

**Acknowledgment of Receipt for the
BEACON HEALTH MANAGEMENT WELFARE BENEFITS PLAN
Summary Plan Description**

Each plan participant must acknowledge their receipt of the Welfare Benefit Plan Summary Plan Description by filling in the information and signing below. Please return to HSP SOUTHERN HEALTHCARE, LLC.

I _____ (name of plan participant)
acknowledge receipt of the Beacon Health Management Welfare Benefits Plan
Summary Plan Description.

Signed: _____

Date: _____