# AMERICAN MEDICAL H E A L T H C A R E Employer Group Application

| ☐ Affiliation/Associat                             | lon                         |  |                          |  |                      | •                            |
|--|-----------------------------|--|--------------------------|--|----------------------|------------------------------|
| EMPLOYER DATA                                      |                             |  |                          |  |                      |                              |
| Employer Tax I.D. No.                              | 5   9   1                   | 18   613   014                             | 121   1                  | J  |                      |                              |
| Full Legal Business Name                           | e Nass                      | au County Bo                               | ard of Cour              | nty Commis                                 | sioners              |                              |
| Street Address 416 Co                              | entre S                     | t, P.O.Box 1                               | 010 City 1               | ernandina                                  | Bch State            | FL ZIP 32035                 |
| Mailing Address (if differe                        | nt)                         |  | City_                    |  | State                | ZIP                          |
| Phone No. (904) 32                                 | 1-5782                      | Fax  |                          |  |                      | lassau                       |
| Nature of BusinessM                                | unicipa                     | lity                                       |                          | Date                                       | Business Start       | ed                           |
|  |                             |  |                          |  |                      | t Gossett                    |
| Names/Addresses of Sub                             |                             |  |                          |  |                      |                              |
| ☐ Yes ☐ No Plan suble                              | ct to collecti              | ve bargaining? If ves.                     | union name See           | Ap.#2                                      | ————                 | rp. date                     |
| Name of workers' compen                            |                             |  |                          | <u> </u>                                   |                      |                              |
| ☐ Yes XX No Are any em                             | •                           |  |                          |  |                      |                              |
| •  | • •                         | •  | •                        | not eligible for an                        | nd not covered t     | by workers' compensation?    |
| If yes, give names of emp                          |                             | -  |                          |  |                      | ·                            |
|  |                             |  |                          |  |                      |                              |
| Yes O No Are you sul<br>of the working days during | bject to COI<br>the previou | BRA? (You are subjec<br>us calendar year.) | t to COBRA if you        | employed at least                          | : 20 full or part-ti | ime employees on at least 5  |
| Give the names of persons<br>Employee/Dependent Na | -                           | Termination Date of Em                     | ployment E               | r within their electi<br>mployee/Dependeni | •                    | Termination Date of Employme |
| see Aden.#3  |                             | or Qualifying Eve                          |                          |  |                      | or Qualifying Event          |
| <del></del>  | <del></del>                 |  |                          |  |                      |                              |
| પંતુ<br>□ Yes X0XNo Have you e                     | over had a g                | roup insurance applica                     | ation denied by any      | / insurer? If yes, g                       | live name of ins     | surer, date and reason:      |
| QuYes □ No Is current g                            | roup health                 | coverage being replac                      | ced? If ves. give ar     | nticipated terminal                        | tion date: 1         | Sept 1996                    |
| If yes to any of the above                         | -                           |  |                          |  |                      |                              |
| Proposed Employer contr                            | •                           | ,,,  |                          |  |                      |                              |
| MEDICAL:   | •                           |  |                          |  |                      |                              |
| Employee   | 100 %                       | •  |                          |  |                      | - *                          |
| Employee & Child(ren) _                            | %                           |  | 7 · - ·                  | <i>د</i>                                   |                      |                              |
| Employee & Spouse _                                |                             | -  | department<br>tional Off |  | _                    |                              |
| Family _   | %                           |  | cional off.              | ±0€2                                       |                      | Florida                      |

| EMPLOYEB 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   |   |  |   |                                     |
| Total number of "enrolling" employees  | Employee  | & Child(ren)                                     | Employee & Spouse   | Family                              |
| ☐ Yes ☐ No Are you establishing a retiree class for  |   |  |   |                                     |
| ☐ Yes ЙNo Any excluded classes of employees? I   | f yes, give description   | s and reasons;                                   | rules   |                                     |
| Employee Classes (give descriptions if applicable):  | <del>-</del>  |  |   |                                     |
| Class I N/A  |   | Class III  |   |                                     |
| Class II   |   | Class IV   |   |                                     |
| Employees working a minimum of 30 hours per week a states. If five or more eligible employees, retiree class   | are eligible. If request<br>may be included for r                   | ed in writing, employees w<br>nedical insurance. | rorking a minimum of 20 hours per wed   | ek are eligible in al               |
| Employee probationary period: . • None • • 3   | 00 days   | s XX90 days 🖸 O                                  | ther <u>may vary (Const</u>   |                                     |
| Employee effective date is the first of the month after p  | probationary period.  |  | •   | Offices)                            |
| Employee termination date is the end of the month.   |   |  |   |                                     |
| ☐ Yes ☐ No Does current health insurer extend cover (If the State requires the Employer's plan to treat pregragrees to be liable for payment of benefits and to notify                             | nancy the same as an  | y sickness and if this cove                      | es, provide copy of policy and/or emplo<br>grage does not provide, the Employer t | yee certificate.<br>Inderstands and |
| MEDICAL: □ Standard □ Basic (Please fill i   | n Al I medical pla  | one heing offered to v                           | our employees up to 4)  |                                     |
| Plan 1   | Plan 2  | Plar   | -   | Non 4                               |
|  | e (As seen on propos  | <del></del>                                      | <del>``</del>   | Plan 4<br>s seen on proposa         |
| Tan Ivania (As seen on proposal)   | o (As seen on propos  | al)  | Trail Name (A   | s seen on proposa                   |
|  |   |  |   |                                     |
|  |   | <b>_</b>   |   | <del></del>                         |
| Benefit Options:  • Point of Service (Indemnity coverage is underwrite)  | itten by United Wisco   | nsin Life Insurance Compa                        | any)  |                                     |
| EMPLOYER SPECIAL REQUESTS (Special   | requests are subjec   | t to written approval fro                        | m American Medical HealthCare)  |                                     |
| Please see Exhibits 1 a  | and 2   |  |   |                                     |
|  |   | _  |   |                                     |
| <del></del>  |   |  | <del></del>   |                                     |
|  |   |  |   |                                     |
| EFFECTIVE DATE / PREMIUM DEPOSIT   |   |  |   |                                     |
| Applications may be submitted with a requested required forms must be complete, accurate, and groups, the effective date will be determined by cuntil you receive written confirmation from our ho | effective date. To o<br>received in our hon<br>our underwriting dep | ne office prior to the requarkment. Do not cance | uested effective date. For medica   | lly underwritten                    |
| Requested effective date:  |   | <del></del>                                      |   |                                     |
| PAYMENT: CASH WITH APPLICATION   |   |  |   |                                     |
| The group's first month's premium must be subm business check.   | itted with the Emplo  | oyer Group Application.                          | All premiums must be paid with the  | ne employer's                       |
| Total Premium Deposit: \$  |   | <del></del>                                      |   |                                     |
|  |   |  |   |                                     |

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| 1 | OY | TE 7. | ACREE | EMENT |
|---|----|-------|-------|-------|

Indessigned acknowledges reading the entire completed application and that the agent has explained the coverages, limitations, and exclusive details of the coverage applied for, and the underwiding rules and regulations of the American Medical HealthCare. As the undersignary received and understand American Medical HealthCare's Rating and Renewal Provisions, it applicable.

rrage is not in effect until the undersigned receives written approval from American Medical HealthCare. Final approval or disapple taken on the employer group coverage application until after all required information in the application, and required information for enrol byses and their dependents, is submitted. No person other than an efficient 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 cant if the application is declined.

| dAt Nassau County, FL   | Dated On 8/12/96 .  |
|---|---|
| d Business Name Nassau County Board   | (North Cay Year)  |
| ature X   |   |
| d Signature and Tris Tomas D. Branat  | ne by a person superiors to curdence coverage for this limit.  Vice Chiairman   |
|   | se Address 🖸 Employee's Home Address 🖸 Agent's Address  |
| ERICAN MEDICAL SECURITY HEALTHCARE AGE  |   |
| Office Charlotte RSO  |   |
| lucer Name Lawrence V. Giu  |   |
| rass 500 (entre Stre  | eet Fernandina Brack FC 32035   |
| phone No. 904-354-3785  | · Fax No. 904-634-1302  |
| •   | Production Split  |
| lucer Name  | ·   |
| (a) Ex  | •   |
| phone No  |   |
| al Security No.   | <b>—</b> _  |
| cnowledge. I am not aware of anything unfavorable ab- plied with the underwriting rules and regulations and ha- e coverage applied for. I have notified the employer not cosptance of this application. Any exceptions are detaile in, have provided the above named employer with Ame int Signature. | tion has been expisined to the employer and that the answers are correct to the becan the employer or any person proposed for coverage except as noted herein. I have explained to the employer the coverages, limitations and exclusions and other deto to terminate present coverage until notified in writing by American Medical Health's indifferent or on an attached sheet. Prior to completing this application, I, the undersignificant Medical Health Care's Rating and Renewal Provisions, it applicable.  Ogte 921   96 |
| nt Name (please print)  | License (denimication No.) Sec. No  |
| SE SUBMISSION   |   |
| use submit the following forms for application of coverages say - First month's premium - A capy of your current of - A capy of the quoted rates.   | ge: Employer Group Application - Employee Enfolment forms - Medical History, in billing if you are replacing coverage - A most recent copy of your Wage, & Tax  |
| ME OFFICE USE ONLY  |   |
| up Effective DateApproved   | d By Date   |
| nmams   |   |
|   |   |



# **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, 1796

[ANNIVERSARY DATE]
January 1, 1998

#### 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 pe  | r subscriber   |
|-------------------------|------------------|----------------|
|                         | HMO/\$15 Copay   | POS/\$15 Copay |
| Employee                | \$132.82         | \$139.33       |
| Employee/Child          | \$233.12         | \$244.54       |
| Employee/Spouse         | <b>\$</b> 271.61 | \$284.93       |
| Family                  | <b>\$378.66</b>  | \$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

MC-0001-12-0-00 6/96

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.

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## 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

Femandina Beach, FL 32035

Signed:

Chief Executive Officer, American Medical HealthCare

# AMERICAN MEDICAL H E A L T H C A R E Employer Group Application

☐ Affiliation/Association

AP-0043-12-0-00 8/95

| EMPLOYER DATA  |      |
|--|------|
| Employer Tax I.D. No. 15 191 118 1 613 1 014 1 21 1 1 1  |      |
| Full Legal Business Name Nassau County Board of County Commissioners   |      |
| Street Address 416 Centre St, P.O.Box 1010City 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  |      |
| The state of the terminal of the state of th |      |
| 🔾 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 of the working days during the previous calendar year.)   | 50%  |
| Give the names of persons currently under COBRA, state continuation plan, or within their election period:  Employee/Dependent Name Termination Date of Employment Employee/Dependent Name Termination Date of Employee  | ment |
| or Qualifying Event or Qualifying Event  see Aden.#3   |      |
| <del></del>  |      |
| Yes XXNo Have you ever had a group insurance application denied by any insurer? If yes, give name of insurer, date and reason:   |      |
|  |      |
| Yes O 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) % varies by department and   |      |
| Employee & Spouse Constitutional Offices   |      |
| Family %   |      |

| EMPLOYED DATA  |  |  |  |   |                   |   |
|--|--|--|--|---|-------------------|---|
| otal number of full-time active employ   |  |  |  |   |                   |   |
| tal number of "eligible" employees   | 400  | Employee   | & Child(ren)   | Employee  | & Spouse          | Family                                  |
| o not include employees waiving en   | rollment in this Pla   | ın due to spouse's (   | coverage.)   |   |                   |   |
| otal number of "enrolling" employees   |  | Employee   | & Child(ren)   | Employee  | & Spouse          | Family                                  |
| Yes D No Are you establishing a  | retiree class for me   | edical? If yes, attair   | ned age <u>cov'g by</u>  |   | ears of Service   |   |
| Yes ZiNo Any excluded classes of   | of employees? If ye  | es, give description   | s and reasons:   | rules   |                   |   |
|  |  |  |  |   |                   |   |
| mployee Classes (give descriptions i   | f applicable):   |  |  |   |                   |   |
| Class I N/A  |  | _  | Class III  |   |                   |   |
| Class II   | ·  |  | Class IV   |   |                   | -                                       |
| mployees working a minimum of 30 tates. If five or more eligible employe   |  |  |  | orking a minimum of   | 20 hours per wee  | k are eligible in all                   |
|  |  | davs Q 60 day  |  | her <u>may var</u>  | v (Consti         | tutional                                |
| mployee effective date is the first of t   |  | •  |  | <u></u>   |                   | offices)                                |
|  | •  | boationary period.   |  |   |                   | ·                                       |
| mployee termination date is the end  |  |  |  |   |                   |   |
| Yes Q No Does current health ins<br>the State requires the Employer's pl   |  |  |  |   |                   |   |
| grees to be liable for payment of ben  |  |  |  | age does not provide  | s, ale Limpoyer u | ilderstalles alle                       |
| <del></del>  |  | -  |  |   |                   |   |
| EDICAL: 🗆 Standard 🗅 Basid   | c (Please fill in  | ALL medical pla  | ans being offered to yo  | our employees, up   | to 4)             |   |
|  |  |  |  |   |                   |   |
| Pian 1   |  | Plan 2   | Plan   | 3   | P                 | lan 4                                   |
| Pian 1 Pian Name (As seen on proposal)   | Plan Name  | Plan 2<br>(As seen on propo  |  |   | · -               |   |
|  | Plan Name  |  |  |   | · -               |   |
|  | Plan Name  |  |  |   | · -               |   |
|  | Plan Name  |  |  |   | · -               |   |
| Plan Name (As seen on proposal)  Benefit Options:  |  | (As seen on propo  | Plan Name (As s  | een on proposal)  | · -               |   |
| Plan Name (As seen on proposal)  |  | (As seen on propo  | Plan Name (As s  | een on proposal)  | · -               |   |
| Plan Name (As seen on proposal)  Benefit Options:  Point of Service (Indemnity cov   | erage is underwritt  | (As seen on propo<br>ten by United Wisco   | Plan Name (As so   | een on proposal)  | Plan Name (A      | s seen on proposal)                     |
| Plan Name (As seen on proposal)  Benefit Options:  Point of Service (Indemnity cov   | erage is underwrite  | (As seen on propo<br>ten by United Wisco   | Plan Name (As so   | een on proposal)  | Plan Name (A      | s seen on proposal)                     |
| Plan Name (As seen on proposal)  Benefit Options:  Description Point of Service (Indemnity cov   | erage is underwrite  | (As seen on propo<br>ten by United Wisco   | Plan Name (As so   | een on proposal)  | Plan Name (A      | s seen on proposal)                     |
| Plan Name (As seen on proposal)  Benefit Options:  Point of Service (Indemnity coverage)   | erage is underwrite  | (As seen on propo<br>ten by United Wisco   | Plan Name (As so   | een on proposal)  | Plan Name (A      | s seen on proposal)                     |
| Plan Name (As seen on proposal)  Benefit Options:  Point of Service (Indemnity coverage)   | erage is underwrite  | (As seen on propo<br>ten by United Wisco   | Plan Name (As so   | een on proposal)  | Plan Name (A      | s seen on proposal)                     |
| Plan Name (As seen on proposal)  Benefit Options:  Point of Service (Indemnity coverage)  BIPLOYER SPECIAL REQUES  Please see Exh  | erage is underwrite STS (Special re ibits 1 a  | (As seen on propo<br>ten by United Wisco   | Plan Name (As so   | een on proposal)  | Plan Name (A      | s seen on proposal)                     |
| Plan Name (As seen on proposal)  Benefit Options:  Point of Service (Indemnity covered)  EMPLOYER SPECIAL REQUES  Please see Exh   | erage is underwrite  STS (Special re ibits 1 a   | (As seen on propo<br>ten by United Wisco<br>equests are subje<br>nd 2  | onsin Life Insurance Compa   | een on proposal) any) m American Medic                        | Plan Name (A      | s seen on proposal                      |
| Benefit Options:  Point of Service (Indemnity covered and Please See Exh.)  EFFECTIVE DATE / PREMIUM pplications may be submitted with the property of the pro | erage is underwrite  ETS (Special re  ibits 1 a  | ten by United Wisconders are subjected and 2   | Plan Name (As some sal)  | een on proposal)  any)  m American Medic                      | Plan Name (A      | s seen on proposal                      |
| Benefit Options:  Point of Service (Indemnity covered and Please See Exh Please S | erage is underwrite  ETS (Special re  ibits 1 a  DEPOSIT  the a requested eraccurate, and re                                     | ten by United Wiscond 2  ffective date. To eceived in our ho   | Plan Name (As some on sin Life Insurance Compared to written approval from the requested effective office prior to the requested of the reques | een on proposal)  any)  m American Medic  ective date on non- | Plan Name (A      | s seen on proposal                      |
| Benefit Options:  Point of Service (Indemnity covered and Please See Exh.)  BEFFECTIVE DATE / PREMIUM pplications may be submitted with equired forms must be complete, roups, the effective date will be complete.  | erage is underwrite  ETS (Special re  ibits 1 a  DEPOSIT  the a requested e accurate, and re  letermined by out                  | ten by United Wiscond 2  ffective date. To eceived in our hour underwriting de   | onsin Life Insurance Compact to written approval from the requested effective office prior to the requestment. Do not cancel   | een on proposal)  any)  m American Medic  ective date on non- | Plan Name (A      | s seen on proposal,                     |
| Benefit Options:  Point of Service (Indemnity covered in the proposal)  Please see Exh  Please see Exh  EFFECTIVE DATE / PREMIUM  pplications may be submitted with a course, the effective date will be contil you receive written confirmate   | erage is underwrite  ETS (Special re  ibits 1 a  DEPOSIT  the a requested eraccurate, and re letermined by outloon from our home | ten by United Wisconders are subjected in our hour underwriting denied office underwriting denied office underwriting denied office underwriting denied in our hour underwriting denied in our underwriting denied | onsin Life Insurance Comparet to written approval from the requested effective office prior to the requested effective of the requested effective  | een on proposal)  any)  m American Medic  ective date on non- | Plan Name (A      | s seen on proposal)  rwritten groups, a |
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| EMPLOYE                           | ATAG   |                                     |   |   |                  |                                     |                                       |
|-----------------------------------|--|-------------------------------------|---|---|------------------|-------------------------------------|---------------------------------------|
| Total number of                   | of full-time active employees                                | 400                                 |   |   |                  |                                     |                                       |
| Total number o                    | of "eligible" employees $40$                                 | 0                                   | Employee                                      | & Child(ren)  | _ Employee &     | Spouse                              | Family                                |
| (Do not include                   | employees waiving enrolln                                    | nent in this Plan                   | due to spouse's co                            | overage.)   |                  |                                     |                                       |
| Total number of                   | of "enrolling" employees                                     |                                     | Employee                                      | & Child(ren)  | _ Employee &     | Spouse                              | Family                                |
| ☐ Yes ☐ No                        | Are you establishing a retir                                 | ee class for med                    | dical? If yes, attaine                        | edage <u>cov'g by FL re</u>   |                  | rs of Service                       |                                       |
| OlYes OXNo                        | Any excluded classes of er                                   | nployees? If ye                     | s, give descriptions                          | and reasons:  | rules            |                                     |                                       |
|                                   |  | <del></del>                         |   |   |                  |                                     |                                       |
|                                   | sses (give descriptions if ap                                |                                     |   |   |                  |                                     |                                       |
|                                   | N/A  |                                     |   | Class III   |                  |                                     |                                       |
| Class II                          |  |                                     |   | Class IV  |                  |                                     |                                       |
| Employees wo<br>states. If five o | orking a minimum of 30 hour<br>or more eligible employees, r | 's per week are<br>retiree class ma | eligible. It requeste<br>ly be included for m | d in writing, employees working a r<br>edical insurance.            | minimum of 20    | nours per week a                    | are eligible in ail                   |
|                                   | bationary period: □ No                                       |                                     | lays 🖸 60 days                                |   | ay vary          | (Constit                            | utional                               |
| Employee effe                     | ctive date is the first of the i                             | month after prob                    | pationary period.                             |   |                  | Of                                  | fices)                                |
| Employee tem                      | nination date is the end of th                               | ne month.                           |   |   |                  |                                     |                                       |
| ☐ Yes ☐ No                        | Does current health insure                                   | r extend covera                     | ge for disabilities at                        | ter termination date? If yes, provide                               | e copy of polic  | y and/or employe                    | e certificate.                        |
| (If the State re                  | quires the Employer's plant<br>able for payment of benefits  | to treat pregnan                    | cy the same as any                            | sickness and if this coverage doe                                   | s not provide, t | he Employer und                     | ierstands and                         |
| agrees to be in                   | able for paymont or benefits                                 |                                     |   |   |                  |                                     |                                       |
| MEDICAL:                          | ⊐ Standard  □ Basic (l                                       | Please fill in A                    | ALL medical pla                               | ns being offered to your emp  | loyees, up t     | o 4)                                |                                       |
|                                   | Plan 1   | 1                                   | Plan 2  | Plan 3  |                  | Pla                                 | ın 4                                  |
| Plan Nam                          | e (As seen on proposal)                                      | Plan Name (                         | As seen on proposa                            | al) Plan Name (As seen on p   | proposal) F      | Plan Name (As s                     | seen on proposal)                     |
| \ <u></u>                         |  | l ———                               |   | _   | -                |                                     |                                       |
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| Domostia                          | Ontions  |                                     |   | `   |                  | <del>-</del>                        |                                       |
|                                   | Options:<br>Service (Indemnity coverage                      | ge is underwritte                   | en by United Wisco                            | nsin Life Insurance Company)  |                  |                                     | <b></b>                               |
|                                   |  | · .                                 |   |   |                  | 11 (11 (2 - 1)                      |                                       |
|                                   |  |                                     |   | t to written approval from Amer                                     | rican Medical    | HealthCare)                         |                                       |
| P1                                | ease see Exhib   | oits 1 ar                           | nd 2  |   |                  |                                     |                                       |
|                                   |  | <del></del> -                       |   |   |                  |                                     |                                       |
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|                                   | E DATE / PREMIUM DE  |                                     |   |   |                  |                                     | · · · · · · · · · · · · · · · · · · · |
| Applications                      | may be submitted with a                                      | a requested ef                      | fective date. To o                            | btain the requested effective d<br>ne office prior to the requested | ate on non-m     | edically underw<br>a. For medically | vritten groups, all<br>vunderwritten  |
| groups, the                       | effective date will be dete                                  | ermined by ou                       | r underwriting de                             | partment. Do not cancel your p                                      | resent covera    | age. Coverage                       | is not in effect                      |
| until you rec                     | eive written confirmation                                    | from our hom                        | e office underwri                             | ting department.  |                  |                                     | •                                     |
| Requested e                       | effective date:  |                                     |   | <del></del>   |                  |                                     |                                       |
|                                   |  |                                     | . <u> </u>                                    |   |                  |                                     |                                       |
|                                   | : CASH WITH APPLICA  |                                     |   |   |                  |                                     |                                       |
| The group's business che          |  | ust be submitt                      | ted with the Empl                             | oyer Group Application. All pre                                     | miums must       | be paid with the                    | employer's                            |
|                                   |  |                                     |   |   |                  |                                     |                                       |
| iotal Premit                      | um Deposit: \$   | <del></del>                         |   |   |                  |                                     |                                       |
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