

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
TAMPA DIVISION**

BRENT DAVIS, individually and on
behalf of all others similarly situated,

Plaintiff,

v.

CASE No.:

ABM FACILITY SERVICES, INC.,

Defendant.

CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL

1. The Plaintiff, Brent Davis, sues Defendant, ABM Facility Services, Inc., on behalf of himself and similarly situated present and former employees, alleging that Defendant failed to provide required notices of their right to continued health care coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).

2. Plaintiff, Brent Davis (“Plaintiff”), on behalf of himself and the Class set forth below, bring this class action against Defendant, ABM Facility Services, Inc. (“Defendant”), for violating the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”).

3. Defendant, the plan sponsor of the Health Plan (“Plan”), has repeatedly violated ERISA by failing to provide participants and beneficiaries in the Plan with adequate notice, as prescribed by COBRA, of their right to continue their health coverage upon the occurrence of a “qualifying event” as defined by the statute. As a result of these violations, which threaten Class Members’ ability to maintain their health coverage, Plaintiffs seek statutory penalties, injunctive relief, attorneys’ fees, costs and expenses, and other

appropriate relief as set forth herein and provided by law.

JURISDICTION AND VENUE

4. This Court has jurisdiction over this action pursuant to 29 U.S.C. § 1132(e) and (f), and also pursuant to 28 U.S.C. §§ 1331 and 1355.

5. Venue is proper in this District pursuant to 29 U.S.C. § 1132(e)(2) because the statutory violations at issue took place in this District, and Defendant has business operations in this District.

PARTIES

6. Plaintiff is a Florida resident and former employee of Defendant who was a covered employee and participant in the Plan the day before the termination of his employment on September 19, 2016, which was a qualifying event within the meaning of 29 U.S.C. § 1163(2), rendering him a qualified beneficiary of the Plan pursuant to 29 U.S.C. § 1167(3).

7. Defendant is a foreign corporation with its headquarters in California, and employed more than 20 employees who were members of the Plan in each year from 2011 to 2016. Defendant is the Plan sponsor within the meaning of 29 U.S.C. § 1002(16)(B), and the administrator of the Plan within the meaning of 29 U.S.C. § 1002(16)(A). The Plan provides medical benefits to employees and their beneficiaries, and is an employee welfare benefit plan within the meaning of 29 U.S.C. § 1002(1) and a group health plan within the meaning of 29 U.S.C. § 1167(1).

FACTUAL ALLEGATIONS

COBRA Notice Requirements

8. The COBRA amendments to ERISA include certain provisions relating to continuation of health coverage upon termination of employment or another “qualifying event” as defined by the statute.

9. Among other things, COBRA requires the plan sponsor of each group health plan normally employing more than 20 employees on a typical business day during the preceding year to provide “each qualified beneficiary who would lose coverage under the plan as a result of a qualifying event ... to elect, within the election period, continuation coverage under the plan.” 29 U.S.C. § 1161.

10. COBRA further requires the administrator of such a group health plan to provide notice to any qualified beneficiary of their continuation of coverage rights under COBRA upon the occurrence of a qualifying event. 29 U.S.C. § 1166(a)(4). This notice must be “[i]n accordance with the regulations prescribed by the Secretary” of Labor. 29 U.S.C. § 1166(a).

11. The relevant regulations prescribed by the Secretary of Labor concerning notice of continuation of coverage rights are set forth in 29 C.F.R. § 2590.606-4 and the Appendix thereto.

12. Section 2590.606-4(b)(1), states:

Except as provided in paragraph (b)(2) or (3) of this section, upon receipt of a notice of qualifying event ..., the administrator shall furnish to each qualified beneficiary, not later than 14 days after receipt of the notice of qualifying event, a notice meeting the requirements of paragraph (b)(4) of this section.

13. Section 2590.606-4(b)(4), in turn, provides as follows:

(4) The notice required by this paragraph (b) shall be written in a manner calculated to be understood by the average plan participant and shall contain the following information:

(i) The name of the plan under which continuation coverage is available; and the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits;

(ii) Identification of the qualifying event;

(iii) Identification, by status or name, of the qualified beneficiaries who are recognized by the plan as being entitled to elect continuation coverage with respect to the qualifying event, and the date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected;

(iv) A statement that each individual who is a qualified beneficiary with respect to the qualifying event has an independent right to elect continuation coverage, that a covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries with respect to the qualifying event, and that a parent or legal guardian may elect continuation coverage on behalf of a minor child;

(v) An explanation of the plan's procedures for electing continuation coverage, including an explanation of the time period during which the election must be made, and the date by which the election must be made;

(vi) An explanation of the consequences of failing to elect or waiving continuation coverage, including an explanation that a qualified beneficiary's decision whether to elect continuation coverage will affect the future rights of qualified beneficiaries to portability of group health coverage, guaranteed access to individual health coverage, and special enrollment under part 7 of title I of the Act, with a reference to where a qualified beneficiary may obtain additional information about such rights; and a description of the plan's procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made;

(vii) A description of the continuation coverage that will be made available under the plan, if elected, including the date on which such coverage will commence, either by providing a description of

the coverage or by reference to the plan's summary plan description;

(viii) An explanation of the maximum period for which continuation coverage will be available under the plan, if elected; an explanation of the continuation coverage termination date; and an explanation of any events that might cause continuation coverage to be terminated earlier than the end of the maximum period;

(ix) A description of the circumstances (if any) under which the maximum period of continuation coverage may be extended due either to the occurrence of a second qualifying event or a determination by the Social Security Administration, under title II or XVI of the Social Security Act (42 U.S.C. 401 et seq. or 1381 et seq.) (SSA), that the qualified beneficiary is disabled, and the length of any such extension;

(x) In the case of a notice that offers continuation coverage with a maximum duration of less than 36 months, a description of the plan's requirements regarding the responsibility of qualified beneficiaries to provide notice of a second qualifying event and notice of a disability determination under the SSA, along with a description of the plan's procedures for providing such notices, including the times within which such notices must be provided and the consequences of failing to provide such notices. The notice shall also explain the responsibility of qualified beneficiaries to provide notice that a disabled qualified beneficiary has subsequently been determined to no longer be disabled;

(xi) A description of the amount, if any, that each qualified beneficiary will be required to pay for continuation coverage;

(xii) A description of the due dates for payments, the qualified beneficiaries' right to pay on a monthly basis, the grace periods for payment, the address to which payments should be sent, and the consequences of delayed payment and non-payment;

(xiii) An explanation of the importance of keeping the administrator informed of the current addresses of all participants or beneficiaries under the plan who are or may become qualified beneficiaries; and

(xiv) A statement that the notice does not fully describe continuation coverage or other rights under the plan, and that more complete information regarding such rights is available in the

plan's summary plan description or from the plan administrator.

14. To facilitate compliance with these notice obligations, the United States Department of Labor (“DOL”) has issued a Model COBRA Continuation Coverage Election Notice (“Model Notice”), which is included in the Appendix to 29 C.F.R. § 2590.606-4. A copy of this Model Notice is attached hereto as Exhibit A. The DOL website states that the DOL “will consider use of the model election notice, appropriately completed, good faith compliance with the election notice content requirements of COBRA.”

15. In the event that a plan administrator declines to use the Model Notice and fails to meet the notice requirements of 29 U.S.C. § 1166 and 29 C.F.R. § 2590.606-4, the administrator is subject to statutory penalties of up to \$110 per participant or beneficiary per day from the date of such failure. 29 U.S.C. § 1132(c)(1). In addition, the Court may order such other relief as it deems proper, including but not limited to injunctive relief pursuant to 29 U.S.C. § 1132(a)(3) and payment of attorneys’ fees and expenses pursuant to 29 U.S.C. § 1132(g)(1).

Defendant’s Notice Is Inadequate and Fails to Comply with COBRA

16. Defendant did not adhere to the Model Notice provided by the Secretary of Labor, and instead drafted notice that served Defendant’s best interests, as critical parts are omitted or altered in violation of 29 C.F.R. § 2590.606-4. Defendant authored and disseminated a notice that was not appropriately completed, deviating from the model form in violation of COBRA's requirements, which failed to provide Plaintiff notice of all required coverage information and hindered Plaintiff’s ability to obtain continuation coverage, as explained further below. A copy of Defendant’s notice is attached hereto as Exhibit B.

Among other things:

- a. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(iii) because it fails to provide the date on which coverage under the plan will terminate (or has terminated) unless continuation coverage is elected.
- b. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(iv) because it fails to provide notice that a covered employee or a qualified beneficiary who is the spouse of the covered employee (or was the spouse of the covered employee on the day before the qualifying event occurred) may elect continuation coverage on behalf of all other qualified beneficiaries.
- c. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(vi) because it fails to provide an explanation of the consequences of failing to elect or waiving continuation coverage and also fails to provide a description of the plan's procedures for revoking a waiver of the right to continuation coverage before the date by which the election must be made.
- d. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(vii) because it fails to provide the date which continuation coverage will commence, either by providing a description of the coverage or by reference to the plan's summary plan description.
- e. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(viii) because it fails to provide an explanation of the continuation coverage termination date.
- f. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(x) because it fails to provide a description of the plan's procedures for providing notices of a second qualifying event and notice of a disability determination.

Plaintiff Brent Davis

17. Plaintiff was employed by Defendant as a Branch Manager from October 2014 to September 2016.

18. Plaintiff experienced a qualifying event (termination) on September 19, 2016. Importantly, for purposes of COBRA, Plaintiff was not terminated for gross misconduct.

19. Following this qualifying event, Defendant mailed Plaintiff the notice attached hereto as Exhibit B on October 4, 2016.

20. The COBRA notice that Plaintiff received was deficient for the reasons set forth in Paragraph 16 above (among other reasons).

CLASS ACTION ALLEGATIONS

21. Plaintiffs bring this action as a class action pursuant to Rule 23 of the Federal Rules of Civil Procedure on behalf of the following persons:

All participants and beneficiaries in the Defendant's Health Plan who were sent a COBRA notice by Defendant during the applicable statute of limitations period, as a result of a qualifying event as determined by Defendant.

22. Because no administrative remedies are required, Plaintiff has sought none and seeks to move forward with the putative class action.

23. Numerosity: The Class is so numerous that joinder of all Class members is impracticable. On information and belief, hundreds or thousands of individuals satisfy the definition of the Class.

24. Typicality: Plaintiffs' claims are typical of the Class. The COBRA notice that Defendant sent to Plaintiffs was a form notice that was uniformly provided to all Class members. As such, the COBRA notice that Plaintiffs received was typical of the COBRA notices that other Class Members received, and suffered from the same deficiencies.

25. Adequacy: Plaintiffs will fairly and adequately protect the interests of the Class members, they have no interests antagonistic to the class, and have retained counsel experienced in complex class action litigation.

26. Commonality: Common questions of law and fact exist as to all members of the Class and predominate over any questions solely affecting individual members of the Class, including but not limited to:

- a. Whether the Plan is a group health plan within the meaning of 29 U.S.C. § 1167(1).

- b. Whether Defendant's COBRA notice complied with the requirements of 29 U.S.C. § 1166(a) and 29 C.F.R. § 2590.606-4;
- c. Whether statutory penalties should be imposed against Defendant under 29 U.S.C. § 1132(c)(1) for failing to comply with COBRA notice requirements, and if so, in what amount;
- d. The appropriateness and proper form of any injunctive relief or other equitable relief pursuant to 29 U.S.C. § 1132(a)(3); and
- e. Whether (and the extent to which) other relief should be granted based on Defendant's failure to comply with COBRA notice requirements.

27. Class Members do not have an interest in pursuing separate individual actions against Defendant, as the amount of each Class Member's individual claims is relatively small compared to the expense and burden of individual prosecution. Class certification also will obviate the need for unduly duplicative litigation that might result in inconsistent judgments concerning Defendant's practices and the adequacy of its COBRA notice. Moreover, management of this action as a class action will not present any likely difficulties. In the interests of justice and judicial efficiency, it would be desirable to concentrate the litigation of all Class Members' claims in a single action.

28. Plaintiff intends to send notice to all Class Members to the extent required by Rule 23(c)(2) of the Federal Rules of Civil Procedure.

29. The names and addresses of the Class Members are available from Defendant's records.

CLASS CLAIM I FOR RELIEF

Violation of 29 U.S.C. § 1166(a) and 29 C.F.R. § 2590.606-4

30. Plaintiff repeats and incorporates the allegations contained in the foregoing paragraphs as if fully set forth herein.

31. The Plan is a group health plan within the meaning of 29 U.S.C. § 1167(1).

32. Defendant is the sponsor and administrator of the Plan, and was subject to the continuation of coverage and notice requirements of COBRA.

33. Plaintiffs and the other members of the Class experienced a “qualifying event” as defined by 29 U.S.C. § 1163, and Defendant was aware that they had experienced such a qualifying event.

34. On account of such qualifying event, Defendant sent Plaintiffs and the Class Members a COBRA notice in the form attached hereto as Exhibit B.

35. The COBRA notice that Defendant sent to Plaintiffs and other Class Members violated 29 U.S.C. § 1166(a) and 29 C.F.R. § 2590.606-4 for the reasons set forth in Paragraph 16 above (among other reasons).

36. These violations were material and willful.

37. Defendant knew that its notice was inconsistent with the Secretary of Labor’s Model Notice and failed to comply with 29 U.S.C. § 1166(a) and 29 C.F.R. § 2590.606-4, but chose to use a non-compliant notice in deliberate or reckless disregard of the rights of Plaintiffs and other Class Members.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff, individually and on behalf of the Class, pray for relief as follows: Designating Plaintiff’s counsel as counsel for the Class;

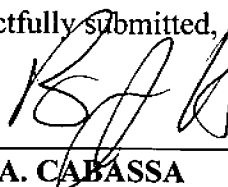
- a. Issuing proper notice to the Class at Defendant's expense;
- b. Declaring that the COBRA notice sent by Defendant to Plaintiffs and other Class Members violated 29 U.S.C. § 1166(a) and 29 C.F.R. § 2590.606-4;
- c. Awarding appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3), including but not limited to an order enjoining Defendant from continuing to use its defective COBRA notice and requiring Defendant to send corrective notices;
- d. Awarding statutory penalties to the Class pursuant to 29 U.S.C. § 1132(c)(1) and 29 C.F.R. § 2575.502c-1 in the amount of \$110 per day for each Class Member who was sent a defective COBRA notice by Defendant;
- e. Awarding attorneys' fees, costs and expenses to Plaintiffs' counsel as provided by 29 U.S.C. § 1132(g)(1) and other applicable law;
- f. Granting such other and further relief, in law or equity, as this Court deems appropriate;
- g. Designating Plaintiffs' counsel as counsel for the Class;
- h. Issuing proper notice to the Class at Defendant's expense;
- i. Declaring that the COBRA notice sent by Defendant to Plaintiffs and other Class Members violated 29 U.S.C. § 1166(a) and 29 C.F.R. § 2590.606-4;
- j. Awarding appropriate equitable relief pursuant to 29 U.S.C. § 1132(a)(3), including but not limited to an order enjoining Defendant from continuing to use its defective COBRA notice and requiring Defendant to send corrective notices;
- k. Awarding statutory penalties to the Class pursuant to 29 U.S.C. § 1132(c)(1) and 29 C.F.R. § 2575.502c-1 in the amount of \$110 per day for each Class Member who was sent a defective COBRA notice by Defendant;
- l. Awarding attorneys' fees, costs and expenses to Plaintiffs' counsel as provided by 29 U.S.C. § 1132(g)(1) and other applicable law; and
- m. Granting such other and further relief, in law or equity, as this Court deems appropriate.

JURY TRIAL

38. Pursuant to Rule 38(b) of the Federal Rules of Civil Procedure, Plaintiff and the Class demand a trial by jury.

Dated this 13th day of January, 2017.

Respectfully submitted,



LUIS A. CABASSA

Florida Bar Number: 053643

Direct No.: 813-379-2565

BRANDON J. HILL

Florida Bar Number: 37061

Direct No.: 813-337-7992

WENZEL FENTON CABASSA, P.A.

1110 North Florida Ave.

Suite 300

Tampa, Florida 33602

Main No.: 813-224-0431

Facsimile: 813-229-8712

Email: lcabassa@wfc law.com

Email: twells@wfc law.com

Email: bhill@wfc law.com

Email: mk@wfc law.com

Attorneys for Plaintiff

Exhibit A

Model COBRA Continuation Coverage Election Notice
Instructions

The Department of Labor has developed a model Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) continuation coverage election notice that the Plan may use to provide the election notice. To use this model election notice properly, the Plan Administrator must fill in the blanks with the appropriate plan information. The Department considers use of the model election notice to be good faith compliance with the election notice content requirements of COBRA. The use of the model notices isn't required. The model notices are provided to help facilitate compliance with the applicable notice requirements.

NOTE: Plans do *not* need to include this instruction page with the model election notice.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 10/31/2016)]

Model COBRA Continuation Coverage Election Notice
(For use by single-employer group health plans)

IMPORTANT INFORMATION: COBRA Continuation Coverage and other Health Coverage Alternatives

[Enter date of notice]

Dear: [Identify the qualified beneficiary(ies), by name or status]

This notice has important information about your right to continue your health care coverage in the [enter name of group health plan] (the Plan), as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election form provided later in this notice.

Why am I getting this notice?

You're getting this notice because your coverage under the Plan will end on [enter date] due to [check appropriate box]:

- | | |
|--|---|
| <input type="checkbox"/> End of employment | <input type="checkbox"/> Reduction in hours of employment |
| <input type="checkbox"/> Death of employee | <input type="checkbox"/> Divorce or legal separation |
| <input type="checkbox"/> Entitlement to Medicare | <input type="checkbox"/> Loss of dependent child status |

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage through COBRA continuation coverage when there's a "qualifying event" that would result in a loss of coverage under an employer's plan.

What's COBRA continuation coverage?

COBRA continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries who aren't getting continuation coverage. Each "qualified beneficiary" (described below) who elects COBRA continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

Who are the qualified beneficiaries?

Each person ("qualified beneficiary") in the category(ies) checked below can elect COBRA continuation coverage:

- Employee or former employee
- Spouse or former spouse
- Dependent child(ren) covered under the Plan on the day before the event that caused the loss of coverage
- Child who is losing coverage under the Plan because he or she is no longer a dependent under the Plan

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other more affordable coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage.

You should compare your other coverage options with COBRA continuation coverage and choose the coverage that is best for you. For example, if you move to other coverage you may pay more out of pocket than you would under COBRA because the new coverage may impose a new deductible.

When you lose job-based health coverage, it's important that you choose carefully between COBRA continuation coverage and other coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option.

If I elect COBRA continuation coverage, when will my coverage begin and how long will the coverage last?

If elected, COBRA continuation coverage will begin on *[enter date]* and can last until *[enter date]*.

[Add, if appropriate: You may elect any of the following options for COBRA continuation coverage: [list available coverage options].

Continuation coverage may end before the date noted above in certain circumstances, like failure to pay premiums, fraud, or the individual becomes covered under another group health plan.

Can I extend the length of COBRA continuation coverage?

If you elect continuation coverage, you may be able to extend the length of continuation coverage if a qualified beneficiary is disabled, or if a second qualifying event occurs. You must notify *[enter name of party responsible for COBRA administration]* of a disability or a second qualifying event within a certain time period to extend the period of continuation coverage. If you don't provide notice of a disability or second qualifying event within the required time period, it will affect your right to extend the period of continuation coverage.

For more information about extending the length of COBRA continuation coverage visit <http://www.dol.gov/ebsa/publications/cobraemployee.html>.

How much does COBRA continuation coverage cost?

COBRA continuation coverage will cost: *[enter amount each qualified beneficiary will be required to pay for each option per month of coverage and any other permitted coverage periods.]*

Other coverage options may cost less. If you choose to elect continuation coverage, you don't have to send any payment with the Election Form. Additional information about payment will be provided to you after the election form is received by the Plan. Important information about paying your premium can be found at the end of this notice.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace below.

What is the Health Insurance Marketplace?

The Marketplace offers “one-stop shopping” to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

When can I enroll in Marketplace coverage?

You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a “special enrollment” event. **After 60 days your special enrollment period will end and you may not be able to enroll, so you should take action right away.** In addition, during what is called an “open enrollment” period, anyone can enroll in Marketplace coverage.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

If I sign up for COBRA continuation coverage, can I switch to coverage in the Marketplace? What about if I choose Marketplace coverage and want to switch back to COBRA continuation coverage?

If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have another qualifying event such as marriage or birth of a child through something called a “special enrollment period.” But be careful though - if you terminate your COBRA continuation coverage early without another qualifying event, you’ll have to wait to enroll in Marketplace coverage until the next open enrollment period, and could end up without any health coverage in the interim.

Once you’ve exhausted your COBRA continuation coverage and the coverage expires, you’ll be eligible to enroll in Marketplace coverage through a special enrollment period, even if Marketplace open enrollment has ended.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

Can I enroll in another group health plan?

You may be eligible to enroll in coverage under another group health plan (like a spouse’s plan), if you request enrollment within 30 days of the loss of coverage.

If you or your dependent chooses to elect COBRA continuation coverage instead of enrolling in another group health plan for which you’re eligible, you’ll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA continuation coverage.

What factors should I consider when choosing coverage options?

When considering your options for health coverage, you may want to think about:

- **Premiums:** Your previous plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse’s plan or through the Marketplace, may be less expensive.
- **Provider Networks:** If you’re currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.
- **Drug Formularies:** If you’re currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.
- **Severance payments:** If you lost your job and got a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA

payments for a period of time. In this scenario, you may want to contact the Department of Labor at 1-866-444-3272 to discuss your options.

- **Service Areas:** Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.
- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

For more information

This notice doesn't 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.

If you have questions about the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, contact [*enter name of party responsible for COBRA administration for the Plan, with telephone number and address*].

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through the Health Insurance Marketplace, and to locate an assister in your area who you can talk to about the different options, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your and your family's rights, keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy of any notices you send to the Plan Administrator.

COBRA Continuation Coverage Election Form

Instructions: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you have 60 days after the date of this notice to decide whether you want to elect COBRA continuation coverage under the Plan.

Send completed Election Form to: *[Enter Name and Address]*

This Election Form must be completed and returned by mail *[or describe other means of submission and due date]*. If mailed, it must be post-marked no later than *[enter date]*.

If you don't submit a completed Election Form by the due date shown above, you'll lose your right to elect COBRA continuation coverage. If you reject COBRA continuation coverage before the due date, you may change your mind as long as you submit 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 submit the completed Election Form.

Read the important information about your rights included in the pages after the Election Form.

I (We) elect COBRA continuation coverage in the *[enter name of plan]* (the Plan) listed below:

Name	Date of Birth	Relationship to Employee	SSN (or other identifier)
a. _____			
[Add if appropriate: Coverage option elected: _____]			
b. _____			
[Add if appropriate: Coverage option elected: _____]			
c. _____			
[Add if appropriate: Coverage option elected: _____]			

Signature

Date

Print Name

Relationship to individual(s) listed above

Print Address

Telephone number

Important Information About Payment

First payment for continuation coverage

You must make your first payment for continuation coverage no later than 45 days after the date of your election (this is the date the Election Notice is postmarked). If you don't make your first payment in full no later than 45 days after the date of your election, you'll lose all continuation coverage rights under the Plan. You're responsible for making sure that the amount of your first payment is correct. You may contact *[enter appropriate contact information, e.g., the Plan Administrator or other party responsible for COBRA administration under the Plan]* to confirm the correct amount of your first payment.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you'll have to make periodic payments for each coverage period that follows. The amount due for each coverage period for each qualified beneficiary is shown in this notice. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due *[enter due day for each monthly payment]* for that coverage period. *[If Plan offers other payment schedules, enter with appropriate dates: You may instead make payments for continuation coverage for the following coverage periods, due on the following dates:].* 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 *[select one: will or will not]* 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'll be given a grace period of 30 days after the first day of the coverage period *[or enter longer period permitted by Plan]* to make each periodic payment. You'll get continuation coverage for each coverage period as long as payment for that coverage period is made before the end of the grace period. *[If Plan suspends coverage during grace period for nonpayment, enter and modify as necessary: If you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. 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 don't make a periodic payment before the end of the grace period for that coverage period, you'll lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to:

[enter appropriate payment address]

Exhibit B

UnitedHealthcare
 Division: Benefit Services
 P.O. Box 221709
 Louisville, KY 40252
 Ph: (866) 747-0048

**COBRA CONTINUATION COVERAGE ELECTION NOTICE
 AND OTHER HEALTH COVERAGE ALTERNATIVES**



BRENT DAVIS
 10609 DIXON DRIVE
 RIVERVIEW, FL 33579

Qualification Date: 09/19/2016
 Termination Date: 10/04/2016

NOTICIA ADICIONAL PARA LOS EMPLEADOS QUE HABLAN ESPAÑOL:

Este aviso contiene información importante acerca de su derecho a continuar con su cobertura de salud. Si necesita ayuda, por favor, póngase en contacto con UnitedHealthcare COBRA al teléfono 1(866) 747-0048 y pida que le transfieran con un Representante del Servicio al Cliente que hable español.

Please carefully read and review the information in this notice as it contains important information about your right to continue your group benefit coverage, as well as other health coverage alternatives that may be available to you through the Health Insurance Marketplace at www.HealthCare.gov or call 1-800-318-2596. You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage.

Please read the information in this notice very carefully before you make your decision. If you choose to elect COBRA continuation coverage, you should use the election agreement on the following page.

You have had an event: Involuntary Termination, that will result in a loss of coverage under the ABM Industries Incorporated group benefit plan(s). Under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, this is a qualifying event that will entitle you, your covered spouse and dependent child(ren), if any, to elect to continue coverage (known as "COBRA coverage") under the plan up to 18 Months from the date of your qualifying event.

Each of the following individuals is entitled to elect to continue coverage he or she was enrolled in under the Plan. If a family member was covered the day before the qualifying event and is not listed below, please add that information to the Election Agreement.

<u>Name (First Last)</u>	<u>Relationship</u>
BRENT R DAVIS	Self

Please note: If your election contains coverage for your dependents, confirmation of the demographics and the social security number of the dependent(s) is required to complete your enrollment.

If you elect to continue your coverage under the Plan, your continuation coverage will begin on the start date shown below. The enclosed Election Agreement must be returned to UnitedHealthcare no later than the Election Expires date. If you do not return the completed Election Agreement by this date, you will lose your right to elect continuation coverage.

Participant Name	Coverage	Amount	Rate	Billing Period	Start Date	Expires
IHC Comprehensive Value Plan	Participant Only	\$ 610.96	\$ 610.96	1 Month	10/01/2016	12/02/2016
MetLife Dental PPO	Participant Only	\$ 40.23	\$ 40.23	1 Month	10/01/2016	12/02/2016
MetLife Vision	Participant Only	\$ 5.75	\$ 5.75	1 Month	10/01/2016	12/02/2016

This notice provides important information concerning your rights and what you have to do to continue your coverage under the Plan. If you have

ELECTION AGREEMENT

The primary qualified beneficiary may elect to continue coverage on behalf of all eligible dependents, which were covered the day before the qualifying event. If the primary qualified beneficiary has declined coverage, a dependent (or legal guardian) may elect independent coverage. Each eligible family member may elect coverage independently by completing a separate copy of this ELECTION AGREEMENT.

UnitedHealthcare offers you the ability to enroll online to save you time and money. To take advantage of this easy enrollment process, go to www.uhcservices.com and register as a user. If you enroll online, you do not need to return this form. You must enroll by the Election Expires date or you and all eligible family members will lose your right to continuation coverage.

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

Carrier Name	Coverage	Amount	Net	Billing	Start Date	End Date
<input type="checkbox"/> UHC Comprehensive Value Plan	Participant Only	\$ 610.96	\$ 610.96	1 Month	10/01/2016	12/02/2016
<input type="checkbox"/> MetLife Dental PPO	Participant Only	\$ 40.23	\$ 40.23	1 Month	10/01/2016	12/02/2016
<input type="checkbox"/> VSP Vision	Participant Only	\$ 5.75	\$ 5.75	1 Month	10/01/2016	12/02/2016

DEPENDENT INFORMATION

Please check the members below who are electing to continue coverage. Should you decide to elect individual coverage for any of your dependents, for example spouse only or child only, the following information must be provided in order to complete the enrollment process. If any of the information is not provided, this could possibly delay your enrollment and eligibility. Please note, in order for you to enroll your dependents, the social security number for that dependent must be provided. If the child is less than six months of age, you will be required to provide the social security number on or before six months of age.

<u>Name (First Last)</u>	<u>Birth Date</u>	<u>Sex</u>	<u>Relationship</u>	<u>Alt.SSN</u>
<input type="checkbox"/> BRENT R DAVIS	04/13/1956	Male	Self	

If a spouse and/or dependent was covered under the plan(s) prior to the qualifying event, but not listed, please provide their information.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I have read the COBRA CONTINUATION COVERAGE ELECTION NOTICE and understand my election rights. I agree to notify UnitedHealthcare or 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	Phone Number
_____	_____	_____
Print Name	Email Address	
_____	_____	

UnitedHealthcare offers you the ability to enroll online to save you time and money. To take advantage of this easy enrollment process, go to www.uhcservices.com and register as a user.

Otherwise, please return this completed Election Agreement to:

UnitedHealthcare
 P.O. Box 221709
 Louisville, KY 40252

aying by check, your premium payment must be returned along with the remittance slip for the payment period(s) you are paying. The initial
im payment must include full payment from the date you lost coverage under the plan to the current month's premium payment. Please make
heck payable to UnitedHealthcare and mail to the address on the remittance slip below.

tedHealthcare offers you the ability to make premium payments through Electronic Funds Transfer (EFT) directly from your checking or
s account. If you decide to sign up for automatic withdrawals, they will continue as the premiums come due until either cancelled by
iting the request in writing or by canceling insurance coverage(s). To take advantage of this easy payment process, login to uhcservices.com
ick on the link to complete the information for your automatic payment.

s returned or EFTs rejected for insufficient funds or checks, which cannot otherwise be cashed, do not constitute payment. Please note invoic
e mailed to you as a courtesy reminder even if you have signed up for Electronic Funds Transfer.

: to delay processing of your payment or request for changes do not include correspondences with your payment. If you do not enroll online,
send all correspondences to:

Healthcare
ox 221709
ille, KY 40252

do not make your payment online, please mail your payment only to:

Healthcare
ox 713082
nati, OH 45271-3082

Please cut the remittance slip below and return with your payment.

S, BRENT
RVIEW, FL 33579

Mail and Make Checks Payable to:
UnitedHealthcare
P.O. Box 713082
Cincinnati, OH 45271-3082



ELECTION AGREEMENT

If the primary qualified beneficiary may elect to continue coverage on behalf of all eligible dependents, which were covered the day before the qualifying event. If the primary qualified beneficiary has declined coverage, a dependent (or legal guardian) may elect independent coverage. Each eligible family member may elect coverage independently by completing a separate copy of this ELECTION AGREEMENT.

UnitedHealthcare offers you the ability to enroll online to save you time and money. To take advantage of this easy enrollment process, go to www.uhcservices.com and register as a user. If you enroll online, you do not need to return this form. You must enroll by the Election Expires date or you and all eligible family members will lose your right to continuation coverage.

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

Plan Name	Coverage	Amount	Cost	Term	Start Date	End Date
<input type="checkbox"/> UHC Comprehensive Value Plan	Participant Only	\$ 610.96	\$ 610.96	1 Month	10/01/2016	12/02/2016
<input type="checkbox"/> MetLife Dental PPO	Participant Only	\$ 40.23	\$ 40.23	1 Month	10/01/2016	12/02/2016
<input type="checkbox"/> VSP Vision	Participant Only	\$ 5.75	\$ 5.75	1 Month	10/01/2016	12/02/2016

DEPENDENT INFORMATION

Please check the members below who are electing to continue coverage. Should you decide to elect individual coverage for any of your dependents, for example spouse only or child only, the following information must be provided in order to complete the enrollment process. If any of the information is not provided, this could possibly delay your enrollment and eligibility. Please note, in order for you to enroll your dependents, the social security number for that dependent must be provided. If the child is less than six months of age, you will be required to provide the social security number on or before six months of age.

Name (First Last)	Birth Date	Sex	Relationship	Alt.SSN
<input type="checkbox"/> BRENT R DAVIS	04/13/1956	Male	Self	

If a spouse and/or dependent was covered under the plan(s) prior to the qualifying event, but not listed, please provide their information.

_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I have read the COBRA CONTINUATION COVERAGE ELECTION NOTICE and understand my election rights. I agree to notify UnitedHealthcare or 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 _____	Phone Number _____
Print Name _____	Email Address _____	

UnitedHealthcare offers you the ability to enroll online to save you time and money. To take advantage of this easy enrollment process, go to www.uhcservices.com and register as a user.

Otherwise, please return this completed Election Agreement to:

UnitedHealthcare
P.O. Box 221709
Louisville, KY 40252

aying by check, your premium payment must be returned along with the remittance slip for the payment period(s) you are paying. The initial
im payment must include full payment from the date you lost coverage under the plan to the current month's premium payment. Please make
heck payable to UnitedHealthcare and mail to the address on the remittance slip below.

tedHealthcare offers you the ability to make premium payments through Electronic Funds Transfer (EFT) directly from your checking or
s account. If you decide to sign up for automatic withdrawals, they will continue as the premiums come due until either cancelled by
tting the request in writing or by canceling insurance coverage(s). To take advantage of this easy payment process, login to uhcservices.com
ick on the link to complete the information for your automatic payment.

s returned or EFTs rejected for insufficient funds or checks, which cannot otherwise be cashed, do not constitute payment. Please note invoic
e mailed to you as a courtesy reminder even if you have signed up for Electronic Funds Transfer.

: to delay processing of your payment or request for changes do not include correspondences with your payment. If you do not enroll online,
send all correspondences to:

Healthcare
ox 221709
ille, KY 40252

do not make your payment online, please mail your payment only to:

Healthcare
ox 713082
incinnati, OH 45271-3082

Please cut the remittance slip below and return with your payment.

S, BRENT
RVIEW, FL 33579

Mail and Make Checks Payable to:
UnitedHealthcare
P.O. Box 713082
Cincinnati, OH 45271-3082



JS 44 (Rev. 12/12)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

<p>I. (a) PLAINTIFFS First Listed Plaintiff KIMBERLY DAVIS</p> <p>(b) County of Residence of First Listed Plaintiff <u>Pinellas</u> <i>(EXCEPT IN U.S. PLAINTIFF CASES)</i></p> <p>(c) Attorneys (Firm Name, Address, and Telephone Number) Gregory A. Owens, Esquire, Bouzas Owens, PA, 2154 Duck Slough Blvd., Suite 101 Trinity, FL 34655 Telephone: 727-254-5255</p>	<p>DEFENDANTS First Listed Defendant L.S.M. BEACH, INC., SHEILA LEAGAS, individually and LEE LEAGAS, individually</p> <p>County of Residence of First Listed Defendant <u>Pinellas</u> <i>(IN U.S. PLAINTIFF CASES ONLY)</i></p> <p>NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.</p> <p>Attorneys (If Known) Unknown</p>
---	---

<p>II. BASIS OF JURISDICTION (Place an "X" in One Box Only)</p> <p><input type="checkbox"/> 1 U.S. Government Plaintiff</p> <p><input checked="" type="checkbox"/> 3 Federal Question (U.S. Government Not a Party)</p> <p><input type="checkbox"/> 2 U.S. Government Defendant</p> <p><input type="checkbox"/> 4 Diversity (Indicate Citizenship of Parties in Item III)</p>	<p>III. CITIZENSHIP OF PRINCIPAL PARTIES (Place an "X" in One Box for Plaintiff and One Box for Defendant)</p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:10%; text-align: center;">PTF</td> <td style="width:10%; text-align: center;">DEF</td> <td style="width:40%;"></td> <td style="width:10%; text-align: center;">PTF</td> <td style="width:10%; text-align: center;">DEF</td> </tr> <tr> <td>Citizen of This State</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td style="text-align: center;"><input type="checkbox"/> 1</td> <td>Incorporated or Principal Place of Business In This State</td> <td style="text-align: center;"><input type="checkbox"/> 4</td> <td style="text-align: center;"><input type="checkbox"/> 4</td> </tr> <tr> <td>Citizen of Another State</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> <td style="text-align: center;"><input type="checkbox"/> 2</td> <td>Incorporated and Principal Place of Business In Another State</td> <td style="text-align: center;"><input type="checkbox"/> 5</td> <td style="text-align: center;"><input type="checkbox"/> 5</td> </tr> <tr> <td>Citizen or Subject of a Foreign Country</td> <td style="text-align: center;"><input type="checkbox"/> 3</td> <td style="text-align: center;"><input type="checkbox"/> 3</td> <td>Foreign Nation</td> <td style="text-align: center;"><input type="checkbox"/> 6</td> <td style="text-align: center;"><input type="checkbox"/> 6</td> </tr> </table>		PTF	DEF		PTF	DEF	Citizen of This State	<input type="checkbox"/> 1	<input type="checkbox"/> 1	Incorporated or Principal Place of Business In This State	<input type="checkbox"/> 4	<input type="checkbox"/> 4	Citizen of Another State	<input type="checkbox"/> 2	<input type="checkbox"/> 2	Incorporated and Principal Place of Business In Another State	<input type="checkbox"/> 5	<input type="checkbox"/> 5	Citizen or Subject of a Foreign Country	<input type="checkbox"/> 3	<input type="checkbox"/> 3	Foreign Nation	<input type="checkbox"/> 6	<input type="checkbox"/> 6
	PTF	DEF		PTF	DEF																				
Citizen of This State	<input type="checkbox"/> 1	<input type="checkbox"/> 1	Incorporated or Principal Place of Business In This State	<input type="checkbox"/> 4	<input type="checkbox"/> 4																				
Citizen of Another State	<input type="checkbox"/> 2	<input type="checkbox"/> 2	Incorporated and Principal Place of Business In Another State	<input type="checkbox"/> 5	<input type="checkbox"/> 5																				
Citizen or Subject of a Foreign Country	<input type="checkbox"/> 3	<input type="checkbox"/> 3	Foreign Nation	<input type="checkbox"/> 6	<input type="checkbox"/> 6																				

IV. NATURE OF SUIT (Place an "X" in One Box Only)				
<p>CONTRACT</p> <p><input type="checkbox"/> 110 Insurance</p> <p><input type="checkbox"/> 120 Marine</p> <p><input type="checkbox"/> 130 Miller Act</p> <p><input type="checkbox"/> 140 Negotiable Instrument</p> <p><input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment</p> <p><input type="checkbox"/> 151 Medicare Act</p> <p><input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excludes Veterans)</p> <p><input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits</p> <p><input type="checkbox"/> 160 Stockholders' Suits</p> <p><input type="checkbox"/> 190 Other Contract</p> <p><input type="checkbox"/> 195 Contract Product Liability</p> <p><input type="checkbox"/> 196 Franchise</p>	<p>TORTS</p> <p>PERSONAL INJURY</p> <p><input type="checkbox"/> 310 Airplane</p> <p><input type="checkbox"/> 315 Airplane Product Liability</p> <p><input type="checkbox"/> 320 Assault, Libel & Slander</p> <p><input type="checkbox"/> 330 Federal Employers' Liability</p> <p><input type="checkbox"/> 340 Marine</p> <p><input type="checkbox"/> 345 Marine Product Liability</p> <p><input type="checkbox"/> 350 Motor Vehicle</p> <p><input type="checkbox"/> 355 Motor Vehicle Product Liability</p> <p><input type="checkbox"/> 360 Other Personal Injury</p> <p><input type="checkbox"/> 362 Personal Injury - Medical Malpractice</p>	<p>PERSONAL INJURY</p> <p><input type="checkbox"/> 365 Personal Injury - Product Liability</p> <p><input type="checkbox"/> 367 Health Care/Pharmaceutical Personal Injury Product Liability</p> <p><input type="checkbox"/> 368 Asbestos Personal Injury Product Liability</p> <p>PERSONAL PROPERTY</p> <p><input type="checkbox"/> 370 Other Fraud</p> <p><input type="checkbox"/> 371 Truth in Lending</p> <p><input type="checkbox"/> 380 Other Personal Property Damage</p> <p><input type="checkbox"/> 385 Property Damage Product Liability</p>	<p>FORFEITURE/PENALTY</p> <p><input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881</p> <p><input type="checkbox"/> 690 Other</p>	<p>BANKRUPTCY</p> <p><input type="checkbox"/> 422 Appeal 28 USC 158</p> <p><input type="checkbox"/> 423 Withdrawal 28 USC 157</p> <p style="text-align: center;">PROPERTY RIGHTS</p> <p><input type="checkbox"/> 820 Copyrights</p> <p><input type="checkbox"/> 830 Patent</p> <p><input type="checkbox"/> 840 Trademark</p>
<p>REAL PROPERTY</p> <p><input type="checkbox"/> 210 Land Condemnation</p> <p><input type="checkbox"/> 220 Foreclosure</p> <p><input type="checkbox"/> 230 Rent Lease & Ejectment</p> <p><input type="checkbox"/> 240 Tort to Land</p> <p><input type="checkbox"/> 245 Tort Product Liability</p> <p><input type="checkbox"/> 290 All Other Real Property</p>	<p>CIVIL RIGHTS</p> <p><input type="checkbox"/> 440 Other Civil Rights</p> <p><input type="checkbox"/> 441 Voting</p> <p><input type="checkbox"/> 442 Employment</p> <p><input type="checkbox"/> 443 Housing/Accommodations</p> <p><input type="checkbox"/> 445 Amer. w/Disabilities - Employment</p> <p><input type="checkbox"/> 446 Amer. w/Disabilities - Other</p> <p><input type="checkbox"/> 448 Education</p>	<p>PRISONER PETITIONS</p> <p>Habeas Corpus:</p> <p><input type="checkbox"/> 463 Alien Detainee</p> <p><input type="checkbox"/> 510 Motions to Vacate Sentence</p> <p><input type="checkbox"/> 530 General</p> <p><input type="checkbox"/> 535 Death Penalty</p> <p>Other:</p> <p><input type="checkbox"/> 540 Mandamus & Other</p> <p><input type="checkbox"/> 550 Civil Rights</p> <p><input type="checkbox"/> 555 Prison Condition</p> <p><input type="checkbox"/> 560 Civil Detainee - Conditions of Confinement</p>	<p>LABOR</p> <p><input checked="" type="checkbox"/> 710 Fair Labor Standards Act</p> <p><input type="checkbox"/> 720 Labor/Management Relations</p> <p><input type="checkbox"/> 740 Railway Labor Act</p> <p><input type="checkbox"/> 751 Family and Medical Leave Act</p> <p><input type="checkbox"/> 790 Other Labor Litigation</p> <p><input type="checkbox"/> 791 Employee Retirement Income Security Act</p>	<p>SOCIAL SECURITY</p> <p><input type="checkbox"/> 861 HIA (1395ff)</p> <p><input type="checkbox"/> 862 Black Lung (923)</p> <p><input type="checkbox"/> 863 DIWC/DIWW (405(g))</p> <p><input type="checkbox"/> 864 SSID Title XVI</p> <p><input type="checkbox"/> 865 RSI (405(g))</p>
			<p>IMMIGRATION</p> <p><input type="checkbox"/> 462 Naturalization Application</p> <p><input type="checkbox"/> 465 Other Immigration Actions</p>	<p>FEDERAL TAX SUITS</p> <p><input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant)</p> <p><input type="checkbox"/> 871 IRS—Third Party 26 USC 7609</p>
<p>OTHER STATUTES</p> <p><input type="checkbox"/> 375 False Claims Act</p> <p><input type="checkbox"/> 400 State Reapportionment</p> <p><input type="checkbox"/> 410 Antitrust</p> <p><input type="checkbox"/> 430 Banks and Banking</p> <p><input type="checkbox"/> 450 Commerce</p> <p><input type="checkbox"/> 460 Deportation</p> <p><input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations</p> <p><input type="checkbox"/> 480 Consumer Credit</p> <p><input type="checkbox"/> 490 Cable/Sat TV</p> <p><input type="checkbox"/> 850 Securities/Commodities/Exchange</p> <p><input type="checkbox"/> 890 Other Statutory Actions</p> <p><input type="checkbox"/> 891 Agricultural Acts</p> <p><input type="checkbox"/> 893 Environmental Matters</p> <p><input type="checkbox"/> 895 Freedom of Information Act</p> <p><input type="checkbox"/> 896 Arbitration</p> <p><input type="checkbox"/> 899 Administrative Procedure Act/Review or Appeal of Agency Decision</p> <p><input type="checkbox"/> 950 Constitutionality of State Statutes</p>				

V. ORIGIN (Place an "X" in One Box Only)

1 Original Proceeding 2 Removed from State Court 3 Remanded from Appellate Court 4 Reinstated or Reopened 5 Transferred from Another District (specify) 6 Multidistrict Litigation

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing (Do not cite jurisdictional statutes unless diversity):
29 U.S.C. § 216(b)

Brief description of cause:
FLSA (Unpaid Overtime and Unpaid Minimum Wages)

VII. REQUESTED IN COMPLAINT:

CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P. DEMAND \$ _____

CHECK YES only if demanded in complaint:
JURY DEMAND: Yes No

VIII. RELATED CASE(S) IF ANY (See instructions): JUDGE _____ DOCKET NUMBER _____

DATE: 01/10/2017 SIGNATURE OF ATTORNEY OF RECORD _____

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

ClassAction.org

This complaint is part of ClassAction.org's searchable class action lawsuit database and can be found in this post: [Lawsuit Says ABM Facility Services Failed to Give COBRA Notice](#)
