

TEAM HEALTH, INC.
NON-QUALIFIED SUPPLEMENTAL EXECUTIVE RETIREMENT PLAN (SERP)
ELECTION FORM
2008 Plan Year

Check all that apply:

Enrollment Stop Contributions Change Distribution Election Change Beneficiary

Part 1 EMPLOYEE DATA

Employee Name (Please Print)			Social Security No. (last 4 digits) XXX-XX-	Employee Number
Street			Date Of Employment	
City	State	Zip Code/Postal Code	Date of Birth	
Daytime Phone		Email Address	Company, Division or Location	

Part 2 CONTRIBUTION ELECTION

Please deduct the following percent of my regular compensation (excludes bonuses) _____% on a pre-tax basis to the annual maximum of \$15,500

OR

Please deduct the following dollar amount of my compensation on a pre-tax basis \$ _____ (Annual Amount)
(Maximum annual contribution is \$15,500 and will be deducted in equal amounts each pay)

OR

I do not wish to participate in the Plan for the 2008 Plan Year

NOTE: Compensation deferral elections must be made prior to the beginning of each Plan Year.

Part 3 New Enrollees Only - BENEFIT PAYMENT ELECTION

When I become entitled to benefits under the Plan, I elect to be paid as follows:

Lump Sum OR Annual Installments for _____ years (3, 5 or 10 years)
 Any change in current election may not be implemented for five years

Part 4 New Enrollees Only INVESTMENT SELECTION

<u>Investment Options</u>	<u>Future Contributions</u>	<u>Investment Options</u>	<u>Future Contributions</u>
American Funds Washington Mutual A	_____ %	Vanguard 500 Index	_____ %
Van Kampen Eq and Inc A	_____ %	Van Kampen Mid Cap GR	_____ %
T. Rowe Price Growth Adv	_____ %	MFS Bond A	_____ %
AMRO/TAMRO Sm Cap N	_____ %	Excelsior Money Fund	_____ %
First Eagle Overseas A	_____ %	Goldman Sachs Mid Val	_____ %
Amer Funds EuroPac	_____ %		_____ %
		_____ %	
		Total: 100 %	

***If you are not a new enrollee, please make any investment election changes through the Voice Response Unit: 1-800- 828-4224 or via the web at www.usicg.com.

Part 5 DESIGNATION OF BENEFICIARY

(Complete only if you are initially enrolling or making a change.)

Please designate the primary and contingent beneficiaries who will receive your account balance in the event of your death **effective as of:** _____

Primary beneficiary (first, middle initial, last)	Relationship	SSN	Address
Contingent beneficiary (first, middle initial, last)	Relationship	SSN	Address

Please indicate the method of benefit payments for any amounts payable upon your death to your beneficiary.

Lump Sum Annual Installments for _____ years (3, 5 or 10 years)

Part 6 EMPLOYEE AUTHORIZATION

I hereby authorize the Plan Administrator to take the actions indicated above with regard to the Plan.

Signature	Date
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Fax enrollment form to **888-422-0106**