First Choice Health

EXHIBIT G
Provider Nomination Form

PROVIDER NOMINATION FORM

To receive the highest level of benefits your group plan allows, you must receive your healthcare from a First Choice Health PPO Network (FCH PPO) preferred provider. If your provider is not contracted with FCH PPO, you may want to ask whether s/he is interested in applying for membership. We would be happy to process your request if you would please complete the following information and send it to us. Our contact information is:

First Choice Health
10260 SW Greenburg Rd, Ste 400
Portland, OR 97223
Fax: (503) 652-8087
Email: Paul Barner, pbarner@fchn.com
Allaire Rosenthal, arosenth@fchn.com

First Choice Health PPO Network (FCH PPO) appreciates your nomination of healthcare providers for membership. All applications are processed to ensure compliance with network membership criteria and credentialing verification. This credentialing process may take several weeks (average 60 days) and membership is subject to approval. We appreciate your patience.

Today's Date: _____

Employee Name: _____

Address: _____

_____

Employer: _____

Physician Name: _____

Telephone Number: _____

Primary Specialty: _____

Primary Address: _____

City, State, Zip: _____