



CompBenefits

100 Mansell Court East, Suite 400 Roswell, GA 30076

Group Application Form

Group Name: Nassau County Type of Business: (SIC Code): _____
 Address: 96161 Nassau Place City: Yulee State: FL Zip: 32097
 Group Administrator: Chili Pope Phone: (904) 321-5908
 Fax: (904) 321-5926 Email: cpope@nassaucountyfl.com
 Billing Address: same as above City: _____ State: _____ Zip: _____
 Billing Contact: same as above Phone: () - -
 Fax: () - - Email: _____ @

Total Number of Eligible Subscribers: _____ Section 125: YES NO
 Domestic Partners: YES NO

Min. Hours Worked Per Week for Eligibility: 20 [30 hours (25 for Vision) if left blank]
 New Hire Eligibility Period: 1st mo. > 90 days (Date of hire for elected or contract employees.)

PLAN(S) SOLD:

DENTAL

VISION

- | | | | | |
|--|---|-----------------------------------|---|--------------------------------|
| <input checked="" type="checkbox"/> DHMO | <input type="checkbox"/> Elite Choice | <input type="checkbox"/> Discount | <input checked="" type="checkbox"/> Section 125 | <input type="checkbox"/> Combo |
| <input type="checkbox"/> Access | <input checked="" type="checkbox"/> Elite Preferred | <input type="checkbox"/> ASO | <input type="checkbox"/> Value Plan | <input type="checkbox"/> ASO |
| <input type="checkbox"/> Advantage | <input type="checkbox"/> Elite Scheduled | <input type="checkbox"/> _____ | <input type="checkbox"/> Core | <input type="checkbox"/> _____ |

Comments: _____

If Subscriber contributions are to be paid by Group on behalf of Subscriber via payroll or similar deduction, Group agrees to permit and make payroll or similar deductions on behalf of Subscriber and to remit the same to CompBenefits. All additions, changes and terminations as well as monthly payments must be received by CompBenefits by the 15th of each month in order to be effective on the 1st day of the following month. The term of the coverage shall be for the rate guarantee period and will automatically renew for successive one-year periods unless terminated as stated in the contract. Please see your state fraud statement listed below.

[Signature]
 Authorized Signature Date: 8/28/06
Jim B. Higginbotham, Vice Chairman
 Nassau County Board of County Commissioners

Agent Signature _____ Date _____
 Name (print) _____ Agent Number _____

NASSAU COUNTY SIGNATURE NEBOCC
 CONTINUES ON NEXT PAGE

Arkansas Residents: 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.

Louisiana Residents: 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 subject to prison or fines.

Kansas Residents: 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 may be guilty of a felony.

Kentucky, Ohio and Tennessee Residents: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance 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.

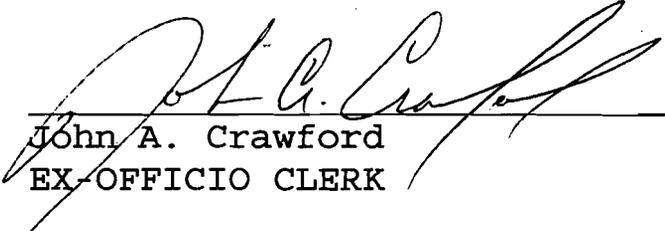
Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

All others: 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 or as determined by a court of competent jurisdiction.

CompBenefits Corp.
10/5/06
Al Hernandez
 Vice President, Inland
 Acct. Mgr.

COMPBENEFITS GROUP APPLICATION FORM
EMPLOYEE DENTAL AND VISION INSURANCE

ATTEST:



John A. Crawford
EX-OFFICIO CLERK

APPROVED AS TO FORM BY THE
NASSAU COUNTY ATTORNEY



MICHAEL S. MULLIN


Alvaro A. Hernandez . 10/3/06
Comp Benefits
Vice-President, Sales
Acct. Mgr.

DESCRIBE PLAN SOLD

VISION

Please attach a copy of the Benefit Summary, Rate Page, and the Rate Calculation Sheet (if applicable).

RATES

Subscriber Only: \$6.30 month

Other Tiers:

EE + One: \$12.58 mo.

EE + Family: \$16.84 mo.

_____ \$ _____ mo.

_____ \$ _____ mo.

_____ \$ _____ mo.

Exam every 12 months

Lenses every 12 months

Frame every 24 months

Exam Copay: \$10

Materials Copay: \$15

Wholesale

Frame Allowance: \$45

Elective Contact Lens (ECL) Allowance: \$105

ECL Type: Exam Plus Flat

Rate Guarantee: 24 months

Group Contribution: Subscriber 0%
Dependent 0%

Group Name: Nassau County BOCC

Plan Name: Section 125 Plan

Proposed Effective Date: 10/1/06

Section 125 Anniversary Date: _____

Total # Enrolled Subscribers: _____

Non-Student Age: 26

Max. Student Age: 26

Multi-state: YES NO

Vision Pass with ID Card: YES NO

COMMENTS


Group's Initials

provided by: National Dental Plans, Inc., CompBenefits Company (Florida only); Dental Care Plus Management Corp. (Illinois only);
Texas Dental Plans, Inc. (Texas only)

DESCRIBE PLAN SOLD

DHMO

Please attach a copy of the Benefit Summary, Rate Page, and the Rate Calculation Sheet (if applicable).

RATES

Subscriber Only: \$11.26 month

Other Tiers:

EE + One: \$21.40 mo.

EE + Fam: \$29.18 mo.

_____: \$ ____ mo.

_____: \$ ____ mo.

_____: \$ ____ mo.

Rate Guarantee Period: 24 months

Group Contribution: Subscriber 0%

Dependent 0%

Group Name: Nassau County BOCC

Plan Name: CS250

Proposed Effective Date: 10/1/06

Total # Enrolled Subscribers: ____

Non-Student Age: 26

Max. Student Age: 26

Multi-state: YES NO

Has this group ever had dental coverage with CompBenefits? YES NO

If yes, what date did the coverage terminate? ____

COMMENTS

XEO
Group's Initials

underwritten by: CompBenefits Insurance Company; CompBenefits Company (Florida only); American Dental Plan of North Carolina, Inc. (North Carolina only); DentiCare, Inc. (d/b/a CompBenefits) (Texas only); CompBenefits Dental, Inc. (Illinois, Kentucky, Missouri & West Virginia only); American Dental Providers of Arkansas, Inc. (Arkansas only); CompBenefits of Alabama (Alabama only)

DESCRIBE PLAN SOLD

ELITE Preferred

Please attach a copy of the Benefit Summary, Rate Page, and the Rate Calculation Sheet (if applicable).

RATES

Subscriber Only: \$22.66 month

Other Tiers:

EE + One: \$43.66 mo.

EE + Family: \$73.28 mo.

_____ \$ _____ mo.

_____ \$ _____ mo.

_____ \$ _____ mo.

Calendar Year Deductible: \$50 per person
Maximum 3 per family

Deductible Waived for Type I: [X] YES [] NO

Max. Calendar Year Payment: \$1,000

Out of Network

Reimbursement: 70th 80th 90th other _____

Coinsurance Percentages:

Type I Diagnostic and Preventive 100%

Type II Basic 80%

Type III Major* 50%

Type IV Orthodontic* _____%

Orthodontics: [] YES [X] NO inc. Adult Ortho? [] YES [X] NO

Ortho Calendar Year Maximum \$ _____

Ortho Lifetime Maximum \$ _____

Rate Guarantee Period: 24 months

Group Contribution: Subscriber 0%
Dependent 0%

Group Name: Nassau County BOCC

Plan Name: EP705

Proposed Effective Date: 10/1/06

Total # Enrolled Subscribers: _____

- *Waiting Periods: [] Full [X] Prior Carrier Credit [] Waiver (at initial enrollment) [] None

Remember to forward prior coverage to credit waiting periods.

Non-Student Age: 26

Max. Student Age: 26

Is this replacement coverage for existing benefits with another carrier? [X] YES [] NO

Is prior carrier information attached? [X] YES [] NO

Does this group currently have dental benefits administered by CompBenefits? [] YES [X] NO

Has this group ever had dental coverage with CompBenefits? [] YES [X] NO

If yes, what date did the coverage terminate? _____

COMMENTS

Group's Initials [Signature]

underwritten by:

CompBenefits Insurance Company

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NOV 1 2006