

Government Subsidy Test Employer

123 Stimulus Road
Houston, TX 77079-

February 25, 2009

Ms. Random Brandon
303 West Houston
Houston, TX 77079-

Dear Ms. Random Brandon:

This notice contains important information about your right to continue your health care coverage in the Government Subsidy Test Employer Group Health Plan (the Plan).

The Health Insurance Assistance for the Unemployed Act of 2009 was enacted as part of the American Recovery and Reinvestment Act of 2009. This new law gives you and your additional qualified beneficiaries who were offered participation in the Group Health Continuation Plan the opportunity to reconsider enrolling in the continuation plan during an extended election period ending on 04/29/2009. You may also be eligible for premium assistance equal to 65% of your paid continuation premiums for up to nine months of your continuation period beginning as early as March 1, 2009.

In order to be certified as qualified for premium assistance, you must (a) have been involuntarily terminated from employment with the employer shown above between September 1, 2008 and December 31, 2009, (b) have become eligible for COBRA or other state-law based continuation coverage subsequent to that involuntary termination and (b) not have become eligible for other group health insurance coverage or Medicare since your original termination date.

Also, premium assistance is reduced for those who are eligible for assistance but whose Modified Adjusted Gross Income (MAGI) is above \$125,000 per year (\$250,000 for joint filers). Premium assistance is not available at all for those whose MAGI is \$145,000 per year (\$290,000 for joint filers).

If you decide to enroll, as evidenced by your completing and signing the enclosed Enrollment Form which confirms your belief that you are an "Assistance Eligible Individual" and that you would like to enroll at this time in the Group Health Continuation Plan, then once we receive your completed and signed Enrollment Form on or before the end of this special enrollment period we will validate your eligibility for premium assistance. Once that verification is complete, you will be notified of our validation and of the amount of premium needed to be paid by you in order to start your continuation coverage. Once that premium payment is received, your new period of continuation coverage will begin as of March 1, 2009 or the date your coverage as an active employee ceased, whichever is later.

No coverage is being offered to you between the date of your original loss of coverage as an active employee and the date your continuation coverage begins under this offer.

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

ADMIN Company
123 Street Address

Houston, TX 77095-

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 03/01/2009 due to:

ARRA Re-Notification on the qualifying event date of 09/15/2008

Each of the following qualified beneficiaries is being offered continuation under the Plan:
Ms. Random Brandon

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 12 months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on 03/01/2009 and can last until 03/16/2010.

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 04/29/2009. 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 dependent 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 ADMINPRINAME at (111)111-1111-1111 during regular business hours.

Sincerely,

Joe Doe
Director, HR

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

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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 ADMIN Company 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 ADMIN Company 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 ADMIN Company 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 ADMIN

Company 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 ADMIN Company to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

ADMIN Company
123 Street Address

Houston, TX 77095-

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:

ADMIN Company
123 Street Address

Houston, TX 77095-

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:

ADMIN Company
123 Street Address

Houston, TX 77095-

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.

HEALTH BENEFITS CONTINUATION PLAN ENROLLMENT FORM

Government Subsidy Test Employer

PQB NAME: Ms. Random Brandon
 ADDRESS: 303 West Houston
 Houston, TX 77079-
 TELEPHONE: () -
 EMPLOYEE: Random Brandon
 BRANCH:

QUALIFYING EVENT: ARRA Re-Notification
 FIRST DAY AFTER LOSS OF COVERAGE/FIRST DAY COBRA WILL BEGIN: 03/01/2009

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

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

Plan Description	Coverage Level	Premium
----- Medical Plan	PQB Only	\$370.00
----- Total Monthly Premium:		\$370.00

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 EQUAL TO 65% 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 Ms. Random Brandon

DATE: _____

NOTE: In order to be enrolled in the Health Benefits Continuation Plan this ENROLLMENT FORM must be received no later than 04/29/2009.

Please send completed form to:
ADMIN Company
123 Street Address
Houston, TX 77095-

PREMIUM COMPUTATION FORM

February 25, 2009

Government Subsidy Test Employer

123 Stimulus Road
Houston, TX 77079-

Principal Qualified Beneficiary:
Ms. Random Brandon

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.

Your Qualifying Event Date: 09/15/2008
Your Last Enrollment Date: 04/29/2009

Plan Description	Coverage Level	Premium
----- Medical Plan -----	PQB Only	\$370.00
Total Monthly Premium:		\$370.00

Schedule Of First Payment	Premium
Amount Due if Enrollment Form Signed And Received In Our Office by: 03/31/2009	\$370.00
Amount Due if Enrollment Form Signed And Received In Our Office by: 04/30/2009	\$740.00
Amount Due if Premium Paid By.....: 05/31/2009	\$1,110.00
Amount Due if Premium Paid By.....: 06/30/2009	\$1,480.00

Premiums must be paid by check or money order. PLEASE DO NOT SEND CASH.

WAIVER LETTER

February 25, 2009

123 Stimulus Road
Houston, TX 77079-

Government Subsidy Test Employer

RE: Waiver of Right to Continue Benefits under COBRA Continuation

Dear Plan Administrator:

I have received the notification of the right to continue certain covered benefits for myself and my covered dependents, if any, and the cost computation form.

At this time, the undersigned Principal Qualified Beneficiary (PQB) waives the right to purchase the continuation coverage. Family coverage, if provided, is also waived by signature of my spouse, if any, in the space provided below.

In waiving this coverage, I (we), hereby acknowledge that at the end of the election period 04/29/2009, my (our), decision will be final and irrevocable. I (we) also understand that any break in continued coverage of more than sixty-three days may cause loss of "portability" of coverage.

Sincerely,

Signature of: Ms. Random Brandon

Spouse Signature

Government Subsidy Test Employer

123 Stimulus Road
Houston, TX 77079-

February 25, 2009

Ms. Random Brandon
303 West Houston
Houston, TX 77079-

Dear Ms. Brandon:

Under a 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 ADMINPRINAME at (111)111-1111-1111 during regular business hours.

Sincerely,

Joe Doe
Director, HR

123 Stimulus Road
Houston, TX 77079-

February 25, 2009

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.

Date of Termination:

Participant Name: Ms. Random Brandon
Participant Identifier: 123-45-6789

Benefit Plan Name:	Medical Plan
Level of Coverage:	PQB Only
Date of First Coverage:	N/A
18 Months of Continuous Coverage:	Yes
Waiting Period Prior to First Coverage:	0 Days
Date Waiting Period Began:	N/A
Last Day Covered as Active Employee/Dependent:	09/15/2008
Date COBRA Continuation Period Started:	Not Yet Enrolled
Date COBRA Coverage Ended:	N/A
COBRA Coverage Ended Because:	N/A

Questions about the coverage listed above should be directed to ADMINPRINAME at (111)111-1111-1111.

Sincerely,

Joe Doe
Director, HR

Statement of HIPAA Portability Rights

IMPORTANT – KEEP THIS CERTIFICATE. This certificate is evidence of your coverage under this plan. Under a federal law known as HIPAA, you may need evidence of your coverage to reduce a preexisting condition exclusion period under another plan, to help you get special enrollment in another plan, or to get certain types of individual health coverage even if you have health problems.

Preexisting condition exclusions. Some group health plans restrict coverage for medical conditions present before an individual's enrollment. These restrictions are known as “preexisting condition exclusions.” A preexisting condition exclusion can apply only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before your “enrollment date.” Your enrollment date is your first day of coverage under the plan, or, if there is a waiting period, the first day of your waiting period (typically, your first day of work). In addition, a preexisting condition exclusion cannot last for more than 12 months after your enrollment date (18 months if you are a late enrollee). Finally, a preexisting condition exclusion cannot apply to pregnancy and cannot apply to a child who is enrolled in health coverage within 30 days after birth, adoption, or placement for adoption.

If a plan imposes a preexisting condition exclusion, the length of the exclusion must be reduced by the amount of your prior creditable coverage. Most health coverage is creditable coverage, including group health plan coverage, COBRA continuation coverage, coverage under an individual health policy, Medicare, Medicaid, State Children's Health Insurance Program (SCHIP), and coverage through high-risk pools and the Peace Corps. Not all forms of creditable coverage are required to provide certificates like this one. If you do not receive a certificate for past coverage, talk to your new plan administrator.

You can add up any creditable coverage you have, including the coverage shown on this certificate. However, if at any time you went for 63 days or more without any coverage (called a break in coverage) a plan may not have to count the coverage you had before the break.

- Therefore, once your coverage ends, you should try to obtain alternative coverage as soon as possible to avoid a 63-day break. You may use this certificate as evidence of your creditable coverage to reduce the length of any preexisting condition exclusion if you enroll in another plan.

Right to get special enrollment in another plan. Under HIPAA, if you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days. (Additional special enrollment rights are triggered by marriage, birth, adoption, and placement for adoption.)

- Therefore, once your coverage ends, if you are eligible for coverage in another plan (such as a spouse's plan), you should request special enrollment as soon as possible.

Prohibition against discrimination based on a health factor. Under HIPAA, a group health plan may not keep you (or your dependents) out of the plan based on anything related to your health. Also, a group health plan may not charge you (or your dependents) more for coverage, based on health, than the amount charged a similarly situated individual.

Right to individual health coverage. Under HIPAA, if you are an “eligible individual,” you have a right to buy certain individual health policies (or in some states, to buy coverage through a high-risk pool) without a preexisting condition exclusion. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more;
- Your most recent coverage was under a group health plan (which can be shown by this certificate);
 - Your group coverage was not terminated because of fraud or nonpayment of premiums;
 - You are not eligible for COBRA continuation coverage or you have exhausted your COBRA benefits (or continuation coverage under a similar state provision); and
 - You are not eligible for another group health plan, Medicare, or Medicaid, and do not have any other health insurance coverage.

The right to buy individual coverage is the same whether you are laid off, fired, or quit your job.

- Therefore, if you are interested in obtaining individual coverage and you meet the other criteria to be an eligible individual, you should apply for this coverage as soon as possible to avoid losing your eligible individual status due to a 63-day break.

State flexibility. This certificate describes minimum HIPAA protections under federal law. States may require insurers and HMOs to provide additional protections to individuals in that state.

For more information. If you have questions about your HIPAA rights, you may contact your state insurance department or the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) toll-free at 1-866-444-3272 (for free HIPAA publications ask for publications concerning changes in health care laws). You may also contact the CMS publication hotline at 1-800-633-4227 (ask for “Protecting Your Health Insurance Coverage”). These publications and other useful information are also available on the Internet at: <http://www.dol.gov/ebsa>, the DOL's interactive web pages - Health Elaws, or <http://www.cms.hhs.gov/hipaa1>.

Letter Output Summary

For: Government Subsidy Test Employer Date: 02/25/2009

Letter Description	Quantity	Letter Description	Quantity
COBRA Election Notice 1	001	Coverage Certification	001
COBRA Election Notice 2	000	State Continuation Notice	000
COBRA Election Notice 3	000	Employer Invoice	000
COBRA Election Notice 4	000	Open Enrollment Letter	000
Enrollment Conf. No Notice	000	Dependent Notification Letter	000
Enrollment Conf. Notice	000	Coverage Confirmation	000
Incomplete Enrollment	000	Free Form Letter 1	000
Deficient Payment	000	Free Form Letter 2	000
Non - Commencement	000	Free Form Letter 3	000
Late Payment Notice	000	Free Form Letter 4	000
Term Notice - Conversion	000	Premium Computation Form	001
Enrollment Confirmation	000	Termination Notice To Carrier	000
Automatic Termination Notice	000	COBRA General Notice(Spouse)	000
Change Of Address	000	Coverage Confirmation (Spouse)	000
Premium Rate Change	000	Email Agreement	000
Eligibility Confirmation	000	COBRA Election Notice 5	000
Premium Notice	000	End of COBRA - State 20+	000
COUPONS	000	Denial Of Coverage	000
SS Disability Elig. Notice	000	Coverage Takeover	000
Medicare Entitlement Notice	000	USERRA Election Notice	000
Enrollment Form Received	000	Medicare Part D General Notice	000
Reinstatement - Enrolled	000	Medicare Part D Creditable	000
Reinstatement - Pending	000	Medicare Part D Non-Creditable	000
Returned Check Notice	000	ADP Cover Letter	000
Enrollment Notice To Carrier	000	ADP Credit Letter	000
Termination Confirmation	000	Enrollment Form	000
Start Of Leave Notification	000	Enroll to Carrier - Attachment	000
End Of Leave Confirmation	000	Term to Carrier - Attachment	000
Leave Termination Notice	000	Coupon Cover Letter	000
Disability Rate Notice	000	Not Available	000
California Residents Notice	000	State Conversion Notice	000
COBRA General Notice	000	State Continuation Enrollment	000
Termination Letter For CA.	000	FSA Free Form Letter	000
1/1/97 Cobra Change Letter	000		

Total Letters Produced: 3

Company Name: Government Subsidy Test Employer
Company Code: JSW
Letter Date: 02/25/2009

COBRA Election Notice 1
Brandon, Random

Total: 1

Coverage Certification
Brandon, Random

Total: 1

Premium Computation Form
Brandon, Random

Total: 1

Grand Total: 3