

ABC SAMPLE CO.
123 SAMPLE LN
EUGENE, OR 97402-

February 12, 2010

Mr. & Mrs. I M POSSIBLE and Family
Ms. YOU R POSSIBLE
456 ADDRESS LANE
ANYWHERE, OR 97406-

Dear Mr. & Mrs. I POSSIBLE, YOU R POSSIBLE:

This notice contains important information about your right to continue your health care coverage in the ABC SAMPLE CO. Group Health Plan (the Plan).

Please read the information contained in this notice very carefully. This notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan for you and your covered dependents, if any, as defined on the enclosed Family Member Enrollment Form. If you have any questions concerning the information in this notice or your rights to coverage, you should contact

MANLEY SERVICES
Attn: COBRA Department
P.O. Box 70168
Eugene, OR 97401-0110

If you do not elect to continue your health care coverage by completing the enclosed "Enrollment Form" and returning it to us, your coverage under the Plan will end on 07/01/2009 due to:

Voluntary/Involuntary Termination

Because of the above event that will end your coverage under the Plan, you are entitled to continue your health care coverage for up to 18 months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on 07/01/2009 and can last until 01/01/2011.

IMPORTANT – To elect continuation coverage, you MUST complete the enclosed "Enrollment Form" and return it to us. You may mail it to the address shown on the Enrollment Form. The completed Enrollment Form must be post-marked by 03/05/2010. If you do not submit a completed Enrollment Form by this date, you will lose your right to elect continuation coverage.

Also, since each covered dependents has the equal right to accept or decline the coverage being offered them, if not all members of your family who are eligible for the coverage offered wish to continue coverage, please indicate that as well on the Dependent/Family Member Enrollment Form, if enclosed. Should some but not all of your dependents wish to continue coverage, you are welcome to call the telephone number shown to obtain information about specific premium amounts due.

The total premiums due each month is shown on the Enrollment Form and on the Premium Computation Form. You should pay the total premium due at the time you send in the Enrollment Form, in order to complete your enrollment and continue your coverage. However, you are allowed to delay the premium payment for up to forty-five days after you have signed, dated and submitted your Enrollment Form. Any claims submitted for expenses incurred following the date of the Qualifying Event may be held in suspense until all premiums which are due have been paid.

Future premiums are due on the first of each month thereafter, and should be mailed on or before the due date. Failure to pay premiums by premium due dates may terminate your participation in the Health Benefits Continuation Plan.

If you have any questions about the coverage, its length or the premiums due, please call MANLEY SERVICES at (800)422-7038 during regular business hours.

Sincerely,
MANLEY SERVICES
COBRA DEPT

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION COVERAGE RIGHTS

What is continuation coverage?

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan. The persons listed on page one of this notice have been identified by the Plan as qualified beneficiaries entitled to elect continuation coverage. Specific information describing continuation coverage can be found in the Plan's summary plan description (SPD), which can be obtained from

MANLEY SERVICES
Attn: COBRA Department
P.O. Box 70168
Eugene, OR 97401-0110

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Page one of this notice shows the maximum period of continuation coverage available to the listed qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify MANLEY SERVICES of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify MANLEY SERVICES of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries listed on page one of this notice who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify MANLEY SERVICES of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify MANLEY SERVICES within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary listed on page one of this notice has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of the continuation coverage if you get continuation coverage for the maximum time available to you.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

What if I am eligible for trade adjustment assistance?

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282. TTD/TTY callers may call toll free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of the continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact MANLEY SERVICES to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

MANLEY SERVICES
Attn: COBRA Department
P.O. Box 70168
Eugene, OR 97401-0110

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan may be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

MANLEY SERVICES
Attn: COBRA Department
P.O. Box 70168
Eugene, OR 97401-0110

If information is available about alternative coverage (coverage in lieu of continuation coverage, or individual conversion rights), it will appear here: NONE AVAILABLE

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description or from the Plan Administrator. You can get a copy of your summary plan description from:

MANLEY SERVICES
Attn: COBRA Department
P.O. Box 70168
Eugene, OR 97401-0110

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the address of family members. You should also keep a copy, for your records, of any notices you sent to the Plan Administrator.



Summary of the COBRA Premium Reduction Provisions under ARRA, as Amended

President Obama signed the American Recovery and Reinvestment Act (ARRA) on February 17, 2009. On December 19, 2009, the President signed the Department of Defense Appropriations Act, 2010. These laws give “Assistance Eligible Individuals” the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 15 months.

To be considered an “Assistance Eligible Individual” and get reduced premiums you:

- **MUST** have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through February 28, 2010;
- **MUST** elect the coverage
- **MUST NOT** be eligible for Medicare; AND
- **MUST NOT** be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.*

Individuals whose nine month premium reduction ended also have an opportunity to make a payment to continue coverage at the reduced rates. These payments must be made by the later of February 17, 2010, 30 days from the date that the notice regarding the ARRA amendment that extended the premium reduction to 15 months was provided, or the end of the otherwise applicable payment grace period.

◆ IMPORTANT ◆

- ◇ If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you **MUST** notify the plan in writing. If you do not, you may be subject to a tax penalty.
- ◇ Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.
- ◇ The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than \$125,000 (or \$250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on ARRA at www.irs.gov.

For general information regarding your plan's COBRA coverage you can contact your Plan Administrator.

For specific information related to your plan's administration of the ARRA Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact your Plan Administrator.

If you are denied treatment as an “Assistance Eligible Individual” you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the ARRA Premium Reduction go to:

www.dol.gov/COBRA or call 1-866-444-EBSA (3272)

* Generally, this does not include coverage for only dental, vision, counseling, or referral services; coverage under a health flexible spending arrangement; or treatment that is furnished in an on-site medical facility maintained by the employer.

To apply for ARRA Premium Reduction, complete this form and return it to us along with your Election Form.

You may also send this form in separately. If you choose to do so, send the completed "Request for Treatment as an Assistance Eligible Individual" to the administrator listed on the Enrollment Form.

You may also want to read the import information about your rights included in the "Summary of the COBRA Premium Reduction Provisions Under ARRA, as Amended."

Plan Name	REQUEST FOR TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL	Plan Mailing Address
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PERSONAL INFORMATION

Name and mailing address of employee (list any dependents on the back of this form)	Telephone number
	E-mail address (optional)

To qualify, you must be able to check 'Yes' for all statements.*

1. The loss of employment was involuntary	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. The loss of employment occurred at some point on or after September 1, 2008 and on or before February 28, 2010.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. I am NOT eligible for other group health plan coverage (or I was not eligible for other group health plan coverage during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. I am NOT eligible for Medicare (or I was not eligible for Medicare during the period for which I am claiming a reduced premium).	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

FOR EMPLOYER OR PLAN USE ONLY

This application is: Approved Denied Approved for some/denied for others (explain in #4 below)
Specify reason below and then return a copy of this form to the applicant.

REASON FOR DENIAL OF TREATMENT AS AN ASSISTANCE ELIGIBLE INDIVIDUAL

1. Loss of employment was voluntary.	<input type="checkbox"/>
2. The involuntary loss did not occur between September 1, 2008 and February 28, 2010.	<input type="checkbox"/>
3. Individual did not elect COBRA continuation coverage.	<input type="checkbox"/>
4. Other (please explain)	<input type="checkbox"/>

Signature of party responsible for continuation administration for the Plan

_____ Date _____

Type or print name _____

Telephone number _____ E-mail address _____

DEPENDENT INFORMATION (Parent or guardian should sign for minor children.)

Name Date of Birth Relationship to Employee SSN (or other identifier)

a. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

b. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

Name Date of Birth Relationship to Employee SSN (or other identifier)

c. _____

1. I elected (or am electing) COBRA continuation coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. I am NOT eligible for other group health plan coverage.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. I am NOT eligible for Medicare.	<input type="checkbox"/> Yes <input type="checkbox"/> No

I make an election to exercise my right to the ARRA Premium Reduction. To the best of my knowledge and belief all of the answers I have provided on this form are true and correct.

Signature _____ Date _____

Type or print name _____ Relationship to employee _____

This form is designed for plans to distribute to COBRA qualified beneficiaries who are paying reduced premiums pursuant to ARRA so they can notify the plan if they become eligible for other group health plan coverage or Medicare.

Use this form to notify that you are eligible for other group health plan coverage or Medicare and therefore not eligible for reduced premiums under ARRA.

Plan Name	Participant Notification	Plan Mailing Address
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PERSONAL INFORMATION

Name and mailing address	Telephone number
	E-mail address (optional)

PREMIUM REDUCTION INELIGIBILITY INFORMATION – Check one

I am eligible for coverage under another group health plan. If any dependents are also eligible, include their names below. Insert date you became eligible _____	<input type="checkbox"/>
I am eligible for Medicare. Insert date you became eligible _____	<input type="checkbox"/>

IMPORTANT

If you fail to notify your plan of becoming eligible for other group health plan coverage or Medicare AND continue to pay reduced COBRA premiums you could be subject to a fine of 110% of the amount of the premium reduction.

Eligibility is determined regardless of whether you take or decline the other coverage.

However, eligibility for coverage does not include any time spent in a waiting period.

To the best of my knowledge and belief all of the answers I have provided on this Form are true and correct.

Signature _____ Date _____

Type or print name _____

If you are eligible for coverage under another group health plan and that plan covers dependents you must also list their names here:

HEALTH BENEFITS CONTINUATION PLAN ENROLLMENT FORM

ABC SAMPLE CO.

PQB NAME: Mr. & Mrs. I M POSSIBLE and Family
 ADDRESS: 456 ADDRESS LANE
 ANYWHERE, OR 97406-
 TELEPHONE: (555)111-2222
 EMPLOYEE: I M POSSIBLE
 QBID #: ABC/456789123

QUALIFYING EVENT: Voluntary/Involuntary Termination

FIRST DAY AFTER LOSS OF COVERAGE/FIRST DAY COBRA WILL BEGIN: 07/01/2009

LIST ELIGIBLE PERSONS TO BE COVERED: (PERSONS PREVIOUSLY COVERED ONLY)

NAME LAST	FIRST MIDDLE	BIRTH DATE	SEX	SOC. SEC. #
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Plan Description	Coverage Level	Premium
----- DENTAL PLAN	PQB and Spouse	\$23.38
MEDICAL PLAN -----	PQB and family	\$364.14
Total Monthly Premium:		\$387.52

I HEREBY REQUEST ENROLLMENT IN THE HEALTH BENEFITS CONTINUATION PLAN FOR MYSELF AND ELIGIBLE QUALIFIED DEPENDENTS LISTED ON THIS FORM AND AGREE TO PAY THE PREMIUM AS REQUIRED. I UNDERSTAND THAT CONTINUATION COVERAGE WILL TERMINATE UNDER SEVERAL CIRCUMSTANCES, INCLUDING: THE DATE I OR A CONTINUED DEPENDENT BECOME COVERED UNDER ANOTHER GROUP HEALTH/DENTAL PLAN, BECOME ENTITLED TO MEDICARE, OR ON THE DATE ON WHICH THE GROUP HEALTH/DENTAL PLAN ENDS. I ALSO UNDERSTAND THAT IF I WAS DISABLED WITHIN 60 DAYS OF THE COBRA QUALIFYING EVENT, I MAY BE ELIGIBLE FOR EXTENDED CONTINUATION COVERAGE.

ADDITIONALLY, I UNDERSTAND THAT MY ELIGIBILITY FOR UP TO NINE MONTHS OF PREMIUM ASSISTANCE REQUIRING PAYMENTS OF THE TOTAL MONTHLY PREMIUMS SHOWN ABOVE WILL BE DETERMINED BY MY PLAN ADMINISTRATOR AFTER RECEIPT OF THIS COMPLETED ENROLLMENT FORM. I BELIEVE THAT I QUALIFY FOR THIS ASSISTANCE BECAUSE (A) I WAS INVOLUNTARILY TERMINATED BETWEEN SEPTEMBER 1, 2008 AND DECEMBER 31, 2009, (B) I HAVE NOT BECOME ELIGIBLE FOR ANY OTHER GROUP HEALTH PLAN OR MEDICARE SINCE MY TERMINATION, AND (C) I FALL BELOW THE INCOME LIMITS REQUIRED BY THE LAW.

 Signature of Mr. & Mrs. I M POSSIBLE and Family

DATE: _____

NOTE: In order to be enrolled in the Health Benefits Continuation Plan this ENROLLMENT FORM must be received no later than 03/05/2010.

Please send completed form to:
 MANLEY SERVICES

Attn: COBRA Department
P.O. Box 70168
Eugene, OR 97401-0110

PREMIUM COMPUTATION FORM

February 12, 2010

ABC SAMPLE CO.
123 SAMPLE LN
EUGENE, OR 97402-

Principal Qualified Beneficiary (PQB): Mr. & Mrs. I M POSSIBLE and Family

The Health Benefits Continuation Plan requires you to pay premiums according to the schedule shown below. The premium for the first partial month, if applicable, has been calculated for the remaining number of days in the month the Qualifying Event occurs.

Subsequent premiums are due each month, as shown. **You must pay all initial premiums due within forty-five days of the day you sign and date the Enrollment Form. All subsequent payments are due the 1st of each month.**

Your Qualifying Event Date: 06/01/2009

Your Last Enrollment Date: 03/05/2010

Plan Description	Coverage Level	Premium
DENTAL PLAN	PQB and Spouse	\$23.38
MEDICAL PLAN	PQB and family	\$364.14
Total Monthly Premium:		\$387.52

Schedule Of First Payment	Premium
Amount Due if Enrollment Form Signed And Received In Our Office: 04/30/2010	\$387.52
Amount Due if Enrollment Form Signed And Received In Our Office: 05/31/2010	\$775.04
Amount Due if Premium Paid By.....:06/30/2010	\$1,162.56
Amount Due if Premium Paid By.....:07/31/2010	\$1,550.08

If you have questions regarding your coverage level please contact Manley Services at 1-800-422-7038.

**Premiums must be paid by check or money order to: Manley Services
Attn: COBRA Department
PO Box 70168
Eugene, OR 97401-0110**

PLEASE DO NOT SEND CASH. We can not accept credit card payments or wire transfers.

FAMILY MEMBER ENROLLMENT FORM

ATTN: All eligible family members of
Mr. & Mrs. I M POSSIBLE and Family

Please elect the coverage you desire under our Health Benefits Continuation Plan by circling the appropriate selection (ACCEPT or DECLINE) and signing in the space provided.

The Principal Qualified Beneficiary (PQB) may accept coverage for all his/her dependents, but only the dependents or responsible party(s) may elect to accept or decline coverage which the Principal Qualified Beneficiary has declined for himself/herself. Please return this form with the Health Benefits Continuation Plan Enrollment Form.

FAMILY MEMBER COVERAGE

Name	Relationship	Signature

YOU R POSSIBLE	Spouse	
DENTAL PLAN	ACCEPT/DECLINE _____	
MEDICAL PLAN	ACCEPT/DECLINE _____	

ABC SAMPLE CO.
123 SAMPLE LN
EUGENE, OR 97402-

February 12, 2010

Mr. & Mrs. I M POSSIBLE and Family
Ms. YOU R POSSIBLE
456 ADDRESS LANE
ANYWHERE, OR 97406-

Dear Mr. & Mrs. POSSIBLE:

Under a new federal law, known as the Health Insurance Portability and Accountability Act of 1996, you are entitled to a Certificate of Health Coverage upon your eligibility for COBRA continuation coverage or, if not eligible for COBRA continuation coverage, upon your losing coverage under a group health plan. It is our understanding that one of these events has occurred and therefore enclosed is your Certificate of Group Health Plan Coverage.

In the event you need to provide evidence of prior health insurance coverage, we encourage you to keep your Certificate in a safe place that is easily accessible. You may use the information on your Certificate to reduce or eliminate a preexisting condition exclusion period with another health insurance carrier.

If you have any questions, please contact MANLEY SERVICES at (800)422-7038 during regular business hours.

Sincerely,

MANLEY SERVICES
COBRA DEPT

ABC SAMPLE CO.
123 SAMPLE LN
EUGENE, OR 97402-

February 12, 2010

CERTIFICATE OF GROUP HEALTH PLAN COVERAGE

IMPORTANT - This certificate provides evidence of your prior health coverage. You may need to furnish this certificate if you become eligible under a group health plan that excludes coverage for certain medical conditions that you have before you enroll. This certificate may need to be provided if medical advice, diagnosis, care, or treatment was recommended or received for the condition within the 6-month period prior to your enrollment in the new plan. If you become covered under another group health plan, check with the plan administrator to see if you need to provide this certificate. You may also need this certificate to buy, for yourself or family, an insurance policy that does not exclude coverage for medical conditions that are present before you enroll.

Participant Name: Mr. & Mrs. I M POSSIBLE and Family
Participant's QBID Number: 456789123

Benefit Plan Name: DENTAL PLAN
Level of Coverage: PQB and Spouse
Date of First Coverage: N/A
18 Months of Continuous Coverage: Yes
Waiting Period Prior to First Coverage: 0 Days
Last Day Covered as Active Employee/Dependent: 06/30/2009
Date COBRA Continuation Period Started: 07/01/2009
Date COBRA Coverage Ended: Currently Enrolled
COBRA Coverage Ended Because: N/A

SSN	ID.	Relation	Continuation Active Start	Continuation Benefit End	18 Months Of Coverage	Orig. Benefit Start
Dependent Name: Ms. YOU R POSSIBLE						
		Spouse	07/01/2009	N/A	Yes	N/A

Benefit Plan Name: MEDICAL PLAN
Level of Coverage: PQB and family
Date of First Coverage: N/A
18 Months of Continuous Coverage: Yes
Waiting Period Prior to First Coverage: 0 Days
Last Day Covered as Active Employee/Dependent: 06/30/2009
Date COBRA Continuation Period Started: 07/01/2009
Date COBRA Coverage Ended: Currently Enrolled
COBRA Coverage Ended Because: N/A

Continuation Continuation 18 Months Orig. Benefit

SSN	ID.	Relation	Active Start	Benefit End	Of Coverage	Start
Dependent Name: Ms. YOU R POSSIBLE						
		Spouse	07/01/2009	N/A	Yes	N/A

Questions about the coverage listed above should be directed to MANLEY SERVICES at (800)422-7038.

Sincerely,

MANLEY SERVICES
COBRA DEPT