AMERICAN MEDICAL
HEALTHCARE
Employer Group Application

☐ **Affiliation/Association** _____

EMPLOYER DATA

Employer Tax I.D. No. 59 1118 6130 1421

Full Legal Business Name Nassau County Board of County Commissioners

Street Address 416 Centre St, P.O.Box 1010 City Fernandina Bch State FL ZIP 32035

Mailing Address (if different) _____ City _____ State ____ ZIP _____

Phone No. (904) 321-5782 Fax No. (904) 321-5784 County Nassau

Nature of Business Municipality Date Business Started _____

Administrative Contact Person Henna Kerins Executive Contact Person Walt Gossett

Names/Addresses of Subsidiaries/Affiliates to be Included: _____

☐ Yes ☐ No Plan subject to collective bargaining? If yes, union name See Ap.#2 exp. date _____

Name of workers' compensation carrier RisCorp

☐ Yes ☒ No Are any employees not covered by workers' compensation?

☐ Yes ☐ No Do you request On-the-Job (medical) Protection for employees not eligible for and not covered by workers' compensation?

If yes, give names of employees N/A

☒ Yes ☐ No Are you subject to COBRA? (You are subject to COBRA if you employed at least 20 full or part-time employees on at least 50% of the working days during the previous calendar year.)

Give the names of persons currently under COBRA, state continuation plan, or within their election period:

Employee/Dependent Name	Termination Date of Employment or Qualifying Event	Employee/Dependent Name	Termination Date of Employment or Qualifying Event
see Aden.#3			

☐ Yes ☒ No Have you ever had a group insurance application denied by any insurer? If yes, give name of insurer, date and reason:

_____

☒ Yes ☐ No Is current group health coverage being replaced? If yes, give anticipated termination date: 1 Sept 1996

If yes to any of the above, please provide a copy of your last billing statement.

Proposed Employer contribution of premiums:

MEDICAL:

Employee	100	%
Employee & Child(ren)	_____	%
Employee & Spouse	_____	%
Family	_____	%

varies by department and Constitutional Offices

EMPLOYEE DATA

Total number of full-time active employees 400

Total number of "eligible" employees 400 Employee _____ & Child(ren) _____ Employee & Spouse _____ Family _____

(Do not include employees waiving enrollment in this Plan due to spouse's coverage.)

Total number of "enrolling" employees _____ Employee _____ & Child(ren) _____ Employee & Spouse _____ Family _____

☐ Yes ☐ No Are you establishing a retiree class for medical? If yes, attained age cov'g by FL retir. rules Years of Service _____

☐ Yes ☒ No Any excluded classes of employees? If yes, give descriptions and reasons: _____

Employee Classes (give descriptions if applicable):

Class I N/A Class III _____

Class II _____ Class IV _____

Employees working a minimum of 30 hours per week are eligible. If requested in writing, employees working a minimum of 20 hours per week are eligible in all states. If five or more eligible employees, retiree class may be included for medical insurance.

Employee probationary period: ☐ None ☐ 30 days ☐ 60 days ☒ 90 days ☐ Other may vary (Constitutional Offices)

Employee effective date is the first of the month after probationary period.

Employee termination date is the end of the month.

☐ Yes ☐ No Does current health insurer extend coverage for disabilities after termination date? If yes, provide copy of policy and/or employee certificate. (If the State requires the Employer's plan to treat pregnancy the same as any sickness and if this coverage does not provide, the Employer understands and agrees to be liable for payment of benefits and to notify the employees of same.)

MEDICAL: ☐ Standard ☐ Basic (Please fill in ALL medical plans being offered to your employees, up to 4)

Plan 1	Plan 2	Plan 3	Plan 4
Plan Name (As seen on proposal)	Plan Name (As seen on proposal)	Plan Name (As seen on proposal)	Plan Name (As seen on proposal)

Benefit Options:

☐ Point of Service (Indemnity coverage is underwritten by United Wisconsin Life Insurance Company)

EMPLOYER SPECIAL REQUESTS (Special requests are subject to written approval from American Medical HealthCare)

Please see Exhibits 1 and 2

EFFECTIVE DATE / PREMIUM DEPOSIT

Applications may be submitted with a requested effective date. To obtain the requested effective date on non-medically underwritten groups, all required forms must be complete, accurate, and received in our home office prior to the requested effective date. For medically underwritten groups, the effective date will be determined by our underwriting department. Do not cancel your present coverage. Coverage is not in effect until you receive written confirmation from our home office underwriting department.

Requested effective date: _____

PAYMENT: CASH WITH APPLICATION

The group's first month's premium must be submitted with the Employer Group Application. All premiums must be paid with the employer's business check.

Total Premium Deposit: $ _____

PLOYER AGREEMENT

undersigned acknowledges reading the entire completed application and that the agent has explained the coverages, limitations, and exclusi r details of the coverage applied for, and the underwriting rules and regulations of the American Medical HealthCare. As the undersig loyer, I have received and understand American Medical HealthCare's Rating and Renewal Provisions, if applicable.

rage is not in effect until the undersigned receives written approval from American Medical HealthCare. Final approval or disappr t taken on the employer group coverage application until after all required information in the application, and required information for enrol loyees and their dependents, is submitted. No person other than an officer of the American Medical HealthCare has the authority to bind or a rage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to icant if the application is declined.

d At Nassau County, FL (City & State) Dated On 8/12/96 (Month, Day, Year)

l Business Name Nassau County Board of Commissioners

ature X [signature] (Must be signed by a person authorized to purchase coverage for this firm.)

d Signature and Title Tomas D. Branan, Vice Chairman

Identification (ID) cards to: ☐ Employer's Business Address ☐ Employee's Home Address ☐ Agent's Address

ERICAN MEDICAL SECURITY HEALTHCARE AGENT / PRODUCER INFORMATION

s Office Charlotte RSO

lucer Name Lawrence V. Giusti

ress 500 Centre Street Fernandina Beach, FL 32035

phone No. 904-354-3785 Fax No. 904-634-1302

ial Security No. 091-44-6886 Production Split ____ %

lucer Name ____

ress ____

phone No. ____ Fax No. ____

ial Security No. ____ Production Split ____ %

reby certify that all information contained in the application has been explained to the employer and that the answers are correct to the bes knowledge. I am not aware of anything unfavorable about the employer or any person proposed for coverage except as noted herein. I h plied with the underwriting rules and regulations and have explained to the employer the coverages, limitations and exclusions and other det e coverage applied for. I have notified the employer not to terminate present coverage until notified in writing by American Medical HealthC ceptance of this application. Any exceptions are detailed herein or on an attached sheet. Prior to completing this application, I, the undersig nt, have provided the above named employer with American Medical HealthCare's Rating and Renewal Provisions, if applicable.

nt Signature X Lawrence V. Giusti Date 8/21/96

nt Name (please print) Lawrence V. Giusti License Identification No./Soc. Sec. No. 091 44 6886

SE SUBMISSION

ase submit the following forms for application of coverage: Employer Group Application • Employee Enrollment forms • Medical History, I essary • First month's premium • A copy of your current billing if you are replacing coverage • A most recent copy of your Wage & Tax sort • A copy of the quoted rates.

OME OFFICE USE ONLY

up Effective Date ____ Approved By ____ Date ____

mments ____

AMERICAN MEDICAL
HEALTHCARE

AMERICAN MEDICAL HEALTHCARE

GROUP MASTER CONTRACT

Based on the application for this Group Master Contract made by Nassau County (herein called the Contractholder) and based on the payment of the premium when due, American Medical HealthCare agrees to pay the benefits as provided on the following pages.

All matter printed or written by American Medical HealthCare on the following pages forms a part of this Group Master Contract. A copy of the Contractholder's application is attached to and made part of this Contract.

This Group Master Contract becomes effective at 12:01 a.m. at the Contractholder's address on the Effective Date shown below.

This Contract is delivered in and governed by the laws of the State of Florida.

[GROUP MASTER CONTRACT NUMBER]

2800-12411, 2800-12412
2800-12413, 2800-12414
2800-12415, 2800-12416
2800-12430

[EFFECTIVE DATE]
September 1, 1996

[ANNIVERSARY DATE]
January 1, 1998

1900 Summit Tower Boulevard, Suite 700
Orlando, Florida 32810
Tel 407/660-1611
Fax 407/660-0203

1.0 INCORPORATION OF PROVISIONS

The provisions of the attached Certificate of Coverage, including the attached Schedule of Covered Services, are made part of the Group Master Contract.

2.0 RELATIONSHIP AMONG THE PARTIES.

The relationship between American Medical HealthCare and any other organization having a Group Master Contract with American Medical HealthCare is an independent contractor relationship. No such organization or employee or agent thereof is an employee or agent of American Medical HealthCare, and neither is American Medical HealthCare, nor any employee or agent of American Medical HealthCare, an employee or agent of such organization.

2.1 Neither the Contractholder nor any Member is the agent or representative of American Medical HealthCare and neither shall be liable for any acts or omissions of American Medical HealthCare, its agents, employees or Participating Providers with which American Medical HealthCare has made or will hereafter make arrangements for the performance of services under this Group Master Contract.

3.0 PREMIUMS

The total premium for coverage is the sum of the amounts below. The amounts are obtained by multiplying the number of Subscribers in each Schedule Classification by the Rate Per Subscriber.

Schedule of premiums

Schedule classification	monthly rate per subscriber	
	HMO/$15 Copay	POS/$15 Copay
Employee	$132.82	$139.33
Employee/Child	$233.12	$244.54
Employee/Spouse	$271.61	$284.93
Family	$378.66	$397.21

3.1 The first premium payment is due on or before the effective date. Each premium thereafter is due on the first day of each coverage month. The grace period under this Group Master Contract shall be 30 days from the date the premium is due. Premiums are due up to the date of termination of the Group Master Contract. A check is not a payment until it is honored by a bank. We reserve the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

3.2 The rates may be changed:
(1) when the Group Master Contract is changed;
(2) when there is a change in the makeup of the covered Subscribers;
(3) when Federal or state mandates require a change or increase in the required provisions of the plan; or
(4) on each Anniversary Date.

The Contractholder will be given 120 days notice before any such rate change occurs.

4.0 TERM AND TERMINATION

Based upon the application by the Contractholder and acceptance by American Medical HealthCare, this Group Master Contract shall become effective on the Effective Date shown herein. The Group Master Contract shall remain in effect until terminated by the Contractholder or American Medical HealthCare.

4.1 A period of 31 days is allowed for paying any premium other than the first one. The Group Master Contract will remain in force during the grace period, unless American Medical HealthCare has been advised in writing that the Group Master Contract is to cease prior to the end of the grace period. The Group Master Contract will cease if the Contractholder fails to pay the premium before the end of the grace period.

4.2 American Medical HealthCare may terminate the Group Master Contract when:
(a) Premium is not paid when due;
(b) Misrepresentation or fraud has occurred on the part of the Contractholder or any of the Contractholder's Members;
(c) The Contractholder does not report to American Medical HealthCare additions and deletions of Members in its health plan under the Group Master Contract within 30 days from the date the changes occur;
(d) Material violation of the Group Master Contract occurs; or
(e) The Contractholder's minimum participation or contribution requirements are not met as described in the Group Master Contract, if applicable.

4.3 In the event this Group Master Contract terminates and there are premiums due to American Medical HealthCare, the Contractholder will be financially responsible for the payment of the premium for the time coverage was in effect during the grace period. If the Group Master Contract is terminated, the Contractholder is solely responsible to notify the Members of the termination.

4.4 American Medical HealthCare will provide the Contractholder with one hundred and twenty (120) days notice prior to the termination of this Group Master Contract.

5.0 MISCELLANEOUS
The Contractholder agrees to participate in programs that may be established by American Medical HealthCare to control the costs of health care.

5.1 This Group Master Contract shall be subject to amendment or modification in accordance with any provisions hereof, or by mutual consent between American Medical HealthCare and the Contractholder, without the consent of the Members.

5.2 By electing coverage pursuant to this Group Master Contract, or accepting benefits hereunder, all Members or their applicable legal representative expressly agree to all terms, conditions and provisions hereof.

5.3 American Medical HealthCare may adopt reasonable policies, procedures, rules and interpretations to promote orderly and efficient administration of this Contract.

5.4 The Contractholder shall permit American Medical HealthCare reasonable access, when such may be requested, for the purposes of examining eligibility records of Members.

5.5 American Medical HealthCare reserves the right to control the use of its name and all symbols, trademarks and service marks presently existing or hereinafter established with respect to it. The Contractholder agrees that it will not use such name, symbols, trademarks, or service marks in advertising or promotional materials or otherwise without prior written consent of American Medical HealthCare and will cease any and all usage immediately upon request of American Medical HealthCare or upon termination of this Group Master Contract.

5.6 The Contractholder reserves the right to, and control of the use of its corporate and trade names, and parts thereof and all symbols and service marks presently existing or hereafter established. American Medical HealthCare will not use any of the foregoing in advertising and

promotional materials or in any other manner without the prior written consent of the Contractholder and will cease all authorized uses immediately upon termination of this Group Master Contract.

5.7 Any Group Master Contract which shall have been terminated as provided herein may be reinstated by American Medical HealthCare at its sole discretion.

5.8 No agent or other person, except an officer of American Medical HealthCare has authority to waive any conditions or restrictions of this Group Master Contract; to extend the time for making a payment; or to bind American Medical HealthCare by making any promise or representation or by giving or receiving any information. No change in this Group Master Contract shall be valid unless evidenced by an amendment signed by an officer of American Medical HealthCare and the Contractholder.

5.9 The Group Master Contract, the Employer Group Application and any amendments constitutes the entire understanding between the parties, supersedes all other contracts, and shall not be altered or amended except in writing.

5.10 The Contractholder agrees to:
(a) offer American Medical HealthCare coverage to all eligible persons;
(b) Deliver to the Members the HMO certificate of coverage, identification cards, and any other Member information as requested by American Medical HealthCare or required by law; and
(c) Comply with all policies and procedures established by American Medical HealthCare for the administration and interpretation of this Group Master Contract.

5.11 Conditions of eligibility and termination will not unfairly discriminate on the basis of age, sex, race, health, or economic status. Reasonable underwriting classifications for the purpose of establishing rates may be applied.

5.12 No statement except a fraudulent statement, made by the Contractholder or by or on behalf of a Member shall be used to void this Group Master Contract or terminate coverage after this Group Master Contract has been in force for a period of two (2) years.

5.13 No action shall be brought hereunder by the Contractholder against American Medical HealthCare, unless commenced within any applicable statute of limitations period.

6.0 NOTICE
Any written notice required under the Group Master Contract shall be sent to the following:

American Medical HealthCare
1900 Summit Tower Blvd., Suite 700
Orlando, FL 32810

To Group:
Nassau County Board of County Commissioners
416 Centre Street
PO Box 1010
Fernandina Beach, FL 32035

Signed:

Contractholder

Chief Executive Officer, American Medical HealthCare

AMERICAN MEDICAL
HEALTHCARE

Employer Group Application

☐ **Affiliation/Association** _____

EMPLOYER DATA

Employer Tax I.D. No. 59 118 6130 1421

Full Legal Business Name Nassau County Board of County Commissioners

Street Address 416 Centre St, P.O.Box 1010 City Fernandina Bch State FL ZIP 32035

Mailing Address (if different) _____ City _____ State _____ ZIP _____

Phone No. (904) 321-5782 Fax No. (904) 321-5784 County Nassau

Nature of Business Municipality Date Business Started _____

Administrative Contact Person Henna Kerins Executive Contact Person Walt Gossett

Names/Addresses of Subsidiaries/Affiliates to be included: _____

☐ Yes ☐ No Plan subject to collective bargaining? If yes, union name See Ap.#2 exp. date _____

Name of workers' compensation carrier RisCorp

☐ Yes ☒ No Are any employees not covered by workers' compensation?

☐ Yes ☐ No Do you request On-the-Job (medical) Protection for employees not eligible for and not covered by workers' compensation?

If yes, give names of employees N/A

☒ Yes ☐ No Are you subject to COBRA? (You are subject to COBRA if you employed at least 20 full or part-time employees on at least 50% of the working days during the previous calendar year.)

Give the names of persons currently under COBRA, state continuation plan, or within their election period:

Employee/Dependent Name	Termination Date of Employment or Qualifying Event	Employee/Dependent Name	Termination Date of Employment or Qualifying Event
see Aden.#3			

☐ Yes ☒ No Have you ever had a group insurance application denied by any insurer? If yes, give name of insurer, date and reason:

☒ Yes ☐ No Is current group health coverage being replaced? If yes, give anticipated termination date: 1 Sept 1996

If yes to any of the above, please provide a copy of your last billing statement.

Proposed **Employer** contribution of premiums:

MEDICAL:

Employee	100	%
Employee & Child(ren)	_____	%
Employee & Spouse	_____	%
Family	_____	%

varies by department and Constitutional Offices

EMPLOYEE DATA

otal number of full-time active employees 400

otal number of "eligible" employees 400 Employee ____ & Child(ren) ____ Employee & Spouse ____ Family ____

o not include employees waiving enrollment in this Plan due to spouse's coverage.)

otal number of "enrolling" employees ____ Employee ____ & Child(ren) ____ Employee & Spouse ____ Family ____

☐ Yes ☐ No Are you establishing a retiree class for medical? If yes, attained age cov'g by FL retir. rules Years of Service ____

☐ Yes ☒ No Any excluded classes of employees? If yes, give descriptions and reasons: ____

mployee Classes (give descriptions if applicable):

Class I N/A Class III ____

Class II ____ Class IV ____

mployees working a minimum of 30 hours per week are eligible. If requested in writing, employees working a minimum of 20 hours per week are eligible in all tates. If five or more eligible employees, retiree class may be included for medical insurance.

mployee probationary period: ☐ None ☐ 30 days ☐ 60 days ☒ 90 days ☐ Other may vary (Constitutional Offices)

mployee effective date is the first of the month after probationary period.

mployee termination date is the end of the month.

☐ Yes ☐ No Does current health insurer extend coverage for disabilities after termination date? If yes, provide copy of policy and/or employee certificate. f the State requires the Employer's plan to treat pregnancy the same as any sickness and if this coverage does not provide, the Employer understands and grees to be liable for payment of benefits and to notify the employees of same.)

MEDICAL: ☐ Standard ☐ Basic (Please fill in ALL medical plans being offered to your employees, up to 4)

Plan 1	Plan 2	Plan 3	Plan 4
Plan Name (As seen on proposal)	Plan Name (As seen on proposal)	Plan Name (As seen on proposal)	Plan Name (As seen on proposal)

Benefit Options:

☐ Point of Service (Indemnity coverage is underwritten by United Wisconsin Life Insurance Company)

EMPLOYER SPECIAL REQUESTS (Special requests are subject to written approval from American Medical HealthCare)

Please see Exhibits 1 and 2

EFFECTIVE DATE / PREMIUM DEPOSIT

Applications may be submitted with a requested effective date. To obtain the requested effective date on non-medically underwritten groups, all required forms must be complete, accurate, and received in our home office prior to the requested effective date. For medically underwritten groups, the effective date will be determined by our underwriting department. Do not cancel your present coverage. Coverage is not in effect until you receive written confirmation from our home office underwriting department.

Requested effective date: ____

PAYMENT: CASH WITH APPLICATION

The group's first month's premium must be submitted with the Employer Group Application. All premiums must be paid with the employer's business check.

Total Premium Deposit: $ ____

EMPLOYEE DATA

Total number of full-time active employees 400

Total number of "eligible" employees 400 Employee ____ & Child(ren) ____ Employee & Spouse ____ Family ____

(Do not include employees waiving enrollment in this Plan due to spouse's coverage.)

Total number of "enrolling" employees ____ Employee ____ & Child(ren) ____ Employee & Spouse ____ Family ____

☐ Yes ☐ No Are you establishing a retiree class for medical? If yes, attained age cov'g by FL retir. rules Years of Service ____

☐ Yes ☒ No Any excluded classes of employees? If yes, give descriptions and reasons: ____

Employee Classes (give descriptions if applicable):

Class I N/A Class III ____

Class II ____ Class IV ____

Employees working a minimum of 30 hours per week are eligible. If requested in writing, employees working a minimum of 20 hours per week are eligible in all states. If five or more eligible employees, retiree class may be included for medical insurance.

Employee probationary period: ☐ None ☐ 30 days ☐ 60 days ☒ 90 days ☐ Other may vary (Constitutional Offices)

Employee effective date is the first of the month after probationary period.

Employee termination date is the end of the month.

☐ Yes ☐ No Does current health insurer extend coverage for disabilities after termination date? If yes, provide copy of policy and/or employee certificate. (If the State requires the Employer's plan to treat pregnancy the same as any sickness and if this coverage does not provide, the Employer understands and agrees to be liable for payment of benefits and to notify the employees of same.)

MEDICAL: ☐ Standard ☐ Basic **(Please fill in ALL medical plans being offered to your employees, up to 4)**

Plan 1	Plan 2	Plan 3	Plan 4
Plan Name (As seen on proposal)	Plan Name (As seen on proposal)	Plan Name (As seen on proposal)	Plan Name (As seen on proposal)

Benefit Options:

☐ Point of Service (Indemnity coverage is underwritten by United Wisconsin Life Insurance Company)

EMPLOYER SPECIAL REQUESTS (Special requests are subject to written approval from American Medical HealthCare)

Please see Exhibits 1 and 2

EFFECTIVE DATE / PREMIUM DEPOSIT

Applications may be submitted with a requested effective date. To obtain the requested effective date on non-medically underwritten groups, all required forms must be complete, accurate, and received in our home office prior to the requested effective date. For medically underwritten groups, the effective date will be determined by our underwriting department. Do not cancel your present coverage. Coverage is not in effect until you receive written confirmation from our home office underwriting department.

Requested effective date: ____

PAYMENT: CASH WITH APPLICATION

The group's first month's premium must be submitted with the Employer Group Application. All premiums must be paid with the employer's business check.

Total Premium Deposit: $ ____

PLOYER AGREEMENT

undersigned acknowledges reading the entire completed application and that the agent has explained the coverages, limitations, and exclusions, r details of the coverage applied for, and the underwriting rules and regulations of the American Medical HealthCare. As the undersigned loyer, I have received and understand American Medical HealthCare's Rating and Renewal Provisions, if applicable.

erage is not in effect until the undersigned receives written approval from American Medical HealthCare. Final approval or disapproval t taken on the employer group coverage application until after all required information in the application, and required information for enrolling loyees and their dependents, is submitted. No person other than an officer of the American Medical HealthCare has the authority to bind or alter erage, and the undersigned agrees that any such attempt by the agent is void and is not effective. The deposit amount will be returned to the icant if the application is declined.

d At Nassau County, FL (City & State) Dated On 8/12/96 (Month, Day, Year)

l Business Name Nassau County Board of Commissioners

ature X [signature] (Must be signed by a person authorized to purchase coverage for this firm.)

d Signature and Title Tomas D. Branan, Vice Chairman

Identification (ID) cards to: ☐ Employer's Business Address ☐ Employee's Home Address ☐ Agent's Address

ERICAN MEDICAL SECURITY HEALTHCARE AGENT / PRODUCER INFORMATION

s Office Charlotte RSO

ducer Name Lawrence V. Giusti

ress 500 Centre Street Fernandina Beach FL 32035

phone No. 904-354-3785 Fax No. 904-634-1302

ial Security No. 091-44-6886 Production Split ____ %

ducer Name ____

ress ____

phone No. ____ Fax No. ____

cial Security No. ____ Production Split ____ %

reby certify that all information contained in the application has been explained to the employer and that the answers are correct to the best of knowledge. I am not aware of anything unfavorable about the employer or any person proposed for coverage except as noted herein. I have mplied with the underwriting rules and regulations and have explained to the employer the coverages, limitations and exclusions and other details he coverage applied for. I have notified the employer not to terminate present coverage until notified in writing by American Medical HealthCare cceptance of this application. Any exceptions are detailed herein or on an attached sheet. Prior to completing this application, I, the undersigned ent, have provided the above named employer with American Medical HealthCare's Rating and Renewal Provisions, if applicable.

ent Signature X Lawrence V. Giusti Date 8/21/96

ent Name (please print) Lawrence V. Giusti License Identification No./Soc. Sec. No. 091 44 6886

ASE SUBMISSION

ase submit the following forms for application of coverage: Employer Group Application • Employee Enrollment forms • Medical History, if cessary • First month's premium • A copy of your current billing if you are replacing coverage • A most recent copy of your Wage & Tax port • A copy of the quoted rates.

OME OFFICE USE ONLY

oup Effective Date ____ Approved By ____ Date ____

mments ____