CITY OF DAYTONA BEACH
P.O. BOX 2451
DAYTONA BEACH, FL. 32115
(386)671-8223 FAX (386) 671-3258

September 21, 2009

Gould & Lamb, LLC
101 Riverfront Blvd. Suite 100
Bradenton, FL. 34205

Re: MMSEA Mandatory Insurance Reporting Service Agreement

Dear Mr. Williams:

Please find enclosed an original signed contract between the City of Daytona Beach and Gould & Lamb, LLC for your records.

Sincerely,

Paula Eatman
Risk Management Specialist

Interoffice Memo

To: **James Chisholm, City Manager**

From: **William Navarra, Risk Manager**

Date: **September 17, 2009**

RE: **Federally Mandated Self-Insurer Reporting**

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 mandates reporting to Medicare an entities workers' compensation, liability, and, no-fault claims. This requirement is also imposed on self insurers, such as the City. Failure to comply with the reporting requirements of Section 111 includes penalties of $1,000 per day per claim.

Attached is an overview regarding Medicare's Mandatory Reporting Requirement provided by Gould & Lamb for your information. Gould & Lamb's fee for the service is a fixed cost of $10,200 per year which includes an indemnification agreement.

Several other companies have been approached regarding the providing of the required service Including the following:

Piatt Consulting provides a service entitled MCS Services.
Piatt Consulting charges $30.00 per claim submitted through them to Medicare. The total annual cost to the City for their service is approximately $7,500 plus a one time initial fee of $5,000 for the software license. Piatt does not provide an indemnification agreement and does not appear to have a dedicated office to service their clients.

MGU Speciality Risk Services
MGU charges an annual fee for their service of $17,500 and a quarterly claims fee of $750, for a total annual cost of $20,500 plus a one time Identification and Registration fee of $2,500. MGU would provide an indemnification agreement.

I recommend that the City select Gould & Lamb to meet the requirements of Section 111 since they are knowledgeable about this subject, charge a fixed cost fee and they provide an indemnification agreement.

Enclosed for your approval is the purchase order. Also attached is the contract, in duplicate, for your signature. The contract has been reviewed and approved by the City Attorney's Office and the Information Technology Division.

C: Sally McCarroll, Human Resources Director

Attachments

G&L GOULD & LAMB

YOUR PARTNER IN COMPLIANCE

Medicare & Medicaid State Children's Health Insurance Program Extension Act of 2007 (MMSEA)

Section 111: Mandatory Insurer Reporting (MIR)

Medicare Overview:

Medicare was established by Congress in 1965 to pay medical expenses for the elderly and disabled. Initially, Medicare paid virtually all expenses for eligible participants. However, in 1980, in an effort to curb inappropriate Medicare spending, Congress passed the Medicare Secondary Payer Statue (MSP). The MSP was designed to prevent cost shifting to Medicare from other parties who might be responsible for, or have caused, the beneficiary's injury or illness. Under the MSP, responsible parties are called "primary payers" – the idea being that they should pay before Medicare – and include providers of Liability insurance, self-insurance, no-fault insurance and Workers' Compensation.

In July of 2001, the Centers for Medicare & Medicaid Services (CMS) introduced the Workers' Compensation Medicare Set-Aside (WCMSA) program, which recommended the review and approval of certain types of settlements by CMS. While this program has been successful for CMS over the last 8 years, it has only scratched to surface of Medicare's recovery potential under the MSP. In search of additional revenue to fund the rapidly depleting Medicare Trust Fund, Congress created Section 111 of the MMSEA. Medicare's recovery rights under the MSP remain unchanged, but they now have the means to enforce them in all instances.

With passage of the Medicare, Medicaid and SCHIP Extension Act of 2007 (commonly referred to as SCHIP), Congress updated the rules, and beginning in April 2010, CMS will require primary payers to provide data that will allow Medicare recover payments that should have been paid by primary payers (commonly referred to as conditional payments or Medicare liens) and ensure that any additional future medical costs are covered by primary payers or the claimant's settlement proceeds, not Medicare. The regulations require primary payers to submit quarterly reports to CMS with detailed information about any claim involving a Medicare beneficiary.

Section 111 of the MMSEA will have serious implications, including:

- *Civil penalties of $1000 per day/claim for failure to comply with reporting requirements*
- *Requirements to discover/resolve conditional payments as part of any settlement agreement*
- *Increased usage of allocations to protect against future risks for the claimant and insurer*

Accordingly, companies that provide Liability insurance, self-insurance, no-fault auto insurance, and Workers' Compensation insurance to individuals entitled to Medicare must be in full compliance with Section 111 by April 1st, 2010 to prevent incurring liability pursuant to the MMSEA. MSP compliance has been required since December 5th, 1980.

Responsible Reporting Entities:

Entities responsible for complying with Section 111 are referred to as Responsible Reporting Entities (RREs). RREs must register with CMS via the Coordination of Benefits Secure Website (COBSW) between May 1, 2009 and September 30th, 2009. Registration after September 30th, 2009 is possible, but any exposure an RRE may have had prior to registration will not be mitigated. RREs must report quarterly, in a single electronic file, to CMS all claims involving Medicare beneficiaries where they have ongoing responsibilities for medicals (ORM) or cases resolved through settlement, judgment, or award. There are specific dates and thresholds around what types of claims need to be reported and RREs should review the CMS web-site to understand all of the guidelines and rules related to reporting exceptions on cases with ORM and settlements, judgments, awards. The site is *http://www.cms.hhs.gov/MandatoryInsRep.com*. Each RRE will receive a reporting period that is seven days in length. There are 12 cycles per quarter and 1 of 12 cycles will be assigned by CMS for each RRE ID. The reporting must be completed within the seven day period assigned by CMS after the completion of the registration process. The reporting timeframes are not uniform and a company with multiple-RRE IDs may have different reporting periods for various lines of business.

Insurance carriers are responsible for compliance with Section 111 for companies covered by an insurance policy with first dollar coverage (no deductible). However, companies with a deductible policy (that do not pay the deductible through a carrier) who pay their own claims are considered self insured pursuant to Section 111. Such self-insured companies must register and report claims that are within the deductible retention. If the claim exceeds the retention and moves into the insurer's layer, the insurer will become the RRE if they are funding the claim and the previous RRE will need to complete a final report indicating no further ORM. There is a great deal of conflicting information in the marketplace on this topic and CMS is expected to provide further guidance at some point.

Section 111 permits RREs to designate a third party to report claims. Third party administrators (TPAs) that manage claims and separate companies independent of the TPA can provide reporting services. Before designating an agent, each RRE must register with CMS. The authorized representative for the RRE must have authority to enter into the CMS agreements on behalf of the RRE. An RRE has two options for SCHIP reporting:

- They can choose to be a direct reporting entity to CMS.
- They can choose to utilize a reporting agent to submit to CMS.

This can become a complex matter when an RRE's claims are managed by multiple administrators. CMS will only allow one input file per quarter per RRE ID. If you have multiple administrators you must determine how those administrators will be reporting and decide if you wish to register multiple times for each administrator or utilize a 3rd party data consolidator to roll-up all administrators data into a single report to CMS. There are substantial advantages to a single registration in these scenarios.

Reportable Events:

What was initially a simple matter has become quite complex with the addition of thresholds and special exclusions from the reporting process. Section 111 mandates the reporting of claims involving

Medicare beneficiaries if there is Ongoing Responsibility for Medical (ORM), if there is a change from the initial report in key data elements, and when the case is resolved through settlement, judgment, or award (S/J/A). There are special exclusions for cases with ORM and thresholds for cases closed through S/J/A. To simplify matters, here are some general guidelines to note when discussing reportable events and the exclusions. One should review CMS guidance on this topic closely.

Reportable Events:

- Cases with ORM as of 7/1/09
- Cases closed through settlement, judgment, or award (S/J/A) on or after 1/1/2010
- Cases closed due to inactivity after 1/1/09, but continue to have ORM as of 7/1/09
- Cases closed due to inactivity prior to 1/1/09, but are re-opened after 1/1/09 and have ORM as of 7/1/09

Excluded Events:

- Contested Cases Exclusion:
  - No ORM and no payments have been made to or for the benefit of the claimant (only excluded until S/J/A occurs).
- Total Payment Obligation to the Claimant (TPOC aka S/J/A amount) Thresholds Exclusions:
  - TPOC amounts below $5000 are not reportable between 1/1/10 and 12/31/10
  - TPOC amounts below $2000 are not reportable between 1/1/11 and 12/31/11
  - TPOC amounts below $600 are not reportable between 1/1/12 and 12/31/12
  - All TPOC amounts are reportable after 1/1/13
- WC Claims with ORM Exclusion:
  - For only Workers' Compensation Claims where all of the following are true; "medical only", loss time of no more than 7 calendar days, total payment does not exceed $600, and all payments have been made directly to the medical provider, are excluded from reporting until 1/1/11.
    - Note: If ORM still exist as of 1/1/11, these cases will be reportable in the next quarterly cycle.

CMS requires submission of over 125 data elements for each claim that meets the reporting criteria. Section 111 reporting requirements were originally scheduled to go into effect July 1, 2009. The period between January 1st, 2010 and March 31st, 2010 will now be a test phase for the transmission of data from RREs to the CMS. RREs must begin submitting actual data in the second quarter of 2010. Failure to comply with the reporting requirements of Section 111 could result in civil money penalties of $1,000 per day per claim for noncompliance. It is wise to start this process sooner than later as registration, data testing, live return response, claims data back-fill, and MIR data testing are all steps that need to be complete prior to MIR live data feeds.

Impact on Settlements:

Implementation of the new rules is expected to complicate the settlement of all claims. Although SCHIP merely establishes claim reporting requirements, the MSP is also at work here and happens to be administered by CMS – the same entity responsible for enforcing Section 111 Reporting. CMS

has the ability to enforce their Secondary Payer rights on every claim now that they have knowledge of them. The industry should expect:

- Numerous conditional payment recovery letters from CMS on old claims.
- CMS stopping payments for medical benefits tied to injury related diagnosis.
- Post-Settlement, CMS exercising it's authority to collect the entire settlement amount.

There is an absolute need to develop claims handling practices now to mitigate the exposure to these rights of recovery. It is imperative that claims handlers be knowledgeable about what to do when a conditional payment recovery letter arrives from CMS, legal counsel must be prepared to address conditional payment and consideration of Medicare future interests in settlements, and proper disclosure needs to be made with regard to Medicare rights of recovery when a settlement is consummated. Contrary to urban legend, there is no requirement to seek CMS review and approval of a liability settlement. While CMS will review and approve certain types of Workers' Compensation settlements, the burden is on the liability insurer to demonstrate that it adequately protected Medicare's interests in each settlement. Insurers should measure their tolerance for risk carefully.

Stay Alert:

CMS continues to publish news, alerts, memorandum, conduct town hall meetings, and update User Manuals. There is a very high probability that something has changed from the time this article was written to the moment when you reading it. Stay alert and pay attention to the changes. Gould & Lamb will continue to monitor this matter and provide updates as necessary.

Should you have any questions, please do not hesitate to contact us directly at 866-672-3453 or online at www.gouldandlamb.com. Thank you for your interest in this topic.

MMSEA Mandatory Insurance Reporting Services Agreement

between

City of Daytona Beach

and

Gould & Lamb, LLC

This MMSEA Mandatory Insurance Reporting Services Agreement ("Agreement") effective on _____, 2009 ("Effective Date") is between City of Daytona Beach (Client), and Gould & Lamb, LLC, a Florida limited liability company ("G&L"). Client and G&L may each be referred to as a "Party" and collectively as the "Parties".

WHEREAS, Client is in the business of insurance or insurance related business and as such, is, on a regular basis, involved in settlements of insurance claims with Medicare Beneficiaries. Client is aware of, and acknowledges that it is subject to, and must comply with, The Medicare, Medicaid, and SCHIP Extension Act ("MMSEA"); Client seeks the services of G&L to ensure that it fully complies with MMSEA, and,

WHEREAS, G&L is a Medical-Financial services company which provides or offers, among many varied services, to its clients an MMSEA Mandatory Insurance Reporting Service to ensure that its clients are in compliance with the MMSEA Mandatory Insurance Reporting requirements as they currently exist or hereafter may be changed; G&L desires to provide its MMSEA Mandatory Insurance Reporting Services for Client, now,

THEREFORE, G&L and Client enter into this Agreement and agree to be bound by the following terms and covenants:

ARTICLE 1 - DEFINITIONS

1. "Claimant" means a person who is covered by any insurance programs of Client.

2. "Services" means the collection of information by G&L from Client necessary to file any reports or notices as may be required to fully comply with MMSEA, and to file all MMSEA reports on behalf of Client as may be required by The Centers for Medicare & Medicaid Services (CMS).

3. "Medicare Set Aside Allocation"(MSA) means a report prepared under requirements of the Medicare Secondary Payer statute and related regulations, that describes the medical condition and likely future costs of care and medications for Medicare covered treatments for an eligible Claimant.

4. "Claim Settlement Allocation"(CSA) means a report providing an estimate of future Medicare covered expenses with less detail than that of an MSA and is recommended in small settlements or those which do not meet the workload review thresholds established by the Centers for Medicare & Medicaid Services.

5. "Conditional Payment Research & Negotiation" means a report providing the amount of conditional payments asserted by CMS and the negotiation of these conditional payments to satisfy Medicare's right of recovery.

ARTICLE 2 – REPRESENTATIONS

2.1 Mutual Representations. Each Party represents to the other Party as follows:

(a) it is a corporation or limited liability company validly existing and in good standing under the Laws of the state in which it is incorporated or created with the power to own all of its properties and assets and to carry on its business as it is currently being conducted;

(b) its board of directors has duly authorized it to execute an Agreement such as this in the manner executed and to perform its obligations under this Agreement, and no other corporate proceedings of it are necessary with respect thereto;

(c) this Agreement constitutes its valid and binding obligation, enforceable in accordance with its terms, except as enforceability is limited by (i) any applicable bankruptcy, insolvency, reorganization, moratorium or similar Law affecting creditors' rights generally, or (ii) general principles of equity, whether considered in a proceeding in equity or at law;

(d) it is not required to obtain the consent of any party, including the consent of any party to any contract to which it is a party, in connection with execution of this Agreement and performance of its obligations under this Agreement; and

(e) its execution of this Agreement and performance of its obligations under this Agreement do not (i) violate any provision of its articles of incorporation or by-laws or its operating agreement as currently in effect, (ii) constitute a material default under any material contract to which it is a party or to which any of its material assets are bound; (iii) constitute an event that would, with notice or lapse of time, or both, result in a default as described in (ii) above; or (iv) violate any Law currently in effect to which it is subject.

ARTICLE 3 – WARRANTIES

3.1 Services. G&L represents and warrants to Client that it:

(a) has obtained and shall maintain all requisite licenses, permits and authorizations necessary to perform the Services;

(b) is and shall be in compliance with all Laws that may relate to the performance of the Services;

(c) shall perform or cause the Services to be performed in a diligent, professional and workmanlike manner, at a minimum, in accordance with industry standards applicable to the performance of the Services or similar services.

ARTICLE 4 – G&L'S OBLIGATIONS

4.1 Insurance. G&L has obtained, and will maintain, insurance coverage in the amount of $5,000,000.00 to cover any damages to Client which may occur as a result of any errors, omissions or negligence of G&L in performing any of its obligations under this Agreement. Proof of this insurance coverage will be available at any time during this Agreement upon request of Client.

4.2 Upon receipt of all fields of information requested by G&L via electronic transfer, G&L will conduct Medicare entitlement research to determine if the Claimant is a Medicare Beneficiary.

4.3 G&L will, when determining that a Claimant is a Medicare Beneficiary, file, electronically, with CMS all initial information which may be required by MMSEA and any ongoing required reports.

4.4 If G&L receives an "Error Notice" from CMS related to information which had been provided by Client, G&L will transmit this Error Notice or information to the designated contact department or employee of Client within five (5) days of receipt of the Error Notice.

ARTICLE 5----INDEMNIFICATION

5.1 Indemnification.

(a) Indemnification. Gould & Lamb, LLC shall indemnify and hold Client and each of their affiliates and assigns (collectively, the "Indemnified Parties") harmless from and against any claim, damage, fine, loss and expense, arising in connection with, or as a result of, any error, omission, or negligent performance of its obligations hereunder, which indemnity shall include all reasonable costs of litigation and attorneys' fees incurred by the Indemnified Party. Without in any way limiting the indemnity set forth in this Agreement, all work performed by Gould & Lamb shall be done in a good and professional manner. The provisions of this Paragraph shall survive the expiration or termination of this Agreement.

(b) G&L shall not indemnify Client, nor be responsible, for any losses, damages or fines incurred by Client as a result of errors, omissions, inaction, or incorrect information of the Client or any errors on the part of CMS or other government agency.

ARTICLE 6 – CLIENT'S OBLIGATIONS

6.1 Client shall do the following:

(a) "register" with CMS as required by MMSEA and subsequent memorandum from CMS or coordinate the registration of their customers which may be Responsible Reporting Entities (RREs) as required by MMSEA and subsequent memorandum from CMS.

(b) designate G&L as its "Reporting Agent" (RA) or require their customers to designate G&L as its RA or identify customers which will utilize another RA and coordinate activities of all of their clients which may be Responsible Reporting Entities "RREs" under MMSEA .

(c) authorize and instruct its IT department to fully cooperate with G&L's IT department to develop an information transfer system as required by G&L to perform its services as outlined herein.

(d) develop a system, at its own expense, as requested and instructed by G&L which is capable of electronically transmitting all information required by G&L to perform its services under this Agreement.

(e) transmit to G&L only correct information on claimants and bear responsibility for any damages of any nature resulting from the transmission of incorrect information.

(f) transmit all information required by G&L to file the report with CMS at least thirty (30) days prior to mandatory reporting date as established by MMSEA .

(g) deliver to G&L the required information and reporting date as required by CMS during the registration process.

(h) correct error reports received from G&L and CMS within Ten (10) days of receipt to ensure timely reporting and to avoid penalties.

(i) provide updated claims data in a timely manner for accurate reporting to CMS.

(j) communicate any changes in CMS profile information, primary contact for the client, client termination of relationship, and any other changes that may affect G&L's ability to accurately report on behalf of the Client.

(k) update fields via the web-portal (iService) with required MIR data as needed to provide accurate reporting to CMS. Client bears all responsibility for erroneous data populated in the web-portal system including any data incorrectly input into the portal or when data is incorrectly put into Client's system and is reflected in G&L's system.

(l) provide claims data to G&L no less than weekly to ensure the timely reporting of up-to-date data to CMS.

6.2 Compensation. G&L will provide MMSEA Mandatory Insurer Reporting functions to Client subject to the following stipulations:

(a) Client shall compensate G&L pursuant to the following schedule:

(1)Client will compensate G&L at a flat rate of $850.00 per month per RRE ID, or,
(2)Reductions may be negotiated based upon the number of RRE's that the Client obtains, and this section may be modified by written agreement executed by both Parties.

6.3 Error Reports. Client must send corrected information within ten (10) days of receipt of the Error Report from G&L. Should Client fail to respond within that time period, G&L will not be responsible for any damages of any nature, whether direct or consequential, resulting from the failure of Client to timely respond.

ARTICLE 7 – CONFIDENTIALITY OBLIGATIONS

7.1 Confidentiality Information.

(a) Subject to the requirements of Florida law, the Parties acknowledge that during their business relationship, confidential and proprietary information will be exchanged and that disclosure of any such information to any third party other than as necessary to carry out the terms of this Agreement will cause irreparable harm and damage, and therefore, the Parties agree to keep, protect, and not disclose any confidential or proprietary information of the other Party to any third party without prior written consent of the non-disclosing Party.

(b) Subject to the requirements of Florida law, confidential or proprietary information shall be defined as, or include, the software, systems, procedures, business plans, business strategies, internal organization, designs, flow charts, plans, specifications, manuals, client or customer lists, customer data, cost and price data, marketing information, the terms of this Agreement, any financial information and any other information received by either Party which would reasonably be considered as confidential or proprietary business information.

(c) Subject to the requirements of Florida law, the Parties shall protect the confidential or proprietary information of the other Party to the same extent or by the same means that it would protect its own confidential and proprietary information, and shall notify the other Party in writing of any unauthorized disclosures, either intentional or unintentional, to any third parties, and shall do so immediately after discovering or determining such unauthorized disclosures. The obligations to protect confidential and proprietary information shall survive termination of this Agreement.

ARTICLE 8 – HIPAA COMPLIANCE

8.1 Both parties acknowledge and are aware of their responsibilities related to confidentiality of Protected Health Information (PHI) and to fully comply with all regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), G&L agrees as follows:

(a) to not use or disclose PHI other than as permitted by this Agreement or as required by law;
(b) to at all times maintain and use appropriate safeguards to prevent use or disclosure of any PHI other than as set forth in this Agreement;
(c) implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that Client creates, receives, maintains, or transmits to G&L;
(d) report to Client any use or disclosure of any PHI of which it becomes aware that is not permitted by this Agreement;
(e) report to Client any Security Incident involving Client's Electronic PHI of which it becomes aware;
(f) make available the information required for Client to provide an accounting of disclosures , in accordance with the HIPAA Privacy Rule;

8.2 The terms of this Section 8 have been included based solely on the understanding by the parties that they are required to comply with HIPAA. To the extent that any relevant provision of HIPAA has been excluded, is materially amended or interpreted in a manner that changes the obligations of Client or G&L under this Agreement, the parties agree to negotiate in good faith an amendment to this Agreement to give effect to such revised obligations. The terms of this Agreement will be construed in light of any interpretation of and/or guidance on HIPAA issued by the Department of Health and Human Services or the Office of Civil Rights, from time to time.

ARTICLE 9 – TERM AND TERMINATION

9.1 Term. This Agreement begins on the Effective Date and shall continue for a term of five (5) years or until otherwise terminated. This Agreement will automatically renew for consecutive 2 year terms unless either party has terminated this Agreement pursuant to the termination terms contained herein.

9.2 Termination. Either Party may terminate this Agreement, with or without cause, upon six months written notice. During the six month termination period, both parties shall continue to perform their obligations or services outlined herein.

9.3 Survival. Provisions of this Agreement relating to Confidentiality, HIPAA, and Indemnification shall survive the termination of this Agreement.

9.4 MQF (Medicare Query Function Agreement): This Agreement and all services and obligations of G&L are contingent upon the development of a MQF service by the Centers for Medicare & Medicaid Services (CMS) for electronic confirmation of the Medicare entitlement status of claimants similar to, or the same as, the MQF currently implemented or used for Group Health Insurance Plans. Should that MQF not be developed or implemented by CMS, this Agreement shall be null and void or shall be automatically terminated if G&L is unable to reasonably establish an alternative method of performing its obligations or services under this Agreement. Client agrees and understands that should G&L be required to develop an alternative solution by CMS, G&L may require additional fees. G&L shall advise Client of those fees in writing, and Client will confirm and agree to same in writing within ten days, or this Agreement shall be null and void as provided herein.

ARTICLE 10 – GENERAL PROVISIONS

10.1 Notices. Each Party shall give or make any notice, authorization, request or other communication in connection with this Agreement in writing by personal delivery, post, express courier to the addresses listed below unless otherwise stated in this Agreement. A notice is effective when deemed received. Notices are deemed received on the date shown on the postal return receipt or the personal delivery, express courier. A Party is entitled to change the person, address, facsimile number or e-mail address for receipt of notices by notice to the other Party.

If to Client:

Name:	William Navarra
Title:	Risk Manager
Address:	P.O. Box 2451
	Daytona Beach FL 32115-2451

If to G&L:

Name:	John Williams
Title:	President & CEO
Address:	Gould & Lamb, LLC
	101 Riverfront Blvd. Suite 100
	Bradenton, FL 34205
Facsimile No.:	(941)798-2138
Telephone No.:	(941)798-2098
E-mail:	john.williams@gouldandlamb.com

10.2 Use of Trade Names. Each Party shall not, without the prior written consent of the other Party (a) issue any press release with respect to this Agreement, or (b) use for the purposes of advertising, promotion, or publicity, or otherwise, the name of the other Party or any trademarks, trade names, service marks, symbols or any abbreviation of the other Party. Despite the previous sentence of this Section, either Party is entitled to make any disclosures required by Law.

10.3 Appendices. The terms of any exhibits and other appendices which may be attached to this Agreement are incorporated into and made a part of this Agreement.

10.4 Amendments. The Parties may amend this Agreement only by a written agreement that identifies itself as an amendment to this Agreement and is signed by an authorized representative of each Party.

10.5 Waivers. No waiver of any breach of this Agreement is a waiver of any other breach, and no waiver is effective unless made in writing and signed by an authorized representative of the waiving Party.

10.6 Severability. If any provision of this Agreement is determined to be invalid, illegal or unenforceable, the remaining provisions of this Agreement remain in full force, if the essential terms and conditions of this Agreement for each Party remain valid, binding, and enforceable.

10.7 Merger; Entire Agreement. This Agreement constitutes the entire and final agreement between the Parties pertaining to the matters contained in this Agreement. All prior and contemporaneous negotiations and agreements between the Parties on the matters contained in this Agreement are

expressly merged into and superseded by this Agreement. In entering into this Agreement, neither Party relied upon any statement, representation, warranty or agreement of the other Party except for those expressly contained in this Agreement. There are no conditions precedent to the effectiveness of this Agreement, other than those expressly stated in this Agreement.

10.8 Force Majeure.

(a) "Force Majeure Event" means any act or event, whether foreseen or unforeseen, that meets all three of the following tests.

(i) The act or event prevents a Party, in whole or in part, from (1) performing its obligations under this Agreement or (2) satisfying any conditions to its obligations under this Agreement.

(ii) The act or event is beyond the reasonable control of and not the fault of the Party.

(iii) The Party has been unable to avoid or overcome the act or event by the exercise of due diligence.

(b) Despite the preceding definition of Force Majeure Event, a Force Majeure Event excludes economic hardship, changes in market conditions and insufficiency of funds.

(c) Upon the happening of a Force Majeure Event, the Party so affected will not be liable, so long as it gives written notice to the other Party and takes all reasonable steps to minimize both the effect and duration of a Force Majeure Event. The obligations and rights of the party so excused will be extended on a day-to-day basis for the period of time equal to that of the underlying cause of the delay.

10.9 Assignment, Subcontracting and Delegation. Neither Party may assign any of its rights or obligations under this Agreement without the prior written consent of the other Party.

10.10 Successors and Assigns. This Agreement binds and benefits the Parties and their respective permitted successors and assigns.

10.11 Third Party Beneficiaries. This Agreement does not and is not intended to confer any rights or remedies upon any person or entity other than G&L and Client.

10.12 Relationship of Parties.

(a) This Agreement does not create nor will it be construed to create any relationship between the Parties other than that of independent contractors. Neither of the Parties nor any of the Parties' employees or agents will be considered to be the employees, partners, co-venturers or owners of the other, nor to have dominion or control or any agency relationship over the other.

(b) Each Party is responsible for the activities and performance of its employees, their contractors and subcontractors, and its agents. Each Party shall be solely responsible for the payment of all compensation and benefits due to its employees including payment of all employment related taxes and workers' compensation insurance premiums.

10.13 Further Assurances. Each Party shall use all commercially reasonable efforts to take or cause to be taken, all further actions necessary or desirable to carry out the purposes of this Agreement.

10.14 Governing Law; Venue.

(a) The Laws of the State of Florida, without giving effect to its conflict of laws principles, govern all matters arising out of or relating to this Agreement, including, without limitation, its interpretation, construction, performance, and enforcement.

(b) Any Party bringing a legal action or proceeding against any other Party arising out of or relating to this Agreement shall bring the legal action or proceeding in any state court located within Volusia County, Florida.

(c) Each Party waives, to the fullest extent permitted by Law, any objection that it may have based on improper venue or inconvenient forum to the conduct of any such action or proceeding in state court located within Volusia County, Florida.

10.15 Remedies. Unless otherwise specified in this Agreement, each Party's rights and remedies are cumulative and not exclusive, are in addition to any other rights and remedies provided at law, in equity, or under this Agreement, and may be pursued separately or concurrently as such Party determines.

The Parties are executing this Agreement effective the day and year first stated in the introductory clause.

City of Daytona Beach

By: James V Chisholm

Name: James V Chisholm

Title: City Manager

Gould & Lamb, LLC

By:

Name: John Williams

Title: President & CEO