

Agenda Item 2016-171



5000 Diamondhead Circle • Diamondhead, MS 39525-3260
Phone: 228.222.4626 Fax: 228.222.4390
www.diamondhead.ms.gov

September 1, 2016

Mr. Clovis Reed, City Manager
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

A handwritten signature in black ink, appearing to be 'CR', is written to the right of the recipient's name.

Dear Mr. Reed:

Re: Compensation for Ward 1 Special Election (Commissioners/Poll Manager and Workers, and Arbitrators)

For your approval and presentation to the Council is the following compensation for individuals associated with the September 27, 2016 Ward 1 Special Election:

1 Poll Manager	\$135.00
4 Poll Workers	\$125.00
3 Arbitrators	\$ 50.00
3 Election Commissioners	\$340.00 (4 days @ \$85 p/day)

Thank you in advance for your approval and for submission to the Council for further consideration and approval.

Sincerely,

A handwritten signature in black ink, appearing to be 'Jeannie Klein', is written below the word 'Sincerely,'.

Jeannie Klein
City Clerk

Agenda Item 2016-172



5000 Diamondhead Circle • Diamondhead, MS 39525-3260
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September 6, 2016

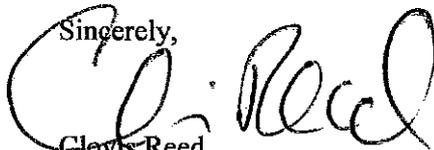
Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

Re: Surplus Equipment/Disposal

Attached is a listing of obsolete/inoperable cellular phones from 2013/2014 that have been removed from service in the Public Works Department and stored at City Hall. These phones are of no use to the City. It is my recommendation the cellular phones as listed on the attached Equipment Disposition Request be declare salvage and disposed of properly.

Thank you for your consideration and approval in this matter.

Sincerely,

Clovis Reed
City Manager

CR:jk

attachment

City of Diamondhead

EQUIPMENT DISPOSITION REQUEST

Department: PUBLIC WORKS

Description of Equipment Item	Quantity Disposed	Month/Year Purchased	Unit Cost	Physical Condition	Disposition Action Recommended
CONCRETE 114	1	8/2013	\$80.00	OBSOLETE	INOPERABLE
" " 126	1	1/2013	\$80.00	POOR	"
" " 127	1	1/2013	\$80.00	"	"
" " 121	1	1/2013	\$80.00	"	"
" " 130	1	1/2013	\$80.00	"	"
" " 123	1	1/2013	\$80.00	"	"
" " 124	1	1/2013	\$80.00	"	"
" " 120	1	1/2013	\$80.00	"	"
" " 129	1	1/2013	\$80.00	"	"
" " 133	1	1/2013	\$80.00	"	"
" " 226	1	6/2014	\$80.00	"	"
" " 132	1	1/2013	\$80.00	"	"
" " 007	1	7/2012	\$353.45	"	"

NET ASSET VALUE
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$7.40
 - \$45.90
 - \$17.40
 - \$3.53

Approvals: _____ Date: _____
 Department Head: [Signature] 9/15/16
 FA Coordinator: [Signature] 9.9.2016
 City Manager: _____

Physical Condition Guide:
 P - Poor
 F - Fair
 G - Good
 E - Excellent

Agenda Item 2016-173



5000 Diamondhead Circle • Diamondhead, MS 39525-3260
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September 15, 2016

Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

For your consideration and approval, I am recommending the City continue website hosting services with The Focus Group in the annual amount of \$300.00. The Focus Group completed and launched the new website in January 2016 with the first-year hosting fee included in the contract for the project.

Thank you for your consideration and approval in this matter.

Sincerely,

A handwritten signature in black ink that reads 'Clovis Reed'. The signature is written in a cursive style with a large, looping 'C' at the beginning.

Clovis Reed
City Manager

CR:jk

attachment



THE FOCUS GROUP

advertising production interactive

11545 Old Hwy. 49, Gulfport, MS 39505

770.842.3547 | www.thefocusgroupinc.com

Proposal for Website Hosting

ATTN: Clovis Reed, City Manager, City of Diamondhead
500 Diamondhead Circle
Diamondhead, MS 39525

Annual website hosting services to be provided by The Focus Group advertising agency at a rate of \$300 per year and billed each January.
The City's first invoice will come in January 2017.

NOTE: The first year of hosting was included in the Hancock Chamber's project management of the new website development.


THE FOCUS GROUP
advertising production interactive

Agenda Item 2016-174



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www.diamondhead.ms.gov

September 15, 2016

Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

RE: East Aloha Access Road – Payment No. 1 (Project SM-15-709)

Attached for your review, consideration and approval is Pay Request No. 1 to Twin L Construction, Inc. in the amount of \$56,548.75. Funding for this project is the Small Municipalities and Limited Population County Grant (SMLP) and local match funding.

If you find this document to be in order, please proceed with authorization for payment.

Sincerely,

A handwritten signature in black ink that reads "Clovis Reed". The signature is written in a cursive style with a large, sweeping initial "C".

Clovis Reed
City Manager

CR:jk

SEYMOUR ENGINEERING

Civil Engineers and Professional Land Surveyors



925 Tommy Munro Drive, Suite G
Biloxi, Mississippi 39532
Phone: 228-385-2350
Fax: 228-385-2353
Toll Free: 888-385-2350

September 15, 2016

Mr. Clovis Reed
City Manager
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 38525

**Re: East Aloha Drive Access Road Alignment No. 2
Contractor's Pay Request No 1**

Dear Mr. Reed:

Enclosed you will find Pay Request No. 1 for the above referenced project. The work has been performed and is acceptable. We recommend to the City of Diamondhead, that Twin L Construction, Inc. be paid the requested amount of \$56,548.75. This amount represents the total work completed and stored thru 9/9/2016 less 5% retainage.

Respectfully submitted,

SEYMOUR ENGINEERING

Sincerely
SEYMOUR ENGINEERING

A handwritten signature in black ink that reads "Roland J. Diaz, Jr." in a cursive script.

Roland J. "Joey" Diaz, Jr., P.E. (MS 18669)
Project Engineer

Cc: Mr. Richard Sullivan, Mr. David Rivers, Ms. Jeannie Klein, Ms. Michele Moore

APPLICATION AND CERTIFICATE FOR PAYMENT

TO (OWNER): CITY OF DIAMONDHEAD
 5000 DIAMOND CIRCLE
 DIAMONDHEAD, MS 39525

PROJECT NAME AND NUMBER:
 EAST ALOHA DRIVE ACCESS ROAD **ALIGNMENT NO. 2**

APPLICATION NUMBER: Distribution to:
 PERIOD TO: () OWNER
 ENGINEER'S PROJECT NO: () ENGINEER
 CONTRACT DATE: AUGUST 21, 2016 () CONTRACTOR
 16
 % Complete Time: 100
 % Complete Value: 100

FROM (CONTRACTOR): TWIN L CONSTRUCTION, INC.
 8292 FIRETOWER RD.
 PASS CHRISTIAN, MS 39571

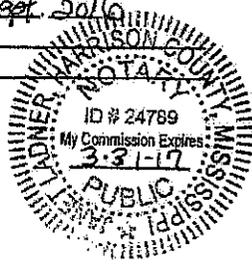
CONTRACTOR'S APPLICATION FOR PAYMENT

Application is made for Payment, as shown below, in connection with the Contract.
 Continuation Sheet is attached.

CHANGE ORDER SUMMARY			
Number	Date Approved		
TOTALS		\$	\$0
Net change by Change Orders		\$	-

The undersigned Contractor certifies that to the best of the Contractor's knowledge, information and belief the Work covered by this Application for Payment has been completed in accordance with the Contract Documents, that all amounts have been paid by the Contractor for Work for the previous Certificates for Payment were issued and payments received from the Owner, and that current payment shown herein is now due.

CONTRACTOR: TWIN L CONSTRUCTION, INC.
 By: Richard Johnson (Signature)
 State of: MISSISSIPPI County of: HARRISON
 Subscribed and sworn to before me this 13 day of Sept 2016
 Notary Public: Scott L. Don
 My Commission expires: 3-31-17



- 1. ORIGINAL CONTRACT SUM \$ 292,500.00
- 2. Net Change by Change Orders \$ -
- 3. CONTRACT SUM TO DATE \$ 292,500.00
- 4. TOTAL COMPLETED AND STORED TO DATE \$ 59,525.00
 (Column G on continuation sheet)
- 5. RETAINAGE:
 - a. 5 % of Completed Work \$ 2,976.25
 (Col. D+E on continuation sheet)
 - b. 5 % of Stored Material \$ -
 (Col. F on continuation sheet)
 Total retainage (Line 5a+5b or total in column I of continuation sheet) \$ 2,976.25
- 6. TOTAL EARNED LESS RETAINAGE \$ 56,548.75
 (Line 4 less Line 5 Total)
- 7. LESS PREVIOUS CERTIFICATES FOR PAYMENT
 (Line 5 from prior Certificate)
- 8. CURRENT PAYMENT DUE \$ 56,548.75
- 9. BALANCE TO FINISH, PLUS RETAINAGE \$0.00
 (Line 3 less Line 4)

ENGINEER'S CERTIFICATE FOR PAYMENT

In accordance with the Contract Documents, based on on-site observations and the data comprising the above application, the Engineer certifies to the owner that to the best of their knowledge, information and belief the work has progressed as indicated, the quality of work is in accordance with the Contract Documents, and the Contractor is entitled to payment of the AMOUNT CERTIFIED.

AMOUNT CERTIFIED \$ 56,548.75

(Attach explanation if amount certified differs from the amount applied for. Initial all figures on this application and on the continuation sheet that are changed to conform to the amount certified.)

ENGINEER: Roland J. Diaz Jr. (Signature)
 By: _____ Date: 9/15/16

CONTINUATION SHEET

APPLICATION AND CERTIFICATE FOR PAYMENT, containing

Contractors signed Certification is attached

In tabulations below, amounts are stated to the nearest dollar.

Use Column J on Contracts where variable retainage for line items may apply.

APPLICATION NUMBER:

1

APPLICATION DATE:

02/09/16

PERIOD TO:

02/09/16

CITY'S PROJECT NO: 973

A ITEM NO.	B1 DESCRIPTION OF WORK	B2 QTY	B3 UNIT	B4 UNIT PRICE	C SCHEDULED VALUE	D TOTAL WORK IN UNITS			E TOTAL WORK VALUE			F MATERIALS PRESENTLY STORED (NOT IN E1 OR E2)	G TOTAL COMPLETED AND STORED TO DATE (E3+F)		H BALANCE TO FINISH - UNITS	I BALANCE TO FINISH - VALUE	J RETAINAGE IF APPL.
						D1 COMPLETED PREVIOUS	D2 COMPLETED THIS PERIOD	D3 COMPLETED TO DATE (D1+D2)	E1 COMPLETED PREVIOUS	E2 COMPLETED THIS PERIOD	E3 COMPLETED TO DATE (E1+E2)		% (G/C)				
1	MOBILIZATION	1	LS	\$ 5,000.00	\$ 5,000.00		1	1		\$ 5,000.00	\$ 5,000.00	\$ -	\$ 5,000.00	100%	0.00	\$ -	\$ 250.00
2	SURVEYING	1	LS	\$ 18,000.00	\$ 18,000.00		0.4	0.4		\$ 7,200.00	\$ 7,200.00		\$ 7,200.00	40%	0.60	\$ 10,800.00	\$ 360.00
3	TRAFFIC CONTROL	1	LS	\$ 18,000.00	\$ 18,000.00		0.47	0.47		\$ 7,520.00	\$ 7,520.00		\$ 7,520.00	47%	0.53	\$ 8,480.00	\$ 376.00
4	SITE CLEARING	1	LS	\$ 30,000.00	\$ 30,000.00		0.84	0.84		\$ 25,200.00	\$ 25,200.00		\$ 25,200.00	84%	0.16	\$ 4,800.00	\$ 1,260.00
5	EROSION CONTROL	1	LS	\$ 8,500.00	\$ 8,500.00		0.73	0.73		\$ 6,205.00	\$ 6,205.00		\$ 6,205.00	73%	0.27	\$ 2,295.00	\$ 310.25
6	22 X 13 RACP	1	LS	\$ 5,000.00	\$ 5,000.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 5,000.00	\$ -
7	22 X 13 FLARED END SEC.	1	LS	\$ 8,000.00	\$ 8,000.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 8,000.00	\$ -
8	44 X 27 RACP	1	LS	\$ 14,000.00	\$ 14,000.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 14,000.00	\$ -
9	44 X 27 SNG HEADWALL	1	LS	\$ 10,000.00	\$ 10,000.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 10,000.00	\$ -
10	CATCH BASIN	1	LS	\$ 6,000.00	\$ 6,000.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 6,000.00	\$ -
11	SUB-BASE & BASE	1	LS	\$ 30,000.00	\$ 30,000.00		0.28	0.28		\$ 8,400.00	\$ 8,400.00		\$ 8,400.00	28%	0.72	\$ 21,600.00	\$ 420.00
12	LIMESTONE	1	LS	\$ 45,700.00	\$ 45,700.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 45,700.00	\$ -
13	2" ASPHALT BASE	1	LS	\$ 34,150.00	\$ 34,150.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 34,150.00	\$ -
14	2" ASPHALT SURFACE	1	LS	\$ 34,150.00	\$ 34,150.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 34,150.00	\$ -
15	ROAD STRIPING & SIGNAGE	1	LS	\$ 18,000.00	\$ 18,000.00			0		\$ -	\$ -		\$ -	0%	1.00	\$ 18,000.00	\$ -
16	CONSTRUCTION ALLOWENCE	1	LS	\$ 10,000.00	\$ 10,000.00			0		\$ -	\$ -		\$ -	0%		\$ 10,000.00	\$ -
TOTALS					\$ 292,500.00					\$ 69,525.00	\$ 69,525.00	\$ -	\$ 69,525.00			\$ 232,975.00	\$ 2,078.25

Agenda Item 2016-175



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www.diamondhead.ms.gov

September 16, 2016

Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

Re: AFLAC – Voluntary Insurance Products

AFLAC began offering products to City of Diamondhead employees effective April 1, 2016. At that time, open enrollment and Section 125 elections had been concluded for the period November 1, 2015 – October 31, 2016. Therefore, AFLAC products purchased by employees were deducted post-tax.

Open enrollment is quickly approaching and in order to allow for pre-tax deductions, AFLAC must be added to our current Section 125 plan administered through Colonial Insurance Company. Attached is the document necessary complete this process. AFLAC products being offered are as follows:

Accident Advantage	AFLAC Plus Rider	Cancer
Short-term Disability	AFLAC Hospital Advantage (Series A49400 Option 2 & 4)	
Cancer	Dental (Level 2)	
Vison NOW		

Thank you in advance for your consideration and approval in this matter.

Sincerely,

A handwritten signature in black ink that reads 'Clovis Reed'.

Clovis Reed
City Manager

attachment

Account Name: City of Diamondhead
 Tax ID: _____ Group No.: J0639 Writing No.: J14279

Payroll Account Acknowledgment

All applicable sections must be completed for processing.

- INSTRUCTIONS**
- ALL accounts must complete Section 8, Authorization and Signatures.
 - Accounts establishing or modifying a WingspanSM cafeteria plan must complete Section 5.
 - Accounts with another carrier's cafeteria plan must complete Section 7.
 - Broker Information must be completed in Sections 9 and 10.
 - Fax the completed form to 1-866-AFL-NASA (1-866-235-6272).

1. GENERAL ACCOUNT INFORMATION

New Aflac Payroll Account
 Changes to an Existing Aflac Payroll Account
 Split or Transferred Account

Group Number: J0639
 Transferring From Account: _____

Will new split account be affiliated with an existing Aflac account? Yes, Account: _____ No

Does this account have multiple locations, each requiring an invoice? Yes No

Are there any existing policies to place on this account? Yes No (If yes, list the policies on a separate page and send it with the completed Payroll Account Acknowledgment form to Aflac WWHQ.)

Name of Account: City of Diamondhead

Type of Business:	Tax ID No.:	SIC Internet Request No.:
-------------------	-------------	---------------------------

Affiliate/Subsidiary of (if applicable):	Master Account No.:
--	---------------------

Mailing Address:

City:	State:	Zip:
-------	--------	------

Location Address: Check if same as mailing address (P.O. Box is not acceptable).

City:	State:	Zip:	Phone:	Fax (if applicable):
-------	--------	------	--------	----------------------

Total Employees: _____ Total Benefits-Eligible Employees: _____ Total Benefits-Eligible W-2 Employees: _____

Total benefits-eligible 1099 Workers: _____	Will benefits-eligible 1099 workers be applying for coverage? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
---	---

Is this a leasing company or staffing agency? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	If yes, will the temporary/leased employees be applying for coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	--

Account Website Address (if applicable): www.diamondhead.ms.gov

Is there an established Aflac New York account? Yes No If yes, provide the name and group number:

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

Please consult with employer's payroll contact to ensure accurate completion of the next section.

- What led your organization to begin offering Aflac products to your employees? (Check all that apply.)
- Employee/Member Request
 - Benefit Package Improvement
 - Benefit Advisor or Broker Recommendation
 - Sales Associate/Agent
 - Commercial Advertising
 - Value of Aflac Products
 - Other: _____

2. ENROLLMENT INFORMATION

Enrollment Period: What is the length of the enrollment period? _____ (Options are 30, 60, or 90 days.)

Will the enrollment period exceed 90 days? Yes No

If yes, has this been approved by Sales Support?
 Yes No

Enrollment Provider(s): Field Broker Enrollment Firm Unknown

(If Enrollment Firm is selected, please provide the Enrollment Firm Name and Writing No.)

Enrollment Firm Name: _____

Enrollment Firm Writing No (if applicable): _____

Enrollment Method(s): One-on-One SNG Paper One-on-One 3rd Party laptop Call Center Web

Enrollment Platform Name (if applicable): _____

3. BILLING INFORMATION

3a. BILLING CONTACT INFORMATION

NOTE: Aflac will contact the designated billing contact to review information.

All accounts with fewer than 1,000 employees will receive their invoice via Aflac's WingspanSM Online Services for Accounts system. With the Online Billing feature, you have the option of making payments and reconciling your account online. Once your account is established, you can submit your invoice and payment electronically from the bank account noted below. At that time, if you prefer, you may also choose to pay by mailing a check. Aflac will not debit your account until you have reconciled and submitted your invoice for payment. Any adjustments or requested changes you submit electronically will not be processed until payment is received and the transaction is complete.

Bank Routing No.: _____ Account No.: _____ Account Type: Checking Savings

Contact for Billing Inquiries: Mr. Ms.

Billing Contact Phone: _____ Ext: _____ Fax (if applicable): _____

Best Time to Make Contact Call: a.m. p.m. Billing Contact Email (required): _____

Will an associate, broker, or other third party be collecting and remitting Aflac premiums? Yes No
If yes, provide the name and contact information below.

Name: _____ Contact Phone: _____

AccountName: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

3b. BILLING FREQUENCIES

Invoice Due Date: On what day of the month would you like your Aflac invoice to be due (o 1st or the o 15th)?

How often would you like to receive your invoice from Aflac?

 Monthly (Aflac will bill for the number of deductions made the previous month. For example: Deductions made January 1st through the 31st will be due in February.)

Note: Moded accounts (8-, 9-, or 10-month billings) cannot accommodate weekly or biweekly deductions.

8-Month (8 invoices) 9-Month (9 invoices) 10-Month (10 invoices)

For 8-, 9-, or 10-month billings, indicate months when no deductions will be made:

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Quarterly (4 invoices)

Semiannual (2 invoices)

Annual (1 invoice)

For quarterly, semiannual, and annual, initial premiums must be submitted with applications.

Account Name: _____
Tax ID: _____ Group No.: _____ Writing No.: _____

3c. BILLING FORMAT

Check if account uses Social Security number for employee number.

N/C

In what order would you like your employees listed on your bill?
(If more than one is checked, please number your choices according to priority.)

Alphabetic _____ Department No. _____ Employee No. _____

EXAMPLE: To request a bill with employees listed alphabetically under their department numbers, you would mark:

Alphabetic 2 Department No. 1 Employee No. _____

4. DEDUCTION INFORMATION

Employer Contributions: Does the employer pay any portion of this benefit? Yes No

If yes, please provide percent: _____% OR flat dollar amount: \$ _____
Percent or dollar amount must be a whole number, such as 50% or \$10.

Based on the information provided in this section, Aflac will determine the number of deduction periods billed each month (when the account selects monthly billing).

If you choose a monthly billing frequency, indicate the number of payroll deductions made annually for insurance premiums.

Check if premiums are deducted at different frequencies for different employees (i.e., some employees are deducted weekly while others are deducted biweekly), and indicate the different frequencies that exist for the account. An additional account(s) will be established using this information.

N/C

Initial Deduction: When will premium deductions begin?

Note: The date of the first deduction should be the date the payroll account physically obtains funds from the employees. It does not necessarily equal the pay date for the employees. The 52, 26, 24, and 12 deductions do not apply to 8-, 9-, or 10-month billing.

52 Deductions – Date of first deduction: ____/____/____ Date of second deduction: ____/____/____

26 Deductions – Date of first deduction: ____/____/____ Date of second deduction: ____/____/____

24 Deductions – Date of first deduction: ____/____/____ Date of second deduction: ____/____/____

12 Deductions – Date of first deduction: ____/____/____ Date of second deduction: ____/____/____

Does employer withhold deductions on weekends? Yes No

NOTE: By initialing this box, the employer understands that premium payments are due to Aflac by the due date listed on each invoice, and payments are considered past due 10 days after the invoice due date. Therefore, the employer will make every attempt to provide premium payments to Aflac by the due date on each invoice.

Account Name: _____
 Tax ID: _____ Group No.: _____ Writing No.: _____

5. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first six months after the disability begins. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, Aflac will notify the employer of the amount of disability benefits to be paid. Aflac will withhold the employee's portion of FICA taxes and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes, and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: Yes No

NOTE: At least one disability type must be marked if the question above is checked yes.

All the remaining questions in the section below must be answered if disability is being offered.

- Authorized disability coverage types: Accident/Disability Short-Term Disability Off-the-job
- Authorized riders: Off-the-job On-the-job Sickness Spouse

Will any portion of disability premiums be funded by employer contributions? Yes No

If yes, please provide percent: _____% OR flat dollar amount: \$ _____ Per

Will any portion of disability premiums be funded by pre-tax employee contributions? Yes No

This employer is a government employer exempt from FICA or a portion of FICA. Yes No

Employees of this employer are eligible for RRTA (Railroad Retirement Tax). Yes No

NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions, and limitations.

6. WINGSPANSM CAFETERIA PLAN

Please consult with employer's cafeteria plan contact to ensure accurate completion of the next section.

- New WingspanSM Cafeteria Plan
- WingspanSM Cafeteria Plan Change Request
- Requesting Additional Payroll Account Number for Existing WingspanSM Cafeteria Plan

Plan/Company Name:	Tax ID:
Plan Type: What type of cafeteria plan will this be? (FSA = Flexible Spending Account) <input type="checkbox"/> Premium Only – no FSAs <input type="checkbox"/> Self-Administered with FSAs (employer processes FSA claims)	
Plan Year: What are the dates of this plan? Plan Start Date: ____/____/____ Plan End Date: ____/____/____	
Plan Sponsor/Legal Representative: List the plan sponsor and legal representative for this cafeteria plan.	
Plan Sponsor/Principal Contact:	Email address:
Phone:	Fax:
Legal Representative's Name:	Title:

Account Name: _____
 Tax ID: _____ Group No.: _____ Writing No.: _____

Is this a leasing company or professional employee organization (PEO)? Yes No

Business Type: Corporation Sub S Corporation Partnership Sole Proprietorship
 Other _____

N/C

Eligibility: Indicate eligibility criteria (e.g., eligibility dates, exceptions) for your cafeteria plan.

Employees will become eligible: Immediately upon the first day of employment.
 On the _____ day following commencement of employment.
 On the first day of the month following _____ days of employment.
 Other _____

All employees will be eligible under the plan except: _____

Authorization to Add Benefits Mid-Year (Complete if adding benefits to a WingspanSM cafeteria plan at mid-year.)

Effective Start Date of Additional Benefits: _____/_____/_____

Cafeteria Plan Benefits: (To add, account must be qualified under Section 106 of the Internal Revenue Code.)

Check plans to add:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Long-Term Disability | <input type="checkbox"/> Vision Care | <input type="checkbox"/> Intensive Care |
| <input type="checkbox"/> Short-Term Disability | Accident | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hospital Indemnity |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Group Term Life | <input type="checkbox"/> Specified Health Event | |
| <input type="checkbox"/> Personal Sickness Indemnity | <input type="checkbox"/> HSA (Section 223) | | |

Affiliated Companies: List the names and tax ID numbers of all affiliated companies adopting this plan.

Company Name: _____	Tax Identification Number: _____
---------------------	----------------------------------

7. SELF-ADMINISTERED FLEXIBLE SPENDING ACCOUNT INFORMATION

(not applicable to Premium-Only Plans)

FSA Type: Which types of FSAs will be included in this cafeteria plan? (Complete for self-administered plans.)

- Section 105: Unreimbursed medical expense annual maximum per participant requested by employer: \$ _____
 Check to include Grace Period option for this benefit.
- Section 129: Dependent child care annual maximum per participant cannot exceed \$5,000 by law.
 Check to include Grace Period option for this benefit.

N/A

8. OTHER CARRIER'S (NOT WINGSPANSM CAFETERIA PLANS) CAFETERIA PLAN INFORMATION

Please consult with employer's cafeteria plan contact to ensure accurate completion of next section.

Current plan year dates required: 11/1/16 through 10/31/17

Renewal dates required: _____/_____/_____ through _____/_____/_____

Authorization to Add Benefits Mid-Year (Complete ONLY if adding benefits to a non-WingspanSM cafeteria plan at mid-year.)

Effective Start Date of Additional Benefits: _____/_____/_____

Benefits (check new benefits to be added):

- | | | | |
|---|---|--|--|
| <input checked="" type="checkbox"/> Medical | <input type="checkbox"/> Long-Term Disability | <input checked="" type="checkbox"/> Vision Care | <input type="checkbox"/> Intensive Care |
| <input checked="" type="checkbox"/> Short-Term Disability | <input checked="" type="checkbox"/> Accident | <input checked="" type="checkbox"/> Cancer | <input checked="" type="checkbox"/> Hospital Indemnity |
| <input checked="" type="checkbox"/> Dental | <input checked="" type="checkbox"/> Group Term Life | <input checked="" type="checkbox"/> Specified Health Event | |
| <input type="checkbox"/> Personal Sickness Indemnity | <input type="checkbox"/> HSA (Section 223) | | |

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

9. AUTHORIZATION AND SIGNATURES – EMPLOYER

Aflac assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. Aflac also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employees, except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under state or federal laws.

The employer agrees to provide Aflac (and its agents) with certain personally identifiable information (including but not limited to compensation, Social Security numbers, addresses, etc.) regarding its officers and employees for Aflac (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan, and Aflac products and services.

Aflac is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to Aflac.

The paragraph below only applies if establishing a WingspanSM cafeteria plan:

The employer plans to establish/amend a flexible benefits plan in accordance with Section 125 of the Internal Revenue Code. The employer acknowledges that neither Aflac nor its agents are providing legal or tax advice, nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. Aflac shall have no power or authority to waive, alter, breach, or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of Aflac. The plan sponsor/administrator should consult its own tax advisor regarding the plan and any changes to the plan. The employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Authorizing Officer's Name/Title (please print): Mr. Ms.

Authorizing Officer's Email Address:

Authorizing Officer's Signature:

Date:

Account Name: _____
Tax ID: _____ Group No.: _____ Writing No.: _____

10. BROKER INDICATOR INFORMATION ONLY

(This section is used for tracking purposes only and does not cause business to pend. This section should contain the writing number of the brokerage firm or producer responsible.)

Broker's Company Name: _____	
Servicing Broker's Name: _____	
Servicing Broker's Writing Number: _____	Employee ID No.: _____

N/C

11. BROKER SECURITY/BLOCK

(This section is to be used only if the broker is going to be compensated via override/sit. code.)

Broker's Name: _____		
Broker's Writing Number: _____	Sit. Code: _____	Level: _____

N/C

Check here if there is no broker involved in this account.

12. ASSOCIATE/AGENT

I acknowledge that Aflac has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and Aflac may assign and/or reassign any account for servicing and designate who may solicit applications from persons in the account. I confirm that I am not an employee, officer, director, owner, or relative of any of the foregoing (or otherwise a party in interest as defined under ERISA). I acknowledge that, for Key Accounts as defined in the Key Account Management Procedures, the proper guidelines will be followed to provide the most efficient service to the account. I confirm that I will register any such account with Key Account Management, regardless of whether I use their assistance in the overall management and coordination of the enrollment. I understand that I am not authorized to collect premium from this account without specific written approval from Aflac.

Associate's/Agent's Signature: _____	Date: _____
--------------------------------------	-------------

Associate's/Agent's Name: _____

Writing Number: _____	Sit. Code: _____	Geographical Code: _____
Phone Number: _____	Fax Number: _____	

Did you obtain the account through a competitive takeover? Yes No

If yes, list the competitor(s) involved: _____

Note: A competitive takeover is when an existing voluntary carrier is already working with the account and the decision-maker decides to switch to Aflac.

Account Name: _____
Tax ID: _____ Group No.: _____ Writing No.: _____

Group Short-Term Disability Insurance

Number of Eligible Employees at Company: _____	Participation Requirements (%): _____
--	---------------------------------------

(A minimum of 30% participation is required for all eligible employees.)

Guaranteed-Issue Only:

Benefit Amount	\$ _____
Elimination Period (Injury/Sickness)	_____
Benefit Period	_____

Simplified-Issue Only:

Benefit Amount	\$ _____
Elimination Period (Injury/Sickness)	_____
Benefit Period	_____

Group Short-Term Disability Approval Date: _____/_____/_____

Group Short-Term Disability Withdrawal Date: _____/_____/_____

Dental Requirements

Dental Plan Start Date: _____/_____/_____

Dental Plan Stop Date: _____/_____/_____

Number of Eligible Employees for Dental at Company: _____	Participation Requirements: _____
---	-----------------------------------

Long-Term Care Requirements

Long-Term Care Plan Start Date: _____/_____/_____

Long-Term Care Plan Stop Date: _____/_____/_____

Revised Personal Short-Term Disability

Exempt From Standard Salary Income Chart: _____

Accident/Disability Revised Income Replacement

Exempt From Standard Salary Income Chart: _____

Agenda Item 2016-176



5000 Diamondhead Circle • Diamondhead, MS 39525-3260
Phone: 228.222.4626 Fax: 228.222.4390
www.diamondhead.ms.gov

September 16, 2016

Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

Re: Insurance Renewal- Blue Cross Blue Shield of Mississippi – Major Medical

Bobbi Kittle with Hub International, Inc. has provided us with renewal premiums for Major Medical written through Blue Cross Blue Shield of Mississippi. The following is a monthly premium breakdown of the renewals:

	Current	Renewal
Single (employer paid)	\$711.28	\$625.14
EE/SP (employee paid)	\$912.82	\$823.12
EE/CH (employee paid)	\$418.69	\$379.73
Family (employee paid)	\$1,387.58	\$1,256.94

The renewal premium constitutes a 12% reduction in the employer paid premium and will be in effect for period the beginning January 1, 2017 and ending December 31, 2017.

Thank you in advance for your consideration and approval in this matter.

Sincerely,

Clovis Reed
City Manager

CR:jk

Agenda Item 2016-177



5000 Diamondhead Circle • Diamondhead, MS 39525-3260
Phone: 228.222.4626 Fax: 228.222.4390
www.diamondhead.ms.gov

September 15, 2016

Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

Re: Approval to advertise for the purchase of equipment for the Public Works Department

Approval is hereby requested to advertise for bids for the purchase of a track hoe and triple axle equipment transport trailer for Public Works Department. These items along with a dump truck to be purchased through state contract pricing are FY17 budgeted items to be acquired with lease purchase fund proceeds.

Thank you in advance for your favorable consideration and approval in this matter.

Sincerely,

A handwritten signature in black ink that reads 'Clovis Reed'. The signature is written in a cursive style with a large, looping 'C' at the beginning.

Clovis Reed
City Manager

CR:jk

Agenda Item 2016-179



5000 Diamondhead Circle • Diamondhead, MS 39525-3260
Phone: 228.222.4626 Fax: 228.222.4390
www.diamondhead.ms.gov

September 15, 2016

Mayor and Council
City of Diamondhead
5000 Diamondhead Circle
Diamondhead, MS 39525

Dear Gentlemen:

Re: Approval to advertise for bids for the Construction of the City Hall Exercise Fitness Trail Project (RTP#0273)

Approval is hereby requested to advertise for bids for the construction of the City Hall Exercise Fitness Trail. Funding for this project will be \$96,000 of grant funds provided through Mississippi Department of Wildlife and Fisheries' Recreational Trail Program and local match funds in the amount of \$24,000.

Thank you in advance for your favorable consideration and approval in this matter.

Sincerely,

A handwritten signature in black ink that reads 'Clovis Reed'. The signature is written in a cursive style with a large, sweeping 'C' at the beginning.

Clovis Reed
City Manager

CR:jk