

Summary Plan Description Receipt and Agreement(s)

I. Receipt

I hereby acknowledge receipt of the Bulloch County Board of Commissioners Employee Health Care Plan Summary Plan Description given to me by my Employer and agree to abide by its terms and conditions.

II. Coordination of Benefits and Subrogation Provisions

I further agree to promptly furnish and/or execute such information and/or forms as may be required from time to time by The Plan. I further agree to comply with The Plan's Coordination of Benefits and Subrogation provisions which state that if I recover monies in the future for any claims previously paid by The Plan on my behalf, or my Dependent's behalf, I will reimburse or cause to have The Plan reimbursed accordingly.

Employee's Signature

Date

This page must be signed by the covered employee and retained by the employer.