BCBS APO ELECTION TO PARTICIPATE

This BCBS APO Election to Participate ("Election") confirms the undersigned health care provider's (who is referred to as "You") agreement to participate in the Blue Cross Blue Shield of Florida, Inc. ("BCBS") Accountable Provier Organization ("APO") program with Integrated Independent Physicians Network, LLC ("IPN").

You understand that Your participation in the BCBS IPN APO will become effective upon notice from IPN.

You understand and agree that if you are a Primary Care Physician (specialty of Family Practice, General Practice, Internal Medicine, Pediatrics, Adolescent Medicine and Geriatric Medicine) you may only participate in one BCBS APO program at a time.

You acknowledge that Your Agreement through which you participate in the BCBS provider network ("Participation Agreement") remains in full force and effect. Should your Participation Agreement terminate for any reason, your participation in the BCBS APO program immediately and automatically terminates.

Date: _____

Signature: _____

Printed Name: _____

Tax Identification Number: _____

Individual NPI: _____

BCBS ID: _____

Address: _____

_____

Phone: _____ Fax: _____

Clinical Contact: _____

Email: _____