



COBRA NOTICE and ELECTION / WAIVER FORM

IF YOU DO NOT RETURN THIS ELECTION FORM WITHIN 60 DAYS YOU WILL LOSE YOUR RIGHT TO ELECT CONTINUATION COVERAGE.

DATE:, 2006

«first» «last»

«Address»

«City» «State» «Zip»

IT IS IMPORTANT THAT ALL COVERED INDIVIDUALS (EMPLOYEE, SPOUSE, AND DEPENDENT CHILDREN) READ THIS NOTICE CAREFULLY. SHOULD YOU HAVE ANY QUESTIONS CONCERNING THE INFORMATION CONTAINED IN THIS LETTER, PLEASE CALL CHRISTY SCOTT AT 720-506-4083.

Your health insurance coverage terminated on November 30, 2006 as a result of your termination of employment. You may elect to continue coverage under this plan retroactively to the date of December 1, 2006 at group rates at your own cost. This form must be returned to Employer Services Group, LLC by February 15, 2007 or you will lose your option to continue insurance coverage.

If you elect this option, coverage for any person to whom continuation applies will terminate on the earlier of the following dates:

1. The expiration of 18 months following the date of December 1, 2006,
2. the employer ceases to provide group health plan for its employees,
3. you cease to pay in a timely manner any required premium for the continued coverage,
4. you and/or your dependents, after electing COBRA, become covered by another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
5. you and/or your dependents become entitled to Medicare benefits after the date of your COBRA election.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage for a participant or beneficiary not receiving continuation coverage (such as fraud). You are required to notify Christy Scott of the events described in items four and five.

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 form the Plan Administrator.

If you do not understand any part of this notice or have questions regarding the information or your obligations, please contact Christy Scott at 720/506-4083.

What is continuation coverage?

Federal law requires that most group health plans 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, and 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, including, if applicable, open enrollment and special enrollment rights.

Each qualified beneficiary has an independent right to elect continuation coverage. Eligible employees and family members may continue the identical health insurance benefits they had at the time of the qualifying event or may choose to continue medical/dental/vision coverage only.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction of hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to and 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.

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Christy Scott 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 qualified beneficiary is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18th month period of continuation coverage. The qualified beneficiary is responsible for giving notice to Christy Scott within 60 days of this disability determination. Each qualified beneficiary 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 include the death of a covered employee, divorce or separation from the covered employee’s enrolling in Medicare, or a dependent child’s ceasing 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. You must notify Christy Scott within 60 days after a second qualifying event occurs.

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 continuation coverage if you get continuation coverage for the maximum time available to you.

Continuation coverage does not apply to life insurance, accidental death and dismemberment, or disability coverage.

Cost of Coverage?

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% of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). If you choose to continue coverage, current rates of coverage are indicated on the COBRA Election Notice. These rates are subject to change.

When and How must payments be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the election form. **However, your first payment must be received within 45 days of the date you return the election form** (This is the date the Election Notice is post-marked, if mailed). Receipt of your election form notifies ESG of your intent to continue coverage, the insurance carrier will not be contacted until your first payment is received by ESG. If you do not make your first payment within **45 days**, you will lose all continuation coverage rights under the Plan.

Your first payment must include the entire cost of continuation coverage from the time your coverage under the Plan 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 Christy Scott to confirm the correct amount of your first premium.

Thereafter, we must receive your payment by the 20th of the month prior to the month you wish to have continued coverage. Payments should be made payable to Employer Services Group and our address is 7000 E. Belleview Ave. Suite 290, Greenwood Village, CO 80111. It is the qualified beneficiary's responsibility to make these monthly payments. You will not receive a monthly billing. There is a grace period of 30 days for the regularly scheduled monthly premiums. If your payment is not received on a timely basis, your insurance will be canceled.



COBRA Election / Waiver Form

Name: «first» «last» SSN#: «SSN» Date: December 1, 2006
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Please complete the following in ink.

Name of Former Employer: «Company»

This form must be returned to **Christy Scott** at **Employer Services Group, 7000 E Belleview Ave. Suite 290, Greenwood Village, CO 80111** by **February 15, 2007** or you will lose your right to elect COBRA continuation coverage. You do not have to send any payment with the election form. However, **payment must be received in order to reinstate coverage. If payment is not received within 45 days of the date you return the election form, you will not be eligible to continue coverage. Thereafter, we must receive your payment by the 20th of the month prior to the month you wish to have continued coverage.**

Waiver	On behalf of myself, I hereby waive the right to receive continuation coverage. <i>[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, your COBRA continuation coverage will begin on the date you furnish the completed election form.]</i>
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Each person ("qualified beneficiary") is entitled to elect COBRA continuation coverage.
 I elect to continue the following coverage(s):

Election <small>(Please Check)</small>	Type	Plan Name	Coverage Level			
			___ Single	___ Staff + Spouse	___ Staff + Child	___ Family
___	Medical	«Medical_Plan»	___ Single	___ Staff + Spouse	___ Staff + Child	___ Family
___	Dental	«Dental_Plan»	___ Single	___ Staff + Spouse	___ Staff + Child	___ Family
___	Vision	«Vision_Plan»	___ Single	___ Staff + Spouse	___ Staff + Child	___ Family

COBRA Monthly Premium Rates	Medical	Dental	Vision
Single	\$«Med_EE»	\$«Dent_EE»	\$«Vis_EE»
Staff + Spouse (Staff + 1)	\$«Med_ES»	\$«Dent_ES»	\$«Vis_ES»
Staff + Child(ren)	\$«Med_EC»	\$«Dent_EC»	\$«Vis_EC»
Family	\$«Med_Fam»	\$«Dent_Fam»	\$«Vis_Fam»

Qualified Dependent/Beneficiary names:

Spouse _____

Dependent _____

Dependent _____

Dependent _____

Dependent _____

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.

Current Address for all covered beneficiaries:

If any address for a covered dependent(s) is different than the address above, please provide it.

Important: Employer Services Group @ 7000 E. Belleview Ave. Suite 290, Greenwood Village, CO 80111 must receive:

1. A completed signed copy of this notice within 60 days from the date of this notice.
2. Your first payment within 45 days following the date you return this form.

Employee _____
Name SSN# Date

Spouse _____
Name Date

Dependent _____
(Over Age 18) Name Date

You should keep a copy, for your records, of any notices you send to the Plan Administrator.