SAMPLE REPORTS AND LETTERS

- HR Simplified has over 60 standard reports and letters.
- All Letters are customized to meet the needs of each client.
- All Standard reports are available at no additional charge.
- All non-standard reports are produced at a cost of $120 per hour.
- Below are just a sample of some of our most produced letters and forms.

Sample COBRA Forms, Letters and Reports:

Page

Sample COBRA Forms Letters and Reports

Data Gathering Form – Used to gather data about the client and their plans during the implementation stage.

COBRA DATA GATHERING FORM		
Employer Name		
Employer Address		
City	State	Zip

Primary Employer Contact Information	
Primary Contact Name	Phone Number
Fax Number	E-mail Address

Billing Contact Information	
Contact Name for Billing	Phone Number
Fax Number	E-mail Address

PROCESSING INFORMATION
*Division processing? Yes ____ No____ If yes, please provide list of divisions.
ERISA Plan Number: 501____ 502____ 503____ 504____ 505____ Other____
Legal Plan Name:
of Minnesota Employees____ (If # of MN is 25 or greater we will need life rates.)
Is there an EAP benefit? Yes____ No____
If EAP, can it be elected separately? Yes____ No____
Do you comply with Cal COBRA? Yes_____ No_____
Do you offer COBRA severance benefits? Yes_____ No_____ If yes: Are there reduced rates or a free period? Yes_____ No _____ If yes: What is the length(s) of time offered? _____# of months. **Please submit severance rates with the rate information.**
Comments:

_____ (Signature)

_____ (Title) _____ (Date)

Client Name:

COBRA PLAN INFORMATION FORM		
Name of Insurance Company or HMO:	**Type of Coverage: (medical, dental, etc.):**	
Renewal Date:	**Plan Number:**	
Carrier/Plan Address		
Address	**City**	
State	**Zip**	
Eligibility Contact Name		
Ph. #	**Fax #**	**E-mail**
Processing Information		
Conversion Option: Yes_____ No_____		
Maximum Age: Non-Student_____ Student_____		
Loss of Coverage Upon Qualifying Event: End of Month_____ Date of Event_____		
Rates		
1. _____	Single	
2. _____	Single+1	
3. _____	Single+Child	
4. _____	Single+Children	
5. _____	Single+Family	
6. _____	If Other – Please Describe	

Do above rates contain 2% COBRA fee? _____Yes _____No

Sample Introduction Letter – Used to communicate to active and pending COBRA beneficiaries. Typically placed on the clients letterhead. HR Simplified can send this letter out if supplied with clients letterhead.

DATE

NAME
ADDRESS
CITY, STATE, ZIP

Dear:

We are pleased to inform you that effective August 1, 2005 we have selected **HR Simplified** to be the new COBRA administrator.

Effective for the period beginning August 1, 2005, correspondence and payments should be directed to **HR Simplified**. The change to **HR Simplified** does not change your continuation coverage or its terms and conditions.

Please wait until you receive coupons from **HR Simplified** before you make payments for the period beginning August 1, 2005.

You may contact HR Simplified at:

HR Simplified
8441 Wayzata Blvd., Suite 300
Minneapolis, MN 55426

Phone (888) 318-7472 toll free
(763) 746-7400 local

Their business hours are 7 a.m. - 7 p.m. Monday through Thursday and 7 a.m. - 5 p.m. Friday.

We appreciate your understanding during this transition period and are sure you will find that HR Simplified will serve you well.

Sincerely,

NAME
TITLE

Sample Initial Notice – Notice to newly covered employees stating their rights under COBRA.

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
(For use by single-employer group health plans)

**** CONTINUATION COVERAGE RIGHTS UNDER COBRA****

Introduction

You are receiving this notice because you have recently become covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage [*choose and enter appropriate information:* must pay *or* are not required to pay] for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

[*If the Plan provides retiree health coverage, add the following paragraph:*]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to [*enter name of employer sponsoring the plan*], and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, [*add if Plan provides retiree health coverage:* commencement of a proceeding in bankruptcy with respect to the employer,] or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days [*or enter longer period permitted under the terms of the Plan*] after the qualifying event occurs. You must provide this notice to: [*Enter name of appropriate party*]. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation.*]

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered

employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts 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 lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. [*Add description of any additional Plan procedures for this notice, including a description of any required information or documentation, the name of the appropriate party to whom notice must be sent, and the time period for giving notice.*]

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. 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 nearest Regional or District Office of 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 family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

[*Enter name of group health plan and name (or position), address and phone number of party or parties from whom information about the plan and COBRA continuation coverage can be obtained on request.*]

Sample COBRA Notice For California – COBRA notice sent to newly qualified beneficiaries.

MR JOHN DOE & FAMILY
333 MAIN STREET
SAN JOSE CA 99999

Notification Date: 12/23/2004

COBRA CONTINUATION COVERAGE ELECTION NOTICE

This notice contains important information about your right to continue your health care coverage in the Plan(s) shown below:

501 Health Benefits for the Employees of Prospect Inc.

Please read the information contained in these notices very carefully. The notice provides important information concerning your rights and what you have to do to continue your health care coverage under the Plan. If you have any questions concerning the information in this notice or your rights to coverage, you should contact:

HR Simplified
8441 Wayzata Blvd.
Suite 300
Minneapolis MN 55426
(888) 318-7472

If you do not elect to continue your health care coverage by completing the "Election Form" and returning it to us, your coverage under the Plan will end on 12/31/2004 due to your Termination of Employment.

Each of the following persons is entitled to elect to continue health care coverage under the Plan:

Sally Doe	Spouse
Joe Doe	Son
Suzy Doe	Daughter

Because of the above event that will end your coverage under the Plan, you, your spouse and/or, any of your dependents who were covered on the day before the event are entitled to continue your health coverage for up to 18 months. If you elect to continue your coverage under the Plan, your continuation coverage will begin on 01/01/2005 and can last until 06/30/2006.

Your continuation coverage will cost:

CIGNA HMO	Sgl+Fam Cigna PPO	$1071.00	1 Month
Delta Dental	Sgl+Fam Delta Dental	$122.40	1 Month

IMPORTANT - To elect continuation coverage you MUST complete the "Election Form" and return it to us. You may mail it to the address shown on the Election Form. The completed Election Form must be post-marked by 03/01/2005. If you do not submit a completed Election Form by this date, you will lose your right to elect continuation coverage. Important information about your rights is provided to you on the pages after the Election Form.

COBRA CONTINUATION COVERAGE ELECTION FORM

IMPORTANT: This form must be completed and returned by mail. If mailed, it must be post-marked no later than 03/01/2005. Sent the completed form to the person below:

HR Simplified
8441 Wayzata Blvd.
Suite 300
Minneapolis MN 55426
(888) 318-7472

ELECTING COVERAGE

Each eligible family member may elect coverage independently by completing a separate copy of this ELECTION AGREEMENT. The primary qualified beneficiary may elect to continue coverage on behalf of all eligible dependents who were covered the day before the qualifying event, but only a dependent or legal guardian may elect or decline coverage which the primary qualified beneficiary has declined. If any family member declines any coverage, please complete the section titled DECLINING COVERAGE. If mailed your completed ELECTION AGREEMENT must be post-marked by 03/01/2005 or you will lose your right to COBRA continuation coverage.

Please note: Although you are not legally required to pay for continuation at the time of your election, coverage will not be reinstated until payment is received.

I (we) elect the coverage(s) that I have checked below for myself and my eligible dependents, if any:

☐	CIGNA HMO	Sgl+Fam Cigna PPO	$1071.00	1 Month
☐	Delta Dental	Sgl+Fam Delta Dental	$122.40	1 Month

You must provide the information below for any dependent not shown who will be covered. Complete any missing information for any dependents listed below.

Doe, Sally	Spouse	06/06/1966	555-44-6666
Doe, Joe	Son	06/06/1990	444-55-6666
Doe, Suzy	Daughter	06/06/1995	333-66-2222

I have read the NOTICE OF RIGHT TO ELECT COBRA CONTINUATION COVERAGE and understand my election rights. I agree to notify the Plan Administrator if I or any covered dependents become covered by another group health plan or entitled to Medicare or have a change of address.

Signature _____ Date _____

Print Name _____ Relationship To Above Individual

(____)_____--_____
Phone Number

IMPORTANT INFORMATION ABOUT YOUR COBRA CONTINUATUION COVERAGE RIGHTS

What is continuation coverage?

Federal Law requires that most group 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 dependant 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: open enrollment and special enrollment rights. 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 by contacting:

Prospect Inc.
123 Main Street
Chicago IL 50222

John Doe
HR Director
(847) 222-3333

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 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 enrollment in Medicare or a dependant child ceasing to be a dependant 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 it's 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 us 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 us of the 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 us of the 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 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, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify us within 60 days after any second qualifying event which may occur.

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

How much does 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 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 (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

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 within those 45 days, 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. The monthly premium required is shown of the first page of this letter. The actual amount of premium required for your first payment depends upon when you elect coverage and the coverage elected. The actual amount required will be forwarded to you as soon as your elections are received and processed.

Your first payment for continuation coverage should be sent to:

HR Simplified
8441 Wayzata Blvd.
Suite 300
Minneapolis MN 55426
(888) 318-7472

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month for which coverage is provided. If you make a periodic payment on or before its due date, 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. Periodic payments for continuation coverage should be sent to:

HR Simplified
8441 Wayzata Blvd.
Suite 300
Minneapolis MN 55426
(888) 318-7472

Grace periods for periodic payments

Although periodic payments are due on the due dates shown above, you will be given a grace period of 30 days 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 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.

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:

Prospect Inc.
123 Main Street
Chicago IL 50222

John Doe
HR Director
(847) 222-3333

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 addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.
HR Simplified
8441 Wayzata Blvd.
Suite 300
Minneapolis MN 55426
(888) 318-7472

NOTICE TO TERMINATING EMPLOYEES

The **California Department of Health Services** will pay the private health insurance premiums for certain persons losing employment under the following circumstances:

For Persons Eligible for Medi-Cal

Medi-Cal beneficiaries who have high-cost medical conditions may qualify for the Health Insurance Premium Payment Program (HIPP) provided they:

1. Have a Medi-Cal share-of-cost of $200.00 or less.
2. Have a high cost medical condition for which the average monthly cost is twice the amount of the monthly health insurance premium.
3. Have current health insurance coverage, or a COBRA continuation or a conversion policy in effect or available.
4. Have filed an application in a timely manner, allowing sufficient time to process the application and start payment of premium.

You do not qualify if:

1. Your insurance policy is issued through the Major Risk Medical Insurance Program (MRMIP).
2. You qualify for Medicare.
3. You are enrolled in a Medi-Cal related pre-paid health plan, San Mateo County Health Plan, Santa Barbara County Health Initiative, or a County Medical Service Program.

To enroll in HIPP or to inquire about requirements call this toll free number 1-800-952-5294 between 8:00 a.m. and 5:00 p.m. Monday - Friday.

For Persons Disabled by HIV/AIDS

Under the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, persons unable to work because of disability due to HIV/AIDS and who are losing their private health insurance may qualify for the Health Insurance Continuation Program (CARE/HIPP) provided they:

1. Are currently covered by a health insurance plan, which includes coverage for outpatient drug prescriptions, and then can be converted to a COBRA/OBRA plan.
2. Have a total monthly income below 250 percent of poverty; approximately $1,500 monthly for a single person.

FOR ADDITIONAL INFORMATION ON CARE/HIPP, please call:

Northern California AIDS Hotline	1 800 367 2437 (English or Spanish)
Southern California AIDS Hotline	1 800 922 2437 (English)
	1 800 922 2438 (Multi-Language)

Payment Coupons – Sent to qualified beneficiaries who elect to continue coverage.

MR DAVID BARRY & FAMILY
123 SAM CLUB STREET
ANYWHERE MN 55111

Employer: Prospect Inc. Qualification Date: 08/15/2003
Division: Gary Transit
Status: Termination of Employment Eligible: 18 Months

SSN. 111-33-4444	Barry, David	**Due: 04/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	04/01/04 - 04/30/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	04/01/04 - 04/30/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

SSN. 111-33-4444	Barry, David	**Due: 05/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	05/01/04 - 05/31/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	05/01/04 - 05/31/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

SSN. 111-33-4444	Barry, David	**Due: 06/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	06/01/04 - 06/30/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	06/01/04 - 06/30/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

** PLEASE RETURN CORRECT COUPON WITH YOUR PAYMENT **

SSN. 111-33-4444	Barry, David	**Due: 07/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	07/01/04 - 07/31/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	07/01/04 - 07/31/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

SSN. 111-33-4444	Barry, David	**Due: 08/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	08/01/04 - 08/31/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	08/01/04 - 08/31/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

SSN. 111-33-4444	Barry, David	**Due: 09/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	09/01/04 - 09/30/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	09/01/04 - 09/30/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

SSN. 111-33-4444	Barry, David	**Due: 10/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	10/01/04 - 10/31/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	10/01/04 - 10/31/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

 ...Continued on Page 3

** PLEASE RETURN CORRECT COUPON WITH YOUR PAYMENT **

SSN. 111-33-4444	Barry, David	**Due: 11/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	11/01/04 - 11/30/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	11/01/04 - 11/30/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

SSN. 111-33-4444	Barry, David	**Due: 12/01/2004**	
Aetna	Sgl+Fam Aetna HMO	$1122.00	12/01/04 - 12/31/04
Delta Dental	Sgl+Fam Delta Dental	$122.40	12/01/04 - 12/31/04

		$1244.40	

Mail payment to: **HR Simplified**
435 Ford Road Suite 320
Minneapolis MN 55426

Employer: Prospect Inc.

HR Simplified
435 Ford Road
Suite 320
Minneapolis MN 55426
(888) 318-7472

Sample Partial Payment Letter - Sent to qualified beneficiaries who make a partial payment.

MR & MRS JOHNATHAN HARRISON
16 TECHNOLOGY DRIVE SUITE 161
IRVINE CA 92618

NOTICE OF

PARTIAL PREMIUM PAYMENT

Employer: American Enterprise Corp.
Division: Corporate Offices
Status: Termination of Employment

Qualification Date: 00/00/0000
Eligible: 18 Months

The premium that you forwarded was not adequate to cover the amount billed. Please remit the balance immediately to avoid coverage termination.

	Coverage Date	Amount	Check#	Paid Date	Due Date
IIIIII:CC	00/00/0000	00000.00			00/00/0000
		00000.00	aaaaaa	00/00/0000	Payment

		000000.00			

For further information, please contact:

HR Simplified
435 Ford Road
Suite 320
Minneapolis MN 55426
(888) 318-7472

Sample Rate Change Letter – Sent to a qualified beneficiaries notifying them of an up coming rate change

MS Jane Doe
103 DENURE CT
FOLSOM CA 95630

The intent of this letter is to update you on the status of your COBRA continuation with Prospect, Inc..

We have been notified that there are pending rate and plan changes beginning November 1, 2004. Information is being sent to you from Prospect, Inc. regarding the changes and offering you open enrollment. As soon as the new rates and plans are available, we will be mailing you coupons with the amount due. We expect to be able to provide you with coupons and payment information prior to the rate and/or plan changes and you should be receiving that information before the last week of October.

If you have any questions, please feel free to contact us at (888) 318-7472.

Sincerely,

COBRA Administration
HR Simplified
435 Ford Road
Suite 320
Minneapolis MN 55426
(888) 318-7472

Sample Termination Letter – Letter sent to a qualified beneficiary who failed to make their payment.

MR & MRS JOHNATHAN HARRISON
16 TECHNOLOGY DRIVE SUITE 161
IRVINE CA 92618

CONTINUATION COVERAGE TERMINATION

Continuation Coverage under COBRA has terminated on the termination date shown below.

Employer: American Enterprise Corp.
Division: Corporate Offices
Status: Termination of Employment

Qualification Date: 00/00/0000
Eligible: 18 Months

FOR: 123-45-7890
Harrison, Johnathan

Termination Date: 00/00/0000

Reason for Termination: **Non-Payment.**

FAMILY MEMBERS WHO WILL BE TERMINATED:		Soc.Sec.No.	Birth
Peter Harrision	Son	000-00-0000	00/00/00
Kayte Harrison	Daughter	000-00-0000	00/00/00

Please review the termination date and, if applicable, the list of persons for whom coverage has terminated, to be certain it is correct.

If the information is not correct, please contact the person listed below.

HR Simplified
435 Ford Road
Suite 320
Minneapolis MN 55426
(888) 318-7472

Sample Newly Added Report – This report show newly notified COBRA beneficiaries.

Census Report

Soc.Sec.No. / Emp#	Name (Last, First) / Addres	D/T	Qual.Code	N/E	Sex	DOB	M/S	Age

PROSPECT — Prospect Inc.

888-99-7777	Anderson, George 88 Hopkins Street Wilmar MN 55555	DV	C	N	M	06/06/1966	M	38.7
						Person Added: 12/03/2004		
	Coverages AETNA : 3M 12/01/2004 - 11/30/2007							
222-11-3333	Doe, John 333 Main Street San Jose CA 99999	TE	C	N	M	06/16/1966	M	38.6
						Person Added: 12/23/2004		
	Coverages CIGNA : 4M 01/01/2005 - 06/30/2006 DELTA : 4D 01/01/2005 - 06/30/2006							
444-66-5555	Smith, Larry 1111 Smith Ave. Mankato MN 55000	TE	C	N	M	06/06/1966	S	38.7
						Person Added: 12/03/2004		
	Coverages AETNA : 1M 12/01/2004 - 05/31/2006 DELTA : 1D 12/01/2004 - 05/31/2006							

Division Totals:

3	Males	1	Single
	Females	2	Married
3	TOTAL		Other

GARY — Division: Gary Transit

887-77-8888	Jim, Johnson 555 Main Street St. Clair MN 56000	TE	C	N	M	06/06/1966	M	38.7
						Person Added: 12/03/2004		
	Coverages AETNA : 2M 12/01/2004 - 05/31/2006 VSP : 1V 12/01/2004 - 05/31/2006							

Division Totals:

1	Males		Single
	Females	1	Married
1	TOTAL		Other

EMPLOYER Totals:

4	Males	1	Single
	Females	3	Married
4	TOTAL		Other

D / T D = Dropped, T = Terminated
N / E N = Notifed, E = Enrolled
M / S S = Single, M = Married, D = Divorced, W = Widowed

Census Report

Soc.Sec.No. / Emp#	Name (Last, First) / Addre:	D/T	Qual.Code	N/E	Sex	DOB	M/S	Age

REPORT TOTALS:

4	Males	1	Single
	Females	3	Married
4	TOTAL		Other

*** End of Report Q001 ***

D / T D = Dropped, T = Terminated
N / E N = Notifed, E = Enrolled
M / S S = Single, M = Married, D = Divorced, W = Widowed

Eligibility Report – This report shows active qualified beneficiaries and their coverage.

***** Carrier: AETNA

Jones, Joyce 455-66-4001 09/01/2002 36 Months Divorce or Legal Separation
617 Elm Street Evanston IL 50222
** Sgl Aetna HMO Eff:10/01/2002 - 09/30/2005 Paid thru:12/31/2004

Nax, Don 777-88-1111 09/09/2004 36 Months Divorce or Legal Separation
333 Nowhere Street Des Moines IA 55555
Sgl Aetna HMO Eff:10/01/2004 - 09/30/2007 Paid thru: *None*

Nix, Don 555-66-2111 09/09/2004 36 Months Loss of Dependent Status
1414 West Dr. Des Moines IA 56666
** Sgl Aetna HMO Eff:10/01/2004 - 09/30/2007 Paid thru:12/31/2004

Nux, Don 888-22-9999 09/09/2004 36 Months Divorce or Legal Separation
999 West Ave. Des Moines IA 55555
Sgl Aetna HMO Eff:10/01/2004 - 09/30/2007 Paid thru: *None*

Patterson, Sam 111-22-3334 07/20/2003 18 Months Termination of Employment
6565 Smith Ave. Des Moines IA 56666
** Sgl Aetna HMO Eff:08/01/2003 - 01/31/2005 Paid thru:12/31/2004

Barry, David 111-33-4444 08/15/2003 18 Months Termination of Employment
123 Sam Club Street Anywhere MN 55111
Dependent: Dana Barry (SPO) Age: 38.7
Dependent: Kyle Barry (SON) Age: 19.7
** Sgl+Fam Aetna HMO Eff:09/01/2003 - 02/28/2005 Paid thru:11/30/2004

Johnson, Debbie 555-66-7777 07/08/2004 18 Months Reduction in Hours
7888 Washington Ave No San Diego CA 95002
Dependent: Jimmie Johnson (SPO) Age: 38.7
Dependent: Sally Johnson (DAU) Age: 18.7
Dependent: Johnny Johnson (SON) Age: 16.7
** Sgl+Fam Aetna HMO Eff:08/01/2004 - 01/31/2006 Paid thru:11/30/2004

Smith, Gary 212-12-2222 07/31/2004 18 Months Termination of Employment
555 Dunes Drive Portland OR 94111
Dependent: Sally Smith (SPO) Age: 38.7
Dependent: Joe Smith (SON) Age: 14.7
Dependent: Susie Smith (DAU) Age: 12.7
** Sgl+Fam Aetna HMO Eff:08/01/2004 - 01/31/2006 Paid thru:12/31/2004

Eligibility

***** Carrier: CIGNA

Smith, Jay 000-00-0002 04/30/2003 18 Months Termination of Employment
444 Smith Ave. Sunshine City AZ 85555
** Sgl Cigna PPO Eff:05/01/2003 - 10/31/2004 Paid thru:08/31/2004

Eligibility

***** Carrier: DELTA

Jones, Joyce 455-66-4001 09/01/2002 36 Months Divorce or Legal Separation
617 Elm Street Evanston IL 50222
** Sgl Delta Dental Eff:10/01/2002 - 09/30/2005 Paid thru:12/31/2004

Nix, Don 555-66-2111 09/09/2004 36 Months Loss of Dependent Status
1414 West Dr. Des Moines IA 56666
** Sgl Delta Dental Eff:10/01/2004 - 09/30/2007 Paid thru:12/31/2004

Smith, Jay 000-00-0002 04/30/2003 18 Months Termination of Employment
444 Smith Ave. Sunshine City AZ 85555
** Sgl Delta Dental Eff:05/01/2003 - 10/31/2004 Paid thru:08/31/2004

Garcia, Jose 555-44-9999 07/05/2004 18 Months Termination of Employment
788 Shane Street Chicago IL 45000
Dependent: Donna Garcia (SPO) Age: 38.7
Dependent: Angel Garcia (DAU) Age: 13.7
Dependent: Jesus Garcia (SON) Age: 11.7
** Sgl+1 Delta Dental Eff:08/01/2004 - 01/31/2006 Paid thru:10/31/2004

Barry, David 111-33-4444 08/15/2003 18 Months Termination of Employment
123 Sam Club Street Anywhere MN 55111
Dependent: Dana Barry (SPO) Age: 38.7
Dependent: Kyle Barry (SON) Age: 19.7
** Sgl+Fam Delta Dental Eff:09/01/2003 - 02/28/2005 Paid thru:11/30/2004

Eligibility

***** Carrier: VSP

Johnson, Debbie 555-66-7777 07/08/2004 18 Months Reduction in Hours
7888 Washington Ave No San Diego CA 95002
Dependent: Jimmie Johnson (SPO) Age: 38.7
** Sgl+1 Vision Eff:08/01/2004 - 01/31/2006 Paid thru:11/30/2004

Smith, Gary 212-12-2222 07/31/2004 18 Months Termination of Employment
555 Dunes Drive Portland OR 94111
Dependent: Sally Smith (SPO) Age: 38.7
Dependent: Joe Smith (SON) Age: 14.7
Dependent: Susie Smith (DAU) Age: 12.7
** Sgl+Fam Vision Eff:08/01/2004 - 01/31/2006 Paid thru:12/31/2004

*** End of Report Q018 ***

Payment Report – This report shows premium collected by HR Simplified during the reporting period.

Payment Detail Report

Coverage Soc.Sec.No.	Name	Employee#	Coverage Start Date	Paid Date	Paid Amount	Check#	Source
PROSPECT	**Prospect Inc.**						
AETNA	**Aetna**						
Cov.: 1M	Aetna : Sgl Aetna HMO						
455-66-4001	Jones, Joyce		11/01/2002	02/17/2004	306.00	001	ET
					306.00	Coverage Total	
					306.00	Carrier Total	
CIGNA	**CIGNA HMO**						
Cov.: 3M	CIGNA HMO : Sgl+Child(ren) Cigna PPO						
554-62-2561	Anderson, Richard		09/01/2003	02/17/2004	765.00	001	ET
					765.00	Coverage Total	
					765.00	Carrier Total	
DELTA	**Delta Dental**						
Cov.: 1D	Delta Dental : Sgl Delta Dental						
455-66-4001	Jones, Joyce		11/01/2002	02/17/2004	51.00	001	ET
					51.00	Coverage Total	
Cov.: 4D	Delta Dental : Sgl+Fam Delta Dental						
554-62-2561	Anderson, Richard		09/01/2003	02/17/2004	112.20	001	ET
					112.20	Coverage Total	
					163.20	Carrier Total	
					1,234.20	Division Total	
OHARE	**O'Hare Transport**						
AETNA	**Aetna**						
Cov.: 1M							
111-22-3334	Patterson, Sam		10/01/2003	02/17/2004	357.00	001	ET
					357.00	Coverage Total	
					357.00	Carrier Total	
					357.00	Division Total	
					1,591.20	EMPLOYER Total	

Payment Detail Report

Coverage Soc.Sec.No.	Name	Employee#	Coverage Start Date	Paid Date	Paid Amount	Check#	Source
					1,591.20		REPORT TOTAL

*** End of Report F001 ***

A = Advance Payment
U = Unapplied Amoun
N = NSF
R = NSF Reversa
F = Refunded
- or 'F' are not included in Totals

Rate Detail Report – This report shows current premiums for the various plans.

Rate Details

Carrier	Division Coverage	Description	Rate Determination Dates	Rate	Admin.Fee	TotalAmount
PROSPECT		Prospect Inc.				
AETNA	1M	Sgl Aetna HMO	01/01/2004 - 12/31/2004	450.00	9.00	459.00
AETNA	1M	Sgl Aetna HMO	01/01/2003 - 12/31/2003	350.00	7.00	357.00
AETNA	1M	Sgl Aetna HMO	01/01/2002 - 12/31/2002	300.00	6.00	306.00
AETNA	2M	Sgl+1 Aetna HMO	01/01/2004 - 12/31/2004	700.00	14.00	714.00
AETNA	2M	Sgl+1 Aetna HMO	01/01/2003 - 12/31/2003	500.00	10.00	510.00
AETNA	2M	Sgl+1 Aetna HMO	01/01/2002 - 12/31/2002	450.00	9.00	459.00
AETNA	3M	Sgl+Child(ren) Aetna HMO	01/01/2004 - 12/31/2004	800.00	16.00	816.00
AETNA	3M	Sgl+Child(ren) Aetna HMO	01/01/2003 - 12/31/2003	600.00	12.00	612.00
AETNA	3M	Sgl+Child(ren) Aetna HMO	01/01/2002 - 12/31/2002	425.00	8.50	433.50
AETNA	4M	Sgl+Fam Aetna HMO	01/01/2004 - 12/31/2004	1100.00	22.00	1122.00
AETNA	4M	Sgl+Fam Aetna HMO	01/01/2003 - 12/31/2003	900.00	18.00	918.00
AETNA	4M	Sgl+Fam Aetna HMO	01/01/2002 - 12/31/2002	700.00	14.00	714.00
CIGNA	1M	Sgl Cigna PPO	01/01/2004 - 12/31/2004	650.00	13.00	663.00
CIGNA	1M	Sgl Cigna PPO	01/01/2003 - 12/31/2003	500.00	10.00	510.00
CIGNA	1M	Sgl Cigna PPO	01/01/2002 - 12/31/2002	400.00	8.00	408.00
CIGNA	2M	Sgl+1 Cigna PPO	01/01/2004 - 12/31/2004	900.00	18.00	918.00
CIGNA	2M	Sgl+1 Cigna PPO	01/01/2003 - 12/31/2003	800.00	16.00	816.00
CIGNA	2M	Sgl+1 Cigna PPO	01/01/2002 - 12/31/2002	600.00	12.00	612.00
CIGNA	3M	Sgl+Child(ren) Cigna PPO	01/01/2004 - 12/31/2004	910.00	18.20	928.20
CIGNA	3M	Sgl+Child(ren) Cigna PPO	01/01/2003 - 12/31/2003	750.00	15.00	765.00
CIGNA	3M	Sgl+Child(ren) Cigna PPO	01/01/2002 - 12/31/2002	550.00	11.00	561.00

Rate Details

Carrier	Division	Coverage	Description	Rate Determination Dates	Rate	Admin.Fee	TotalAmount
CIGNA		4M	Sgl+Fam Cigna PPO	01/01/2004 - 12/31/2004	1050.00	21.00	1071.00
CIGNA		4M	Sgl+Fam Cigna PPO	01/01/2003 - 12/31/2003	950.00	19.00	969.00
CIGNA		4M	Sgl+Fam Cigna PPO	01/01/2002 - 12/31/2002	900.00	18.00	918.00
DELTA		1D	Sgl Delta Dental	01/01/2004 - 12/31/2004	34.00	0.68	34.68
DELTA		1D	Sgl Delta Dental	01/01/2003 - 12/31/2003	32.00	0.64	32.64
DELTA		1D	Sgl Delta Dental	01/01/2002 - 12/31/2002	50.00	1.00	51.00
DELTA		2D	Sgl+1 Delta Dental	01/01/2004 - 12/31/2004	80.00	1.60	81.60
DELTA		2D	Sgl+1 Delta Dental	01/01/2003 - 12/31/2003	76.00	1.52	77.52
DELTA		2D	Sgl+1 Delta Dental	01/01/2002 - 12/31/2002	75.00	1.50	76.50
DELTA		3D	Sgl+Child(ren) Delta Dent	01/01/2004 - 12/31/2004	80.00	1.60	81.60
DELTA		3D	Sgl+Child(ren) Delta Dent	01/01/2003 - 12/31/2003	67.00	1.34	68.34
DELTA		3D	Sgl+Child(ren) Delta Dent	01/01/2002 - 12/31/2002	65.00	1.30	66.30
DELTA		4D	Sgl+Fam Delta Dental	01/01/2004 - 12/31/2004	120.00	2.40	122.40
DELTA		4D	Sgl+Fam Delta Dental	01/01/2003 - 12/31/2003	110.00	2.20	112.20
DELTA		4D	Sgl+Fam Delta Dental	01/01/2002 - 12/31/2002	100.00	2.00	102.00
Division Total:		36	Rate(s)				
	GARY		Gary Transit				
VSP		1V	Sgl VSP Vision	01/01/2004 - 12/31/2004	12.00	0.24	12.24
VSP		1V	Sgl VSP Vision	01/01/2003 - 12/31/2003	11.00	0.22	11.22
VSP		1V	Sgl VSP Vision	01/01/2002 - 12/31/2002	10.00	0.20	10.20
VSP		2V	Sgl+1 VSP Vision	01/01/2004 - 12/31/2004	13.50	0.27	13.77
VSP		2V	Sgl+1 VSP Vision	01/01/2003 - 12/31/2003	12.50	0.25	12.75
VSP		2V	Sgl+1 VSP Vision	01/01/2002 - 12/31/2002	12.00	0.24	12.24
VSP		3V	Sgl+Child(ren) VSP Vision	01/01/2004 - 12/31/2004	19.50	0.39	19.89

Rate Details

Carrier	Division Coverage	Description	Rate Determination Dates	Rate	Admin.Fee	TotalAmount
VSP	3V	Sgl+Child(ren) VSP Vision	01/01/2003 - 12/31/2003	18.50	0.37	18.87
VSP	3V	Sgl+Child(ren) VSP Vision	01/01/2002 - 12/31/2002	18.00	0.36	18.36
VSP	4V	Sgl+Fam VSP Vision	01/01/2004 - 12/31/2004	23.50	0.47	23.97
VSP	4V	Sgl+Fam VSP Vision	01/01/2003 - 12/31/2003	22.50	0.45	22.95
VSP	4V	Sgl+Fam VSP Vision	01/01/2002 - 12/31/2002	22.00	0.44	22.44

Division Total: 12 Rate(s)

EMPLOYER Total: 48 Rate(s)

Rate Details

Carrier	Division Coverage	Description	Rate Determination Dates	Rate	Admin.Fee	TotalAmount

REPORT TOTAL: 48 Rate(s)

*** End of Report P004 ***

Sample Termination Report – This report shows Active qualified beneficiaries who have terminated coverage in the reporting period.

Terminations

Soc.Sec.No. / Emp#	Name (Last, First)	State	Zip Code	Term Date	Paid Thru	Termination Status
PROSPECT	**Prospect Inc.**					
200-02-2222	Smith, John TE C	CA	90002	07/31/2002		Terminated: Non-Payment
Coverages	AETNA : 1M 06/01/2002 - 11/30/2003				07/31/2002	
	DELTA : 1D 06/01/2002 - 11/30/2003				07/31/2002	
212-12-1211	Gomez, Manuel TE C	CA	95022	08/31/2003		Terminated: Non-Payment
Coverages	AETNA : 1M 09/01/2003 - 02/28/2005					
500-50-5000	Chin, Kim TE C	IL	60016	09/30/2003		Terminated: Non-Payment
Coverages	CIGNA : 2M 05/01/2002 - 10/31/2003				12/31/2002	
	DELTA : 2D 05/01/2002 - 10/31/2003				09/30/2003	
544-55-4444	Cobb, Ty TE C	MN	56666	10/31/2003		Terminated: Non-Payment
Coverages	AETNA : 1M 10/01/2003 - 02/28/2005				10/31/2003	
	AETNA : 2M 12/01/2003 - 02/28/2005					
	CIGNA : 1M 11/01/2003 - 02/28/2005					
	DELTA : 1D 10/01/2003 - 02/28/2005				10/31/2003	

Division Totals:

Voluntary	
Medicare Entitled	
Other Coverage	
Deceased	
SPECIAL	
4	Non-Payment
Enrollment Expired	
End of Eligibility	
4	

GARY **Division: Gary Transit**

111-33-4444	Barry, David TE C	MN	55111	11/30/2003		Terminated: Non-Payment
Coverages	AETNA : 4M 09/01/2003 - 02/28/2005				11/30/2003	
	DELTA : 4D 09/01/2003 - 02/28/2005				11/30/2003	

Division Totals:

Voluntary	
Medicare Entitled	
Other Coverage	
Deceased	
SPECIAL	
1	Non-Payment
Enrollment Expired	
End of Eligibility	
1	

EMPLOYER Totals:

Voluntary	
Medicare Entitled	
Other Coverage	
Deceased	
SPECIAL	
5	Non-Payment
Enrollment Expired	
End of Eligibility	
5	

Terminations

Soc.Sec.No. / Emp#	Name (Last, First)	State	Zip Code	Term Date	Paid Thru	Termination Status

REPORT TOTALS:

	Voluntary
	Medicare Entitled
	Other Coverage
	Deceased
	SPECIAL
5	Non-Payment
	Enrollment Expired
	End of Eligibility
5	

*** End of Report Q020 ***