DentiCare, Inc.
(A Prepaid Limited Health Service Organization Licensed Under Chapter 636 of the Florida Statutes)
8130 Baymeadows Way West, Suite 200
Jacksonville, FL 32256
(904) 731-1870
(800) 697-7341

GROUP DENTAL SERVICE AGREEMENT

It is agreed between Nassau County Government Employees ("Group") and DentiCare, Inc. ("Plan") as follows.

Important Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

ARTICLE I
COVERAGE INFORMATION

1.1 **Group:**

Name: Nassau County Government Employees

Address: P.O. Box 1010

City, State, Zip: Fernandina Beach, FL 32035

1.2 **Group Coverage Basis:**

☐ Contributory ☐ Non-Contributory

1.3 **Class of Members to be Covered:**

☐ Active ☐ Retirees

1.4 **Form of Coverage (choose one):**

☐ Group requests coverage under the _____ plan with Specialty Benefit Option.

☒ Group requests coverage under the Summit plan without Specialty Benefit Option.

1.5 **Monthly Prepayment Fee:** The Prepayment Fee for the number of Members in each total monthly fee category below is due and payable from Group as set out in this Agreement.

	Prepayment Fee +	Specialty Benefit	= Total Monthly Fee
[Subscriber Only	$_____	$_____	$ 11.08
Subscriber + One	$_____	$_____	$ 18.74
Subscriber + Two	$_____	$_____	$_____
Subscriber + Family	$_____	$_____	$ 29.56
Monthly Administrative Fee	$_____	$_____	$_____]

1.6 **Effective Date:** This Agreement shall become effective on the first day of **January, 2003** ("Effective Date"). It may be renewed pursuant to the renewal provisions of Agreement unless first terminated by Plan or Group.

The initial Plan Year shall commence on the Effective Date and shall terminate on **January 1, 2004** unless terminated before this date by Plan or Group.

ARTICLE II
ENTIRE CONTRACT

The Group Dental Service Agreement, Evidence of Coverage, Copayment Schedule and any applicable exhibits or amendments, hereinafter called "Agreement," form the entire agreement of the parties. This Agreement may be amended or modified. Changes must be in writing executed by Group and an authorized officer of Plan.

ARTICLE III
DEFINITIONS

The following terms shall be defined as follows:

3.1 **Anniversary Date:** Shall mean the day after the initial Plan Year ends. The Anniversary Date occurs on the same date in each subsequent calendar year.

3.2 **Copayment:** Shall mean an additional fee charged to Member by Plan Provider as identified in the Copayment Schedule.

3.3 **Dependent:** Shall mean the spouse of any Subscriber and all newborn infants from and after the moment of birth, natural children, adopted children from the date of placement, stepchildren and foster children under age nineteen (19) who are unmarried and chiefly dependent on Subscriber for support and live in Plan Service Area. Dependents shall be eligible for coverage on the day Subscriber is eligible for coverage or on the day Subscriber acquires such Dependent, whichever is later. Eligibility may be extended up to age twenty eight (28) for unmarried children who are chiefly dependent on Subscriber for maintenance and support and are registered students in regular, full-time attendance at an accredited school, college or university. Dependent shall also mean the child of Subscriber age nineteen (19) or over not capable of self-sustaining employment by reason of a disability or physical handicap and chiefly dependent on Subscriber for maintenance and support.

3.4 **Effective Date:** The date coverage begins under Agreement.

3.5 **Emergency Services:** Shall mean bona fide emergency services, including necessary palliative treatment, provided after sudden onset of a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate dental attention could reasonably be expected to result in serious jeopardy to the patient's dental health.

3.6 **Enrollment Form**: Shall mean the Member Enrollment Form.

3.7 **Member**: Shall mean a Subscriber or Dependent who is enrolled in Plan.

3.8 **Plan Dentist:** Shall mean a General Dentist who is under contract with Plan and responsible for providing dental services to Members of Plan.

3.9 **Plan Provider:** Shall mean a Plan Dentist or Plan Specialist under contract with Plan. The term shall include any hygienists and technicians recognized by the dental profession who act with and assist Plan Dentist or Plan Specialist. Establishment and location of all Plan Providers are within the sole discretion and determination of Plan. A list of Plan Providers shall be published in Plan Dentist Directory.

3.10 **Plan Specialist:** Shall mean a dentist practicing in a dental specialty under contract with Plan to provide specialty services to Members including, but not limited to, Endodontics, Orthodontics, Pedodontics, Periodontics and Oral Surgery.

3.11 **Plan Benefits:** Shall mean services provided under Agreement, subject to any limitations and exclusions.

3.12 **Plan Year:** The initial Plan Year shall begin on the Effective Date and last for a period of [(number)] calendar months. Each subsequent Plan Year shall begin on the Anniversary Date and last for a period of twelve (12) calendar months. The Anniversary Date for this plan is January 2004.

3.13 **Prepayment Fee:** Shall mean the monthly fee paid by Group to Plan for each Member, including administrative or other fees necessary for provision of coverage.

3.14 **Service Area:** Shall mean the area where Plan is licensed to provide Plan Benefits.

3.15 **Subscriber:** Shall mean an employee, member, or beneficiary of Group who is eligible to participate in Plan under the eligibility requirements determined by Group.

ARTICLE IV
PREPAYMENT FEE AND ELIGIBILITY

4.1 **Prepayment Fee:** Group shall pay Plan the monthly Prepayment Fee for each covered Member. This starts on the Effective Date and on the first day of each month thereafter while Agreement is in force. After the initial Plan Year, Plan reserves the right to change the Prepayment Fee upon sixty (60) days written notice. Group's payment of any amended Prepayment Fee indicates its acceptance of the amended Prepayment Fee.

4.2 **Provision of Plan Benefits/Plan Providers:** Group acknowledges that unless there is a need for Emergency Services, Agreement provides exclusively for services performed by a Plan Provider. Plan shall not have any liability due to treatment by any non-Plan dentist, physician, hospital, other person, institution or group. Each Member shall select a Plan Dentist from Plan Dentist Directory furnished by Plan to Group. Agreement provides for services only. It is not an insurance policy. It does not reimburse Member or Group in cash, except for Emergency Services.

4.3 **Eligibility List:** Group shall be responsible for providing Plan, by the 20th day of the month, the names and other identifying data for each Member to be covered in order for eligibility to be effective on the 1st day of the succeeding month. Group shall identify those Members who are newly eligible to receive Plan Benefits. It shall name the Plan Dentist selected by each Member who is newly eligible. It shall identify those Members whose coverage will terminate. Group shall be responsible for payment of Prepayment Fees due Plan for Members. Payment shall continue until notice of a change in eligibility is provided to Plan.

4.4 **Eligibility:** Group shall determine eligibility for initial participation in Plan and any re-enrollment in Plan. Plan may rely upon such decision until Group provides notice of a change in eligibility. Any disputes or inquiries from Members regarding eligibility, including renewal, re-enrollment or continuation of coverage, shall be referred by Plan to Group. Group shall advise Plan of its decision. Each Member must work or live in Plan Service Area in order to participate in Plan.

Subscriber and his Dependent(s) are eligible to become Members of Plan during the open enrollment period set by Group. A newly acquired Dependent of Subscriber shall be eligible for coverage on the day Subscriber acquires Dependent or on the day Subscriber is eligible for coverage, whichever is later. All newborn infants shall be eligible for coverage from and after the moment of birth. If an additional Prepayment Fee is required for coverage of a newborn infant, Group must notify Plan. Any resulting Prepayment Fee must be paid within thirty one (31) days after the date of birth.

4.5 **Coverage of Members:** The Effective Date of coverage for Subscriber or Dependent shall be the first day of the month after written notice and payment of the Prepayment Fee is accepted by Plan. Each Subscriber or Dependent enrolled in Plan and whose proper Prepayment Fee has been accepted by Plan prior to the 20th will be covered beginning the first day of the following month. Each Subscriber or Dependent enrolled in Plan and whose proper Prepayment Fee has been accepted by Plan between the 20th and the last day of the month will be covered beginning the first day of the second following month.

4.6 **Enrollment Forms:** Each Member shall complete an Enrollment Form or suitable proof of enrollment.

ARTICLE V
BENEFITS

5.1 **Plan Benefits:** Plan shall provide dental services in the following areas: appointments, diagnostics, preventive dentistry, restorative dentistry, endodontics, periodontics, removable prosthodontics, fixed prosthodontics and oral surgery to Members. Specific service treatment descriptions are set forth in the Copayment Schedule. Services are subject to limitations and exclusions. Services are provided for the term of Agreement. Plan reserves the right to change Plan Benefits after the initial Plan Year. Notice of change is subject to sixty (60) days written notice.

5.2 **Copayments:** Member shall be responsible for payment of all Copayments and charges for non-covered services. Specific Copayment amounts are listed on the Copay Schedule. Member shall make pay dental provider at the time service is rendered. Member may have an option to pay according to provider's billing procedures.

ARTICLE VI
MEMBER/PLAN PROVIDER RELATIONSHIP

6.1 **Member/Plan Provider Relationship:** The relationship between Member and Plan Provider shall be an independent professional one. Plan Provider shall be solely responsible, without intrusion by Plan or Group for all services within the professional relationship between Member and Plan Provider. Plan or Plan Provider shall have the right to refuse treatment to any Member who: (1) fails to follow a prescribed course of treatment; (2) fails to keep confirmed appointments; (3) fails or refuses to pay proper Copayments, including missed appointment fees or charges for non covered procedures; (4) uses the relationship for illegal purposes; or (5) otherwise makes the professional relationship unduly burdensome.

6.2 **Plan Provider Facilities:** The operation and maintenance of Plan Provider's facilities and equipment shall be completely under the control of Plan Provider. This includes the selection of staff, supervision of personnel and operation of the professional practice. It also includes rendition of any particular professional service or treatment.

ARTICLE VII
ADMINISTRATION

7.1 **Distribution of Plan Materials and Notices to Members:** Plan may be obligated under state law to give any notice or Plan materials to Member. If so, it shall be sufficient for Plan to give notice or Plan materials to the Group's delegate. This shall apply unless state law requires otherwise. Group shall then be responsible for providing notice or Plan materials to Subscribers.

7.2 **Grievance Resolution Procedures:** Any inquiry, complaint or grievance may be made by contacting Plan or Plan Provider. Or Member may contact the Florida Department of Insurance for assistance, at any time, by calling its consumer hotline (1-800-342-2762) or by addressing mail to 200 East Gaines Street, Larson Building, Tallahassee, Florida 32399-0300. Plan inquiries or dissatisfactions may be conveyed by telephone or in writing.

Definition: A complaint is defined as any dissatisfaction regarding any aspect of the company's operation. This includes dissatisfaction with plan administration; appeal of an adverse determination; a denial, reduction or termination of a service; the way a service is provided; or disenrollment decisions. Any such complaint, or grievance, will be considered informal if it is received verbally. A grievance will not be considered formal until it is received by Plan in writing.

A. Informal Grievance: Member may contact Plan Customer Service department at 1-800-347-3331 regarding any inquiry, complaint or informal grievance that cannot be resolved to Member's satisfaction. Plan Customer Service Representative will assess and resolve Member's concern. If Member is not satisfied with the resolution, Member may file a written complaint to Plan. Plan Customer Service Representative will provide Member with the guidelines. In addition, such representative will provide complaint form to be completed.

B. Formal Grievance: Plan expects receipt of a completed complaint form or correspondence from Member expressing dissatisfaction with service or care delivered by Plan or Plan Dentist. Any formal grievance may be mailed to: DentiCare, Inc., Director of Customer Service, P. O. Box 830626, Birmingham, AL 35283-0626. Plan shall process the written grievance within sixty (60) days. In matters of quality of care or clinical issues, an appropriate health professional will be consulted. If the complaint is not resolved to Member's satisfaction, Plan shall provide an appeal procedure.

C. Appeal Procedure: If Member is not satisfied with the resolution of a written complaint, Member may request an appeal of Plan's assessment. Upon receipt of an appeal request, Plan will provide Member with Plan's written appeal process as defined by Plan or applicable State law.

7.3 **Selection of Provider/Obtaining Benefits:**

A. Plan Dentist: Each Member shall select a Plan Dentist from Plan Dentist Directory. To obtain Plan Benefits, Member shall contact selected Plan Dentist and schedule an appointment. Either Member or Plan Dentist may request a change of Plan Provider selection by contacting Plan.

B. Plan Specialist: If Member requires specialty services covered under Plan that cannot be provided by Member's selected Plan Dentist, Member may obtain services from a Plan Specialist. No referral from the selected Plan Dentist is needed. Plan does not cover services received from non-Plan Providers.

7.4 **Emergency Services:** Plan shall arrange for Emergency Services twenty four (24) hours a day, seven (7) days a week. Procedures for obtaining Emergency Services are in the Evidence of Coverage. A copy of the procedures may also be obtained by contacting Plan.

7.5 **Assignment of Benefits:** Member's coverage is intended for sole use and benefit of Member. Coverage cannot be transferred to a third party.

ARTICLE VIII

LIMITATIONS AND EXCLUSIONS

This Agreement contains no exclusions for pre-existing conditions.

1. Medical costs associated with dental procedures are not covered.
2. The parent or guardian is responsible for affecting behavior of dependents so that provider may safely render proper dental care. Services rendered by a specialist because of behavior adjustment may affect Member's out of pocket expense. Such services needed may be physical restraint, sedation or other method of control.
3. Dentures or appliances will be replaced only after five years since dentures or appliances were provided by Plan. If denture or appliance becomes unserviceable due to illness or causes not controlled by ordinary means, the following will apply: Replacement will be made only if existing denture or appliance cannot be made serviceable.
4. Replacement of dentures, appliances or bridgework due to loss or theft is not covered.
5. Dental treatment provided or started prior to Member's eligibility to receive benefits is not covered. Dental treatment started after Member's termination is not covered.
6. Failure to follow prescribed treatment may result in additional charges. Accidents occurring during the course of any treatment may result in additional charges.
7. Restorations and endodontic posts and cores placed after root canal therapy are separate procedures from actual root canal treatment. Therefore, the specific co-payments listed for restorations or posts and cores will apply.
8. Orthodontic Treatment is limited as follows:
   - Minor treatment of tooth guidance/interceptive orthodontia is limited to eighteen (18) consecutive months.
   - Retention treatment is limited to eighteen (18) consecutive months. Ongoing treatment past eighteen (18) consecutive months is not covered. Also, ongoing treatment past eighteen (18) consecutive months may be subject to additional fees. This would be determined as outlined in the Copayment Schedule and determined by provider.
9. Orthodontic treatment involving therapy for myofunctional problems, T.M.J. dysfunctions, micrognathia, macroglossia, cleft palate or hormonal imbalances causing growth and developmental abnormalities, is not covered.
10. Extractions for Orthodontic purposes only are at a 25% discount off of Plan Provider's normal retail charge.
11. Orthodontic cases, involving orthognathic surgery, are not covered.
12. Treatment for malignancies, neoplasms or cysts, including biopsy, is not covered.
13. Services provided by non-Plan dentists are not covered unless preauthorized by Plan.
14. Copayments listed for restorations do not include the cost of lab fees.
15. Restorations and splints used to increase vertical dimension, restore occlusion, or replace/stabilize tooth structure loss by attrition are not covered.
16. Fixed prosthetic restoration of six (6) or more existing teeth, when performed as a simple procedure as part of a complete oral rehabilitation or reconstruction is not covered.
17. Complete oral rehabilitation or reconstruction involving replacement of six (6) or more missing teeth using fixed prosthetic restorations and/or appliances is not covered.
18. Dental treatment is not covered if Member's general health or physical limitations prevent provider from rendering appropriate dental treatment.
19. Costs associated with prescriptions or over the counter medications are not covered.
20. Implants, surgery for the insertion of implants, all related implant appliances and restorations, removable or fixed, are not covered.
21. The surgical removal of implants, or any surgery required to adjust, replace, or treat any problem related to an existing implant, or implant appliance, is not covered.
22. Plan payments for services of non-Plan providers are limited to a total of $2.000.00 per calendar year.

ARTICLE IX
EMERGENCY SERVICES

9.1 **Emergency Services:** Plan shall arrange for Emergency Services twenty four (24) hours a day, seven (7) days a week. Emergency Services are defined as bona fide emergency services, including necessary palliative treatment, provided after sudden onset of a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate dental attention could reasonably be expected to result in serious jeopardy to the patient's dental health.

A. Inside Plan Service Area: If Member is in Plan Service Area and needs Emergency Services, Member should do the following: Contact Member's selected Plan Dentist to arrange for Emergency Services. If Member's Plan Dentist is unavailable, Member may obtain Emergency Services from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Services only, subject to any Copayments, limitations and exclusions.

B. Outside Plan Service Area: If Member is not in Plan Service Area and needs Emergency Services, Member should seek treatment from any licensed dentist. Plan will reimburse Member for the actual cost of Emergency Services, less a [twenty-five dollar ($25.00)] administrative charge, subject to any Copayments, limitations and exclusions.

C. Additional Conditions: Reimbursement for Emergency Services provided by non-Plan dentists is subject to the following additional conditions:

1. Covered Dental services include only those necessary to relieve acute symptoms of sufficient severity. This includes severe pain, bleeding, swelling, and the like. It also includes acute symptoms of severity, which, within reason, may place Member's dental health in serious jeopardy. It includes severity which may cause dysfunction of any bodily organ or part. It includes these cases of severity which last until Member can either: (1) return to Plan Service Area or (2) continue treatment with Plan Dentist.

2. The Member must notify Plan or Plan Dentist of his condition and the service arrangements within forty-eight (48) hours after provision of Emergency Services. The Member must also return to Plan Dentist for continued services if indicated. It may happen that a Member's physical condition does not allow him to notify Plan within the prescribed time. He will need to notify Plan as soon as reasonably possible.

3. Reimbursement requests must be in writing. Such requests must be received by Plan within sixty (60) days of the date of service for which payment is requested. These requests must include invoices or other evidence of payment.

4. Failure to furnish proof within the required time shall not nullify or reduce claim. This applies if it was not reasonably possible to give proof within the required time. This is true provided proof is furnished as soon as reasonably possible.

5. If Emergency Services are performed at a hospital or outpatient care facility other than a dentist's office, Plan shall pay only applicable dental charges.

ARTICLE X
COORDINATION OF BENEFITS

10.1 **Coordination of Benefits:** Is the process for determining payment responsibility in cases where Member has benefit coverage with more than one carrier. The "primary" plan is the plan whose coverage applies first. The "secondary" plan may provide additional benefits after the primary benefits are applied.

Plan is "primary" under the following conditions:

1. If Member has coverage under more than one managed care plan, the plan that covers the individual as Member or subscriber of Group is primary.
2. If Member has coverage under both a managed care plan and an indemnity plan, the managed care plan is primary.
3. In the case of covered Dependents who are not directly covered under a group plan, the plan of the parent whose birthday occurs earliest in the year (not the one who is oldest) is primary.

The above may not apply in the case of a divorce decree, court action or the like, which may mandate that other coverage be primary.

ARTICLE XI
TERM AND TERMINATION

11.1 **Term/Renewal:** After the initial Plan Year, each Plan Year of Agreement shall have a twelve month term. It shall be automatically renewed at the Anniversary Date unless otherwise terminated. If Agreement is not renewed due to claim experience, Group shall be entitled to receive the loss experience record at a reasonable expense.

11.2 **Termination of Group:** Group may be terminated, other than at renewal, for reasons listed below. Termination notice will be given in writing, forty five (45) days prior to effective date, to the Group. Such notice will state the reason for termination.

(1) For failure to pay proper monthly Prepayment Fees prior to the 10th of the month in which Prepayment Fees are due, subject to a [ten(10)] day grace period. This provision means that if any required premium is not paid on or before the date it is due, it may be paid subsequently during the grace period. During the grace period, Agreement will stay in force.
(2) For fraud or misrepresentation of fact in obtaining coverage under Plan.

11.3 **Continuation of Coverage:** If Agreement is terminated, each Plan Provider shall complete all dental procedures started prior to the date of termination. This will be pursuant to the terms of Agreement, subject to a maximum ninety (90) day limit as required by state law, except for orthodontia treatment. Should a Member in orthodontia treatment terminate for any reason, Member shall be responsible for payment of all services rendered after the termination date.

11.4 **Termination of Member:** Member coverage may terminate, other than at renewal, for reasons listed below. Termination notice will be given in writing, forty five (45) days prior to the effective date, to the Group. Such notice will state the reason for termination.

A. If Member commits fraud or material misrepresentation in applying for or presenting any claim for benefits under Plan.

B. If Member misuses Plan documents as evidence of benefits available under Plan.

C. If Member furnishes to Plan incorrect or incomplete information for the purposes of fraudulently obtaining services. This provision will not be enforced after two (2) years from the time Member's coverage begins.

D. If Member's behavior is disruptive, unruly, abusive, unlawful, fraudulent or uncooperative to the extent it impairs the Plan's ability to provide dental services to other Members. Prior to termination, Plan will attempt to resolve any problems through grievance procedures. Plan will also determine that Member's behavior is not due to services provided or mental illness. Plan will document all information related to the problems, resolution efforts and dental conditions.

E. Coverage for a Dependent child of a Subscriber will terminate when Dependent child reaches limiting age. Coverage shall not terminate while a Dependent child of Subscriber is and continues to be incapable of self-sustaining employment. This is by reason of a disability or physical handicap. Dependent child must be chiefly dependent upon Subscriber for maintenance and support. Subscriber must furnish proof of incapacity and dependency to Plan within thirty one (31) days of the child attaining limiting age and every year thereafter, if requested by Plan.

F. If Member no longer works or lives in Plan Service Area.

11.5 **Conversion Privilege:** If any Subscriber or Dependent of a Subscriber ceases to meet eligibility requirements of Group and has been continuously covered under Plan for at least 3 months, he may convert to an individual dental plan. This occurs without furnishing evidence of insurability. In order to obtain an individual dental plan, Member must submit a completed individual enrollment form and all required Prepayment Fees to Plan within thirty-one (31) days after termination date. Plan will notify Member in writing of coverage effective date. Conversion privileges shall not be made available to any Member terminated due to:

(1) failure to pay required prepayment fee or contribution,
(2) fraud or material misrepresentation in applying for benefits under the Group Agreement,
(3) willful and knowing misuse of Plan identification or documents
(4) willful and knowing furnishing to Plan incorrect or incomplete information to obtain coverage from Plan,
(5) no longer working or residing in the Plan Service Area,
(6) disruptive, unruly, abusive or uncooperative behavior that impaired Plan's ability to furnish services to other Members,

or to any Member who will have similar replacement coverage within 31 days.

11.6 **Continuation of Coverage under COBRA:** If under the provisions of Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Public Law 99-272, Member is granted the right to continuation of coverage beyond the date Member's coverage would otherwise terminate, the following applies. Agreement shall be deemed to allow continuation of coverage as necessary to comply with the provisions of applicable statutes. Member should contact Group concerning eligibility.

ARTICLE XII
GENERAL PROVISIONS

12.1 **Amendments:** By mutual consent, Plan and Group may modify, amend or alter Agreement. Such change shall be in writing and duly executed by both parties. Any change shall be attached to Agreement. Plan may amend Agreement unilaterally to comply with germane law.

12.2 **Waiver:** The waiver by either party of one or more defaults shall not be construed as a waiver of any other or future default. This applies to any covenant or other condition contained in Agreement. Only an authorized officer of Plan may waive any conditions or restrictions of Agreement. Only an authorized office of Plan can amend Agreement, extend time for making a payment or bind Plan by making any promise or representation. Such promise or representation shall be in writing. No change in Agreement shall be valid unless endorsed by an authorized officer of Plan.

12.3 **Notice:** Notice to either party under this Agreement shall be in writing. Notice shall be sent to the address shown in Agreement.

12.4 **Terms:** Throughout Agreement, the singular shall include the plural and the plural the singular. The masculine shall include the neuter and feminine. The neuter shall include the masculine and feminine.

12.5 **Invalidity:** If any provision of Agreement is determined to be illegal or invalid, all other provisions remain valid. This is true unless the illegality or invalidity prevents the purposes of Agreement from being realized.

12.6 **Assignment of Agreement:** No assignment of Agreement is binding upon Plan unless Plan agrees to it in writing. Any such assignment shall not waive Plan's right to withhold its consent to any other assignment. There may occur a merger or acquisition involving Group. If so, Agreement shall remain in force with the surviving entity for the balance of the term of Agreement.

12.7 **Acknowledgment:** Each of the parties acknowledges that it has read Agreement and understands its contents. Each party acknowledges it executes Agreement voluntarily.

12.8 **Authority:** Group represents it has the authority under applicable law and its charter instrument to execute Agreement.

12.9 **Worker's Compensation:** Agreement is not in place of and does not affect any requirement for coverage by Worker's Compensation.

12.10 **Governing Law:** Agreement shall be governed by and construed according to laws of the State of Florida.

12.11 **Circumstances Beyond Plan's Control:** Rendition of dental services may be delayed or made impractical due to circumstances not within Plan's control. If this occurs, neither Plan nor Plan Provider shall have any liability or obligation to provide services on account of such delay. This includes, but is not limited to, complete or partial destruction of facilities, war, riot and civil insurrection. It also includes labor disputes or disability of a significant number of Plan Providers.

12.12 **Major Disaster or Epidemic:** If a major disaster or epidemic occurs, Plan Provider shall render dental services as practical according to his judgment. Such disaster or epidemic may limit available facilities or personnel. In such a situation, neither Plan nor Plan Provider shall have any liability or obligation for delay or failure to provide dental services.

12.13 **Attorney's Fees and Costs:** If Group defaults in any of its obligations, Group agrees it will pay all of Plan's costs to enforce its rights hereunder. This includes, but is not limited to, Plan's attorneys' fees and court costs.

12.14 **ERISA:** If Group is regulated under the Employee's Retirement Income Security Act of 1974 (ERISA), Plan will work with Group in supplying Group with any information in its possession in meeting any reporting requirements. Plan is not and shall not be the chosen administrator or fiduciary for reporting requirements.

IN WITNESS WHEREOF, the parties have affixed their signature to this Agreement.

PLAN: DentiCare, Inc.

By:
Signature

[Chris Calos, President]
Print Name and Title

Date

Approved as to Form by the
Nassau County Attorney

Michael S. Mullin

PDC-FL-0079 (R6/00)

GROUP Nassau County
Board of County Commissioners

By:
Signature

Vickie Samus, Chairman
Print Name and Title

1/13/03
Date

ATTEST:

J. M. "Chip" Oxley, Jr.
Ex-Officio Clerk

GDSA 6/00

FORTIS
Solid partners, flexible solutions™

FRAUD STATEMENTS

Please read the following before completing the attached form.

+ **If you live in the states of Arkansas and Louisiana the following statement applies to you:**
  Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

+ **If you live in the state of California, the following statement applies to you:**
  For your protection California law requires the following to appear on the form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

+ **If you live in the state of Colorado, the following statement applies to you:**
  It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

+ **If you live in the District of Columbia, the following statement applies to you:**
  WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

+ **If you live in the state of Florida, the following statement applies to you:**
  Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

+ **If you live in the state of Kansas, Maryland or Oregon, the following statement applies to you:**
  Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

+ **If you live in the state of New Jersey, the following statement applies to you:**
  Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

+ **If you live in the state of Virginia, the following statement applies to you:**
  Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

+ **If you live in a state other than mentioned above, the following statement applies to you:**
  Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

To avoid unnecessary delays, be sure all parts of the Application are completed according to the instructions, and DO NOT SEPARATE the pages.

Group Dental Insurance Preliminary Application

FORTIS
Solid partners, flexible solutions™

The undersigned Applicant hereby applies to the Fortis Benefits Insurance Company for a Group Policy of Dental Care Insurance.

Legal name of applicant Nassau County Board of County Commissioners

Address of applicant 213 Nassau Place, Yulee, Florida 32097

Name(s) of subsidiaries, divisions or affiliates to be insured See attached

Member eligibility requirements _____

Eligible class _____

Eligibility period: Initial employees/members None New employees/members 90 days or date in offi

Number of hours worked to be eligible *(if applicable)* 20 per week or date in office

Requested effective date January 1, 2003

Requested anniversary date January 1, 2003

$_____initial deposit accompanies this application.

NOTICE TO APPLICANTS

A. COVERAGE IS NOT EFFECTIVE UNTIL THIS APPLICATION IS APPROVED AND ACCEPTED BY THE GROUP INSURANCE HEADQUARTERS OF FORTIS BENEFITS LOCATED IN KANSAS CITY, MISSOURI.
B. The applicant certifies that all information provided is correct and is bound by the terms and conditions of the group policies.
C. Fortis Benefits will apportion experience refunds, if any, in accordance with its formula for calculating such refunds.
D. Tailored Plans: The group policy will be issued to the applicant, if approved. A final application will be executed when the policy is delivered.
E. Small Group or Voluntary Trust Plans: This application is to participate in the Trust which holds the small group or voluntary plan group policies.
F. ERISA - The coverage applied for provides benefits for the employee welfare benefit plan established and maintained by the employer under the Employee Retirement Income Security Act (ERISA), unless otherwise exempted by law. The employer is the Plan Administrator unless otherwise noted.
G. Coverage will automatically terminate if the premiums are not paid before the end of the grace period following the due date. Payment of premiums for coverage provided during the grace period is required.
H. All insurance coverage may be terminated if the number or percentage of participants falls below that required by the policy.
I. No one except the President, Vice President, Secretary or Chief Financial Officer of Fortis Benefits can make, alter or discharge contracts or waive any of Fortis Benefits' rights or requirements.

Certain coverages may be required to be offered in the state of issue. Such coverages, if any, are listed on an attached Supplement to Application for Group Insurance. Each coverage checked "Yes" is to be included. Each coverage checked "No" is not to be included.

Signed at _____, this 13th day of January, 2003.

Connie H. Crichton
(Witness)

Vickie Samus
(Signature) Vickie Samus, Chairman
Nassau County Board of County Commissioners

_____
(Licensed resident agent if required by law))

(Title)
P. O. Box 1010
Fernandina Beach, FL 32035
(Principal address of applicant)

Approved as to Form by the
Nassau County Attorney

Michael S. Mullin

ATTEST:
J. M. "Chip" Oxley, Jr.
Ex-Officio Clerk

NAME OF SUBSIDIARES, DIVISIONS OR AFFILIATES TO BE INSURED:

Clerk's Office, Mr. Chip Oxley
Property Appraiser, Mr. James Page
Sheriff's Department, Mr. Larry Vaught
Supervisor of Elections, Vickie Cannon
Tax Collector, Ms. Gwendolyn Miller
Nassau County Board of County Commissioners