PIC®

EMPLOYER AGREEMENT

(TO BE COMPLETED IN FULL)

PROFESSIONAL INSURANCE CORPORATION

GENERAL INFORMATION

Name of Organization Nassau Conty Baord of County Commissioners Year Established _____

Account Contact Name: T.J."Jerry" Greeson

Address P.O. Box 1010 City Fernandina Bch. State Fl Zip 32035

Phone (904) 321-5700 (Include Area Code) Nature of Business County Government

Total Number of Eligible Full-Time Employees 200

INSURANCE COVERAGES

____	LIFE:	Employer will pay ____ %	Employee will pay ____ % of Premium
_X_	DISABILITY INCOME:	Employer will pay ____ %	Employee will pay 100 % of Premium
____	MEDICAL EXPENSE:	Employer will pay ____ %	Employee will pay ____ % of Premium
____	CANCER:	Employer will pay ____ %	Employee will pay ____ % of Premium

ACCOUNT DESCRIPTION

Is this Account a Cafeteria Benefit Program (Section 125)? X Yes ___ No

Disability Income is _X_ included in (under) Section 125. ___ not included in (under) Section 125.

___ partially included in (under) section 125.

If partially included, what _____ % of premium is included in (under) Section 125.

Are your employees exempt from Social Security taxes? ___ Yes _X_ No

BILLING INSTRUCTIONS

Bill: _X_ Monthly ___ Semi-Monthly ___ Bi-Weekly Other: _____ ($^{8}/_{12}$, $^{9}/_{12}$, $^{10}/_{12}$, Account Bills PIC)

Deductions Will Begin: _____ (Month, Day) Must Receive First Billing By: _____ (Month, Day)

Send Billings To: Board of County Commissioners, P.O. Box 1010 Fernandina Bch. Fl 32035

(If Different Than Above) _____

AUTHORIZATION

This Agreement authorizes the contact of employees/members of this Organization concerning insurance to be provided by Professional Insurance Corporation. Authorization is given to send billings to the location named above. The responsibility in assuring that premiums have been remitted to Professional Insurance Corporation on behalf of their employees/members is that of the Organization named above. Either the Organization or Professional Insurance Corporation may, upon reasonable notice to the other, terminate this Agreement, in which event the payment of premiums will be a matter of accounting directly between each employee/member and Professional Insurance Corporation.

Date 9-26-94 Signature _____ Title Chairman

Employer Authorized Official

_____

Signature of PIC Insurance Representative

Employer may be subject to certain State and/or Federal Employment related laws (including ERISA, IRC Sections 89 and 125, and COBRA) and is solely responsible for compliance with these laws including any required benefit payments not covered by an Insurance Plan.

PIC HOME OFFICE USE ONLY

Account Number ☐☐☐☐☐ Due Day _____ Due Code _____ Eff. Day _____

SIC Code ☐☐☐☐

Agent # _____ RAD # _____ No. of Insureds _____ Guarantee Issue ☐Yes ☐No

Plans of Coverage _____

PIC Home Office Approval

Original and 1 Copy - Home Office; 1 Copy - Employer

Supply No. 1-85-0684-3-0392