



**GROUP MASTER APPLICATION
PRINCIPAL HEALTH CARE OF FLORIDA, INC.**

Coverage and Premiums

Principal Health Care of Florida, Inc. (PHC) and Nassau County Government #2411 (Group), hereby agree that PHC shall arrange for the provision of health care services in accordance with the provisions of the applicable PHC HMO Membership Handbook (Handbook) and HMO Group Member Services Contract (Member Services Contract) and any Supplemental Benefit Explanations (Riders) and amendments thereto, to eligible Employees of Group and their Family Dependents who enroll in PHC. The applicable Group Enrollment Forms are hereby incorporated and made fully a part of the Handbook and Member Services Contract and Group Master Application. It is understood and agreed that no benefits will be provided until such time as the Handbook, Member Services Contract, and Group Master Application have been executed by PHC. Any change in the Handbook, Member Services Contract, or Group Master Application must be approved by an officer of PHC and attached to the affected Handbook, Member Services Contract, or Group Master Application. No agent or representative other than an officer of PHC has authority to change the Handbook, Member Services Contract, or Group Master Application or waive any of its provisions. The coverage(s) selected by Group are as follows:

Plan HMO Secure 5 PLUS _____

<u>Employee</u> \$133.52	<u>Employee + Spouse</u> \$287.07	<u>Employee + Child(ren)</u> \$267.04	<u>Family</u> \$394.95
< 30 \$ ____/mo	< 30 \$ ____/mo	< 30 \$ ____/mo	< 30 \$ ____/mo
30-34 \$ ____/mo	30-34 \$ ____/mo	30-34 \$ ____/mo	30-34 \$ ____/mo
35-39 \$ ____/mo	35-39 \$ ____/mo	35-39 \$ ____/mo	35-39 \$ ____/mo
40-44 \$ ____/mo	40-44 \$ ____/mo	40-44 \$ ____/mo	40-44 \$ ____/mo
45-49 \$ ____/mo	45-49 \$ ____/mo	45-49 \$ ____/mo	45-49 \$ ____/mo
50-54 \$ ____/mo	50-54 \$ ____/mo	50-54 \$ ____/mo	50-54 \$ ____/mo
55-59 \$ ____/mo	55-59 \$ ____/mo	55-59 \$ ____/mo	55-59 \$ ____/mo
60+ \$ ____/mo	60+ \$ ____/mo	60+ \$ ____/mo	60+ \$ ____/mo

The applicable benefits shall become effective on 10/1/94 (Effective Date), and will continue until and be renewed from month to month thereafter unless thirty-one (31) days advance notice is given by PHC to change, modify, or terminate said benefits. PHC reserves the right to change the rates applicable to these benefits upon thirty-one (31) days written notice to Group after the first anniversary date.

The amount of each Premium due from Group shall be the aggregate of the several amounts with respect to each Member enrolled hereunder at the time such Premium falls due; and the amount so payable with respect to each Member of Group shall be determined according to the benefits for which the Member is enrolled and the rates applicable to such benefits.

Because Premiums are based on the number of Members enrolled, it is the responsibility of Group to notify PHC of an enrollment or disenrollment of a Member of Group by submitting a Group Enrollment Form to PHC within thirty-one (31) days of the enrollment or disenrollment. PHC will not accept a retroactive enrollment or disenrollment beyond thirty-one (31) days of such enrollment or disenrollment.

Such Premiums shall be made on or before the first day of the month, for each month in which said benefits are in force, with respect to all persons enrolled hereunder at the time such Premium falls due. Benefits for a new Member or for additional or increased benefits for an existing Member that become effective on or before the fifteenth (15) day of any month shall be provided on the basis of Premium for the full month, whereas benefits for a new Member, or for additional or increased benefits for an existing Member that become effective after the fifteenth (15th) day of any month shall be provided for the balance of such month without Premium. This shall also apply to family benefits.

Coverage Specific to Group

The hours per week and months per year an Employee must be regularly scheduled to work to be considered Actively At Work and eligible for benefits are:

The following categories of Subscribers (e.g., Actively At Work, Disabled, Part-Time, Retired) are eligible for benefits:

Family Dependents _____ include _____ do not include the Subscriber's Spouse or eligible former Spouse as defined by Applicable State law or Court Decree; Dependent child under nineteen (19) years of age; Dependent Child who is a Full-Time Student under twenty-four (24) years of age; Dependent Child who is a Disabled Dependent. If Family Dependents do not include the above, explain:

The period of time newly hired Subscribers and their Family Dependents must wait before becoming eligible for coverage is:

90 days from date of hire

If husband and wife are both employed by Group, then each _____ shall _____ shall not be considered as an eligible dependent of the other for purposes of obtaining insurance. When there are Dependent Children covered, then one employee may elect to waive coverage and be an eligible dependent of the other employee so the Subscriber and all Family Dependents are covered on one Group Enrollment Form.

The date of termination of coverage shall be _____ the date of termination of employment, or x the last day of the month in which termination of employment occurs.

PHC's Pre-Existing condition and Evidence of Insurability provisions x are _____ are not waived by PHC under this Group Master Application.

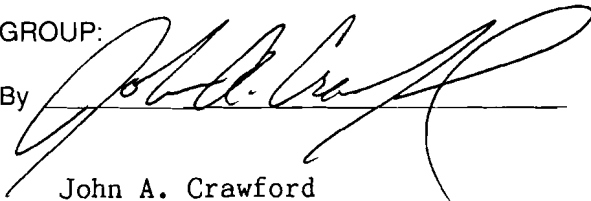
Group accepts/declines the following Supplemental Benefit Explanations (Riders):

- I. Prescription Drugs
 - a) ~~\$5/\$8~~ \$7/\$14 x Accepts _____ Declines
- II. Mental Health x Accepts _____ Declines
- III. Substance Abuse x Accepts _____ Declines

This Contract is made in the State of Florida.

IN WITNESS WHEREOF, the parties hereto have caused this Contract to be executed by duly authorized representatives this _____ day _____, 19_____.


GROUP:

By 

John A. Crawford
(Please Print Name)

Chairman
(Title)

9-26-94
(Date Signed)

By 

Bruno Littleton
(Please Print Name)

Executive Director
(Title)

9/15/94
(Date Signed)

(Licensed Resident Agent)

(Please Print Name)

(Date Signed)

(Witness)

(Date Signed)

(CORPORATE SEAL)

**PRINCIPAL HEALTH CARE OF FLORIDA, INC.
ACCEPTANCE/WAIVER**

In witness whereof, the parties enter into the Principal Health Care of Florida, Inc. Group Services Contract through the execution of this Face Sheet by their duly authorized representatives. Optional riders included in the Group Services Contract are accepted/declined as indicated below.

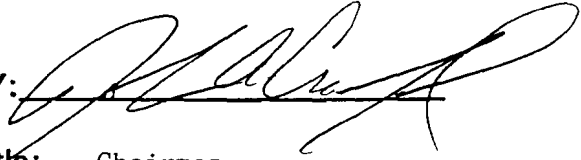
OPTIONAL RIDERS

	<u>ACCEPTS</u>	<u>DECLINES</u>
<p>I. Prescription Drugs \$5/\$8 \$7/\$14</p>	<p>_____</p> <p style="text-align: center;">x</p> <p>_____</p>	<p style="text-align: center;">x</p> <p>_____</p> <p>_____</p>
<p>II. Mental Health (State extended) Inpatient, Outpatient, and Partial Hospitalization</p>	<p>_____</p>	<p style="text-align: center;">x</p> <p>_____</p>
<p>III. Substance Abuse (State extended) Intensive Treatment, inpatient/outpatient confinement</p>	<p>_____</p>	<p style="text-align: center;">x</p> <p>_____</p>
<p>IV. PHC Mental Health/Substance Abuse</p>	<p style="text-align: center;">x</p> <p>_____</p>	<p>_____</p>

GROUP NAME: Nassau County Government

Address: P.O. Box 1010

Fernandina Beach, FL 32034

BY:  _____

Title: Chairman

Date: 9-26-94