford does not predict or in any way guarantee favorable tax results.

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