

**COBRA CONTINUATION COVERAGE
ELECTION NOTICE**

Date: _____, 20____
 To: _____

This notice contains important information about your right under Federal law to continue your health care coverage in the Welfare Benefit Plan of _____ ("Plan"). Please read the information contained in this notice very carefully.

Print name of the covered employee (the employee or former employee who is or was covered for the benefit(s) under the Plan): _____

To elect Federal COBRA continuation coverage, complete the enclosed Election Form and submit it to the Employer, following the instructions at the top of the Election Form.

If you do not elect to continue your benefit coverage by completing the enclosed "Election Form" and returning it to us, your coverage under the Plan will end on the date _____, 20____ due to:

- | | |
|--|---|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of dependent child status |

Each of the following persons ("qualified beneficiary") whose name is entered below is entitled to elect Federal COBRA continuation coverage for the specified benefit(s), which will continue group health care coverage under the Plan for up to [] 18 months [] 36 months:

Qualified Beneficiary	Benefit(s) covered by this COBRA Election Notice
<input type="checkbox"/> Employee or former employee Name: _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Spouse or former spouse Name: _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision
<input type="checkbox"/> Dependent children covered under benefit under the Plan on the day before the event that caused the loss of coverage (<i>list by name if possible or by status</i>) Name(s): _____ _____ _____ _____ _____ _____ _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

Qualified Beneficiary	Benefit(s) covered by this COBRA Election Notice
<input type="checkbox"/> Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan <i>(list by name if possible or by status)</i> Name(s): _____ _____	<input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision

If elected, COBRA continuation coverage will begin on _____, 20____, and can last through _____, 20____.

Partial Month Premium. *(Complete only if there is a partial month premium.)* If the first period of coverage will be a partial calendar month, the cost of COBRA continuation coverage for the first partial calendar month of coverage is *(cost listed per type of benefit, see above chart to determine which benefit is available):*

FIRST PARTIAL MONTH PREMIUM

	Single	Employee and Spouse	Employee and Children	Full Family
Medical	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Vision	_____	_____	_____	_____
Other <i>(describe):</i>	_____			

Monthly Premium. The current monthly cost of COBRA continuation coverage for a full calendar month of coverage is *(cost listed per type of benefit, see above chart to determine which benefit is available):*

MONTHLY PREMIUM

	Single	Employee and Spouse	Employee and Children	Full Family
Medical	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Vision	_____	_____	_____	_____
Other <i>(describe):</i>	_____			

(Note that these amounts are subject to change in the future and most likely will be higher than they are now. You will be notified of COBRA premium changes.)

You do not have to send any payment with the Election Form. Note that any premium that is paid will be applied first to the amount due for the earliest month of coverage for which an amount is payable. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form.

If you have any questions regarding the information in this Notice or your rights to COBRA continuation coverage, you should contact the Plan Administrator, in care of the Employer, at the following address:

Human Resources Department

Address: _____

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**COBRA CONTINUATION COVERAGE
ELECTION FORM**

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under Federal law, you must have 60 days after the date of this Notice (or, if later, no later than 60 days after the date that the benefit coverage terminates) to decide whether you want to elect COBRA continuation coverage under the Plan.

Name of Plan: Welfare Benefit Plan of _____

Send completed Election Form to: Human Resources Department

Address: _____

You may fax this Form if a fax number is provided: Fax Number: _____.

This Election Form must be completed in writing and returned by mail, hand-delivery, or fax if a fax number is provided. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA continuation coverage, including in-person or telephone statements about an individual's COBRA continuation coverage; and electronic communications, including e-mail. (See above to see if faxed communications are allowed.) If mailed, your election must be postmarked; if faxed (if a fax number has been provided), your election must be electronically transmitted; and if hand-delivered, your election must be received by the individual at the address specified above no later than _____, 20_____
(60 days after the date of the COBRA election notice provided to you at the time of your qualifying event or, if later, 60 days after the date that the benefit coverage terminates.)

If you do not submit a completed Election Form by the due date shown above, you will lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, but before the due date, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

Print name of the covered employee (the employee or former employee who is or was covered for the benefit(s) under the Plan): _____

Continuation coverage in the Plan is hereby elected for the following individuals in the benefits (see Election Notice for benefit(s) that are available) as indicated below:

a. Name: _____ Date of Birth: _____
Relationship to Employee: _____ SSN (or other identifier): _____
Benefit(s) elected: Medical Dental Vision

b. Name: _____ Date of Birth: _____
Relationship to Employee: _____ SSN (or other identifier): _____
Benefit(s) elected: Medical Dental Vision

c. Name: _____
Relationship to Employee: _____
Benefit(s) elected: Medical Dental Vision

Date of Birth: _____
SSN (or other identifier): _____

d. Name: _____
Relationship to Employee: _____
Benefit(s) elected: Medical Dental Vision

Date of Birth: _____
SSN (or other identifier): _____

e. Name: _____
Relationship to Employee: _____
Benefit(s) elected: Medical Dental Vision

Date of Birth: _____
SSN (or other identifier): _____

Type of Coverage: If coverage is elected on this form for only one individual, the default coverage provided will be single coverage. If coverage is elected on this form for more than one individual, the default coverage provided will be employee and spouse, employee and children, or full family coverage, as may be available and applicable. If coverage other than the default coverage is desired, and available (see the Plan Sponsor if you have questions about what coverage options are available), list the names of the individuals and type of coverage desired: _____

Is the covered employee, spouse, or any dependent child entitled to Medicare Part A, Part B, or both? Yes No
If yes, name and date(s) of entitlement (shown on Medicare card): _____

If a qualified beneficiary becomes entitled to Medicare (or first learns that he or she is entitled to Medicare) after submitting this Election Form, immediately notify the Employer of the date of Medicare entitlement at the address shown above. Note that it is important to enroll in Medicare Parts A and B to avoid gaps in coverage. Continuation coverage is provided secondary to Medicare unless otherwise required by law.

Signature

Date

Print Name

Relationship to individual(s) listed above

Telephone number

Print Address

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**IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATION
COVERAGE RIGHTS**

What is COBRA 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 (or retired employee) covered under the group health plan, the covered employee's spouse, and the dependent children of the covered employee. The term "covered employee" can include non-employee Directors, if Director coverage is offered by the Employer, and retirees, if Retiree coverage is offered by the Employer.

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the benefit under the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in benefits under the Plan, the child must satisfy the otherwise applicable benefit eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order ("QMCSO") received by the Employer during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under that benefit under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under that benefit under the Plan as other participants or beneficiaries covered for that benefit under the Plan, including any open enrollment and special enrollment rights. COBRA (and the description of COBRA coverage contained in this Notice) applies only to the group health benefits offered under the Plan (medical, dental, and vision benefits) and not to any other benefits offered under the Plan or by the Employer (such as life insurance, accidental death and dismemberment, short term disability, or long term disability benefits, except to the extent that such benefits may provide benefits for medical care subject to COBRA, if any).

Except as specified in the Plan document, the Plan provides no greater COBRA rights than what COBRA requires - nothing in this Notice is intended to expand your rights beyond COBRA's requirements. (See the Appendix C of the Summary Plan Description for special rules where the Employer has less than 20 employees.)

How long will COBRA 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 only for up to a total of 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 a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee can last until up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months before the termination or reduction of hours. The Election Notice shows the maximum period of COBRA continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated for a benefit before the end of the maximum period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan for a benefit (medical, dental, or vision) covered under COBRA (but only after any preexisting condition exclusions

- of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage for medical benefits;
- The Employer ceases to provide any group health plan for its employees; or
- During a disability extension period (the disability extension is explained below), the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled.

Continuation coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

You must notify the Employer in writing within 30 days if, after electing COBRA for medical benefits, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or if, after electing medical, dental, or vision benefits, becomes covered under another group health plan coverage for medical, dental, or vision benefits (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You should use the Plan's form "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability" (copy attached) and you must follow the Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability that appear in the Summary Plan Description. You may obtain a copy of the Form or Summary Plan Description from the Employer.

COBRA continuation coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement (with respect to medical benefits) or as of the beginning date of the other group health coverage for a benefit (medical, dental, or vision) covered under COBRA (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Employer will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice of Medicare entitlement or other group health plan coverage.

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage in a situation with a maximum period of coverage of 18 months (that is, a loss of coverage due to end of employment or reduction in hours of employment), 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 the Plan Administrator 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 determined by the Social Security Administration ("SSA") to be disabled. The disability has to have started at some time before the 61st day of COBRA continuation coverage, and must last at least until the end of the 18 month period of COBRA continuation coverage.

The disability extension is available only if you notify the Employer in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage for the benefit under the terms of the Plan as a result of the covered employee's termination or reduction of hours.

You also must provide this notice before the end of the initial (18-month) period of COBRA continuation coverage in order to be entitled to a disability extension.

In providing this notice, you must use the Plan's form "Notice of Disability" (copy attached) and you must follow the Notice Procedures for Notice of Disability that appear in the Summary Plan Description. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period and before the end of the initial (18-

month) period of COBRA continuation coverage, **then there will be no disability extension of COBRA continuation coverage.**

If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the Employer of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability" (copy attached) and you must follow the Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability that appear in the Summary Plan Description.

Each qualified beneficiaries who has 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 the Plan of that fact within 30 days after 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 may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

This extension due to a second qualifying event is available only if you notify the Employer in writing of the second qualifying event within 60 days after the later of: (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage for the benefit(s) under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered for the benefit(s) under the Plan). In providing this notice, you must use the Plan's form "Notice of Second Qualifying Event" (copy attached) and you must follow the Notice Procedures for Notice of Second Qualifying Event that appear in the Summary Plan Description. If these procedures are not followed or if the notice is not provided in writing to the Employer during the 60-day notice period, **then there will be no extension of COBRA continuation coverage due to a second qualifying event.**

You may obtain copies of the Forms and Summary Plan Description referenced above from the Employer.

How can you elect COBRA continuation coverage?

To elect COBRA continuation coverage, you must complete the Election Form and furnish it according to the directions on the Election Form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent or legal guardian may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

You may elect COBRA under any or all of the group health benefits under the Plan (medical, dental, or vision) under which you were covered on the day before the qualifying event. For example, assume an employer offers medical, dental, and vision benefits, and a qualified beneficiary was covered under the medical and dental benefits on the day before a qualifying event, he or she may elect COBRA under the dental benefit only, the medical benefit only, or both medical and dental.

Additional information about the medical, dental, and vision benefits under the Plan is available in the Plan's Summary Plan Description. If you do not have a copy of the Summary Plan Description, you may obtain one from the Employer.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. Under COBRA, Medicare "entitlement" means that a person who is eligible for Medicare actually has become enrolled in Medicare. However, as discussed in more detail above, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits (with respect to medical benefits) or becomes covered under other

group health plan coverage for the benefit (medical, dental, or vision) covered by COBRA (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the paragraph above entitled "How long will COBRA coverage last?"

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage can affect your future rights under Federal law. First, you can lose the right to avoid having preexisting 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 can lose the Federal guaranteed conversion rights to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under Federal law. You may 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 also may have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you. As a general matter, the Federal rights in this paragraph may apply only to medical benefits. See Section IV.E of the Summary Plan Description for more information.

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.

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 Coverage 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 COBRA continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 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 COBRA continuation coverage rights under the Plan.

You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

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. The amount due for each coverage period for each qualified beneficiary is shown in this Notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. 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 not 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 the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage for the benefit under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. 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 coverage period, you will lose all rights to COBRA continuation coverage under the Plan.

Your first payment and all periodic payments for COBRA continuation coverage should be sent to:
Human Resources Department at the address under the paragraph "For More Information" below.

No other payment methods are allowed unless specified here and in Section II.A of the Summary Plan Description: _____

_____.

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.

If you have any questions concerning the information in this Notice, your rights to coverage, or if you want a copy of your Summary Plan Description, you should contact:

Human Resources Department

Address: _____

Telephone: _____

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. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

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

Attachments: NOTICE OF DISABILITY FORM;
NOTICE OF SECOND QUALIFYING EVENT FORM;
NOTICE OF OTHER COVERAGE, MEDICARE
ENTITLEMENT, OR CESSATION OF DISABILITY FORM;
AND APPENDIX C

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