MULTIPLE SIGNATURE VERIFICATION AGREEMENT

Account Number: _____

In consideration of the mutual promises and undertakings expressed herein, this Agreement is entered into between _____ Bank ("Bank"), located in the State of Florida, and _____ Health Plan ("Health Plan"), effective as of the _____ day of _____, 20__.

1. Health Plan is opening the Bank business investment account referenced by number above ("the Account"), pursuant to the conditions contained in the agreement entered between Health Plan and the Office of the Director of Medicaid, State of Florida Agency for Health Care Administration ("Medicaid") dated _____ ___, 20___.

2. Pursuant to its agreement with Medicaid, Health Plan desires, and Bank agrees to provide, a "hold" on the account so that withdrawals may be made only by properly authorized written request, and upon manual examination of the requests, which service shall be subject to the terms and restrictions set forth below.

3. Bank will only honor written requests for withdrawals which bear the signatures of two authorized representatives of Medicaid and two signatures of authorized representatives of Health Plan. Medicaid and Health Plan is providing to Bank examples of the signatures of the authorized representatives.

4. Health Plan will present the written, properly executed requests for withdrawal to the attention of _____, at Bank, located at _____._____, Florida, _____, between the hours of 8:00 am and 4:00 pm, EST, during banking business days. The request will contain the Account number, the amount of the funds to be withdrawn, a description of the payee who shall receive the funds, and the signatures of two of the authorized representatives of Medicaid and the two signatures of the authorized representatives of Health Plan.

5. Bank agrees to review the requests; draft the Account for the amount of the requested withdrawal, and prepare a Bank Official Check in the withdrawn amount, in accordance with the terms of the request. Bank agrees to undertake the above and make the Check available to Health Plan no later than the close of the banking day following the banking day in which the request was presented to Bank in accordance with Paragraph 4, above. [Optional language: Health Plan agrees to pay to Bank a fee of $5.00 for each Official Bank Check issued.]

6. Bank shall return to Health Plan any request that does not meet the above-described requirements. Bank shall have the sole discretion to determine whether the requirements have been met.

7. Pursuant to its agreement with Medicaid, Health Plan agrees that in the event that Medicaid determines Health Plan to be insolvent and notifies Bank of its determination, Medicaid may make withdrawals on the account by two authorized representatives of Medicaid, without the authorized signatures from Health Plan. Bank shall not be responsible or liable for determining insolvency. Bank shall not be required to permit withdrawals upon the sole order of Medicaid until written notification is received from Medicaid at the address described in Paragraph 4, and Bank has had a reasonable time to act thereon but in no event later than two (2) business days.

8. Except to the extent that Bank is negligent in performing its duties under this Agreement, Health Plan shall indemnify and hold Bank harmless against any claim, loss, liability, damage, cost or expense (including reasonable attorneys' fees incurred by Bank) arising out of or in any way relating to Bank's compliance with the terms of this Agreement.

9. This Agreement shall supplement the Bank Deposit Agreement, any corporate or other resolution of Health Plan relating to the Account, and any other agreements or terms affecting the Account. All legal rights and obligations of Health Plan and Bank under such other documents and pursuant to any applicable laws and banking regulations shall remain in effect, except as expressly modified by this Agreement.

10. This Agreement shall be executed by all currently authorized signers on the Account, and it shall continue in effect notwithstanding any subsequent change of authorized signers, and without any requirement that it be re-executed or amended.

11. This Agreement may be terminated at any time by Bank or Health Plan, provided Health Plan provides Bank written approval from Medicaid, and provided that the indemnification provision of paragraph 7 above shall continue in effect after any

such termination with respect to any withdrawals or requests handled by Bank prior to such termination. This Agreement shall be binding upon and shall inure to the benefit of any successors and assigns of Health Plan, Medicaid, and Bank.

The undersigned parties have executed this Agreement through their duly authorized representatives as of the date shown above.

BANK

By:_____
Signature

_____
Print Name

_____
Title

HEALTH PLAN

By: _____
Signature

_____
Print Name

_____
Title

HEALTH PLAN'S CERTIFICATION OF AUTHORITY

The undersigned hereby certifies that: (1) (S)He is the Secretary of _____ Health Plan; and (2) the foregoing Agreement is consistent with any corporate or other resolution(s) of Health Plan previously or contemporaneously provided to Bank.

By_____
Signature

_____
Print Name

Date of Certification:_____

[Affix corporate seal]

AUTHORIZED SIGNATURES

HEALTH PLAN	AGENCY FOR HEALTH CARE ADMINISTRATION
_____ Signature _____ Title _____ Print Name _____ Signature _____ Title _____ Print Name _____ Signature _____ Title _____ Print Name	_____ Deputy Secretary, Medicaid Print Name: Justin M. Senior _____ Asst. Deputy Secretary, Medicaid Health Systems Print Name: David Rogers _____ Asst. Deputy Secretary, Medicaid Finance - AHCA Print Name: Stacey Lampkin