

**HEALTH BENEFITS CONTINUATION PLAN ENROLLMENT FORM**  
ARRA TEST

02/27/2009

Mr. Merv George  
1920 Dofc27  
Houston, TX 77079

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 may give you and your additional qualified beneficiaries 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
- (c) 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 we will validate your eligibility for premium assistance.

Once that verification is complete, you receive a confirmation of your eligibility.

Telephone:

Department:

Qualifying Event: Termination

First Day After Loss of Coverage / First Day Continuation Coverage will Begin: 12/01/2008

List Eligible Persons to be Covered Below: (Persons Previously Covered Only)

Name: Last	First	M	DOB	Sex	SSN #
_____	_____	_____	___/___/___	M / F	- - -
_____	_____	_____	___/___/___	M / F	- - -
_____	_____	_____	___/___/___	M / F	- - -
_____	_____	_____	___/___/___	M / F	- - -
_____	_____	_____	___/___/___	M / F	- - -

Medical Standard    QB and Child    \$218.87  
HMO

Total: \$218.87

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.

DATE: \_\_\_\_\_

\_\_\_\_\_  
Signature of Merv George

NOTE: In order to be enrolled in the Health Benefits Continuation Plan this ENROLLMENT FORM must be received no later than 01/27/2009.  
Please send completed form to:

Development Testing Account  
111 Customer Way  
Paris, TX 75460