DEDICATED CARE CENTER ENROLLMENT FORM

I hereby enroll as a member of the Dedicated Care Center program as described on this Enrollment Form and the attached Exhibits.

A. Dedicated Care Services. As a member of the Dedicated Care Center program, Sentara Medical Group ("SMG") will provide to me the dedicated care services listed on Exhibit A. I understand that these services may be changed by SMG from time to time. Routine medical treatment services are *not* included in the Dedicated Care Center program.

B. Dedicated Care Services Not Covered by the Medicare Program or Insurance Companies. I understand and agree that the Dedicated Care Center program services are not covered by Medicare (or other government program) or my insurance company. Neither SMG nor I will bill Medicare (or other government program) or my insurance company for the services provided to me by SMG under the Dedicated Care Center program. Neither SMG nor I will seek reimbursement from Medicare (or other government program) or my insurance company for my Dedicated Care Center program or other fees.

C. Routine Medical Services Not Included in the Dedicated Care Center Program. Except for the dedicated care services provided to me under the Dedicated Care Center program, all other medical services (for example routine office visits and condition-specific diagnostic tests) that SMG provides to me are not included within the Dedicated Care Center program. However, these other services may be covered benefits under Medicare (or other government program) or my insurance policy. SMG may bill Medicare (or other government program) or my insurance company for these other services if these other services are covered services that are eligible for payment by Medicare (or other government program) or my insurance company. I agree to pay any deductibles, co-insurance or co-payment amounts related to these covered services. I also agree to pay for any non-covered services that are provided to me by SMG.

D. Dedicated Care Center Program Fees. I agree to pay the monthly membership fee established by SMG for participation in the Dedicated Care Center program. I understand that SMG will provide me with advance notice of any change in the membership fees. The current Dedicated Care Center program fees are:

- Dedicated Care Center membership is $125 per month per person.
- Dependent children ages 18 to 25 are an additional $59 per month per dependent child.

All program fees are due and payable on the 25th day of the month for which the membership fees apply. My first payment is due on _____. Past due balances are subject to late charges. I agree to make all payments by electronic funds transfer ("EFT"), by credit card or pursuant to a monthly statement. Until I cancel my membership, I will not be relieved of my obligation to make any payments, nor will I be entitled to any deductions or allowances from my payments because of my failure to utilize the services provided under the Dedicated Care Center program.

E. Other Documents. I have received and agree to be subject to the Sentara Healthcare Integrated Notice of Privacy Practices and the Sentara Medical Group Financial Agreement & Release of Information, which are part of the Dedicated Care Center program and may be revised from time to time.

F. Termination. My enrollment is effective as of _____. I understand that either SMG or I may cancel my membership for any reason upon thirty (30) days' written notice.

MEMBER

_____
Signature

_____
Printed Name

Date: _____

SENTARA MEDICAL GROUP

_____
Signature

_____
Title