

I, _____ (your name) , the
 _____ (title) of
 _____ (Company Name), pursuant to the full, plenary and discretionary authority
 assumed by me as plan administrator of the _____ (Plans), hereby mandate that
 Ameriflex undertake the following action: Accept late COBRA election and payment of COBRA
 premiums from _____ (Cobra Participant) until _____ (Date).

*Note: Please confirm with the carriers that they will allow the reinstatement of benefits to be processed
 outside of the normal processing timeframe **prior** to completion of this document.*



*****PLEASE INITIAL ALL DESIGNATED SPACES*****

___ I acknowledge that a representative of Ameriflex has advised the Company that this action may
 not be allowable under the Consolidated Omnibus Reconciliation Act of 1985 ("COBRA") and/or any
 rules, regulations or court decisions promulgated thereto.

___ I acknowledge that the Company is mandating this action against the advice of Ameriflex.

___ I acknowledge that this action or similar may result in negative legal consequences to the Plan
 and/or the Company, including but not limited to the imposition of monetary penalties.

___ The Company hereby holds Ameriflex and its employees harmless and fully indemnifies
 Ameriflex for this action and any other actions derivative therefrom, notwithstanding any language
 in the administrative agreement for services to the contrary.

___ The Company shall not communicate to any third party that Ameriflex authorized,
 recommended or otherwise endorsed this action.



(Optional) Please initial only if you wish to confirm the following:

___ I wish to apply this grace period to all future COBRA premium payments for all qualified
 beneficiaries in the future.



Signature: _____

Date _____