

**UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF FLORIDA  
WEST PALM BEACH DIVISION**

**JAMIE BRYANT**, individually and on  
behalf of all others similarly situated,

**Plaintiff,**

v.

**CASE No.:**

**WAL-MART STORES, INC.,**

**Defendant.**

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**CLASS ACTION COMPLAINT AND DEMAND FOR JURY TRIAL**

1. The Plaintiff, Jamie Bryant, sues Defendant, Wal-Mart Stores, Inc., on behalf of herself 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, Jamie Bryant (“Plaintiff”), on behalf of herself and the Class set forth below, bring this class action against Defendant, Wal-Mart Stores, 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 her employment on April 8, 2016, which was a qualifying event within the meaning of 29 U.S.C. § 1163(2), rendering her a qualified beneficiary of the Plan pursuant to 29 U.S.C. § 1167(3).

7. Defendant is a foreign corporation with its headquarters in Arkansas, 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 partially adhered to the Model Notice provided by the Secretary of Labor, but only to the extent 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) because Defendant has failed to provide a notice of continuation coverage written in a manner calculated to be understood by the average plan participant. The notice provided to Plaintiff is confusing, ambiguous and critical components, if included, are piecemealed throughout the notice rather than being made clear and understandable to the average plan participant.
- b. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(i) because it fails to provide

the name, address and telephone number of the party responsible under the plan for the administration of continuation coverage benefits. Nowhere in the notice provided to Plaintiff is any party or entity clearly and unambiguously identified as the Plan Administrator.

- c. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(iv) because it fails to provide all required explanatory information; There is no explanation that a spouse of the covered employee may elect continuation coverage on behalf of all other qualified beneficiaries.
- d. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(iv) because it fails to provide all required explanatory information; There is no explanation that a legal guardian may elect continuation coverage on behalf of a minor child, or a minor child who may later become a qualified beneficiary.
- e. The Notice violates 29 C.F.R. § 2590.606-4(b)(4)(vi) because it fails to provide all required explanatory information. There is no “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.”. Further, there is no “reference to where a qualified beneficiary may obtain additional information about such rights.”

***Plaintiff Jamie Bryant***

17. Plaintiff was employed by Wal-Mart as a Store Manager from 2009 to 2016.

18. Plaintiff experienced a qualifying event (termination) on April 8, 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 April 26, 2016.

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

21. Plaintiff was unable to obtain continuation coverage after receiving the deficient election notice.

### **CLASS ACTION ALLEGATIONS**

22. 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.**

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

24. 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.

25. 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.

26. 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.

27. 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.

28. 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.

29. 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.

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

**CLASS CLAIM FOR RELIEF**

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

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

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

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

34. 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.

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

36. 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).

37. These violations were material and willful.

38. 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**

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

Dated this 17th day of November, 2016.

Respectfully submitted,

/s/ Chad a. Justice

**CHAD A. JUSTICE**

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# **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](mailto: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](http://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](http://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](http://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](http://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](http://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**



CONEXIS  
P.O. Box 226101  
Dallas, TX 75222-6101

Date: 4/28/2016  
Form: CLC02-Wal-Mart  
Doc ID: 63914842  
Account #: 0121966997



To JAMIE N BRYANT and Covered Dependents  
8320 Commerce Way  
Unit 813  
Hialeah, FL 33016-1624

Doc: 63914842 Sequence: 300 Form: 2 Server: 1

Participant Name: JAMIE N BRYANT  
Qualifying Event Reason: Termination  
Election Deadline Date: 6/27/2016  
Plan: Wal-Mart Associates' Health and Welfare Plan ("Plan")

Date of Notice: 4/28/2016  
†Date of Coverage Loss: 4/13/2016  
‡Coverage Start Date if Electing: 4/14/2016

To: JAMIE N BRYANT and Covered Dependents

**This notice has important information about your right to continue your health care coverage under the Wal-Mart Stores, Inc. Associates' Health and Welfare Plan ("Plan"), which consists of the Medical plan, the HMO plan, the GeC PPO plan, the Dental plan, the Vision plan, and other health care benefits offered under the Plan, as well as other health coverage options that may be available to you, including coverage through the Health Insurance Marketplace ("Marketplace") at [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596. You may be able to get coverage through the Marketplace that costs less than COBRA continuation coverage. More information regarding the Marketplace is provided at the end of this notice.**

Please read the enclosed information on your COBRA rights and obligations very carefully before you make your decision and keep it for your records.

You are receiving this notice because you experienced a qualifying event and may be eligible for COBRA continuation coverage under the Plan. This notice includes your COBRA COVERAGE ELECTION FORM and Important Information About Your COBRA Continuation Coverage Rights.

If elected, COBRA continuation coverage will begin on 4/14/2016 and can last until 10/13/2017. If you do not elect COBRA coverage, your coverage under the Plan will end on 04/13/2016.

To elect COBRA continuation coverage, please follow the instructions and complete the enclosed COBRA Election Form. Information regarding available coverage options and costs are provided on the COBRA Coverage Election Form.

Instead of enrolling in COBRA coverage, there may be other more affordable coverage options for you and your family through the 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 coverage.

You should compare your other coverage options with COBRA 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.

**If you are eligible for Medicare Parts A and/or B and terminate employment (or lose coverage under the Plan), you should be aware that if you do not enroll in Medicare Part A and/or B during the Medicare special enrollment period, you may have to wait to enroll in Medicare Part A and/or B (i.e., until the next Medicare annual enrollment period) and may have to pay a higher Medicare premium when you do enroll. The eight month special enrollment period runs from the date that you are no longer employed by the Company (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage (e.g., following termination of employment). For additional information, please refer to *Medicare & You* handbook, published annually. The handbook can be obtained directly from Medicare by calling 800-633-4227 or from the Medicare website at [medicare.gov](http://medicare.gov).**

When you lose job-based health coverage, it's important that you choose carefully between COBRA coverage and other

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coverage options, because once you've made your choice, it can be difficult or impossible to switch to another coverage option. Also, if you elect coverage through the Marketplace, you may experience a gap in coverage between the date you lose coverage under the group health plan and the date coverage through the Marketplace begins (whereas you will not experience a gap if you elect and pay for COBRA continuation coverage).

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact CONEXIS at (800) 570-1863, or refer to the COBRA section in your *Associate Benefits Book*.

### **Important Notes**

- You are able to continue medical, dental, vision and other benefits eligible for COBRA coverage you had on the day prior to your qualifying event; You may choose a lesser tier level and/or select an alternate medical plan, if applicable.
- If you or your eligible dependents were enrolled in a medical plan (including the HMO or GeC PPO plan options) offered by Walmart at the time of a COBRA qualifying event, you or your covered dependents can choose to change your medical plan to one of the alternate medical plans available.
- If you change medical plans due to a status change event, your annual deductible(s) and out-of-pocket maximum will reset, and you will be responsible for meeting the new deductible(s) and out-of-pocket maximum in their entirety.
- The exception to this rule is if you change from one of the HRA plans to another, in which case your annual deductible and out-of-pocket maximum will not reset as a result of your change in medical coverage options. If you change from one of the HRA plans to another during the Plan year as the result of a status change event, the amount credited to your HRA will be prorated according to the time remaining in the year. If you change from one of the HRA plans to a non-HRA plan, your HRA balance will be forfeited.
- As a COBRA participant or COBRA eligible dependent, you are automatically enrolled in Resources For Living (RFL). RFL is a confidential counseling and wellbeing assistance program that is free to all COBRA participants and their COBRA eligible dependents. You can call a professional counselor at 800-825-3555 any time day or night for help with things like stress management, family relationships, career issues, and many other personal challenges. You can find additional information about RFL in your COBRA Benefits Book or in the RFL Summary of Benefits and Coverage (SBC), which can be requested, free of charge by calling Walmart Benefits Customer Service at 800-421-1362.
- Each qualified beneficiary has separate election rights.
- Your first premium amount covers the period from the time your coverage was lost because of a Qualifying Event up to the end of the month in which your election is made. This will be reflected in your first invoice. If you elect online, the amount will be automatically calculated for you or you may contact CONEXIS to confirm the correct amount of your first payment.
- After the initial payment, premium payments are due on the first of each month and will be returned if not paid (or postmarked if mailed) within 30 days of this due date. **If your COBRA continuation coverage is cancelled for failure to pay your premiums within 30 days of the date your premium is due, it cannot be reinstated.**
- If you experience a second qualifying event that might permit an extension of COBRA coverage, you must notify CONEXIS within 60 calendar days of that event in order to be eligible for an extension.

### **Instructions to Elect COBRA Continuation Coverage**

1. You can elect COBRA coverage in one of the following ways:
  - Complete and return the enclosed COBRA Coverage Election form to CONEXIS by mail to CONEXIS, P.O. Box 226101 Dallas, TX 75222 or by fax to (877) 353-2948.
  - Complete your election online at [mybenefits.conexis.com](http://mybenefits.conexis.com). You will need your Social Security Number and birth date in order to log-in to the Employees and Continuant's section.

To elect COBRA coverage, your completed election form must be postmarked on or before 6/27/2016, (the "Election Deadline Date") if mailed. If you do not submit a completed election by the Election Deadline Date, you will lose your right to elect COBRA continuation coverage.

2. If you elect COBRA coverage, you do not have to send any payment with the Election Form. Important additional information about payment for COBRA continuation coverage is included in the pages following the Election Form. 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 post-marked, if mailed.) If you do not make your first payment for continuation coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan.
  - You should receive a payment invoice within two weeks of the date we receive your election. However, premiums are due regardless of your receipt of a payment invoice. Please contact CONEXIS if you do not receive an invoice.

Premium payments are considered paid on the date you mail them (*as evidenced by your postmark date*). If your premium payment is made by check, and your check is returned because of insufficient funds, your premium is treated as unpaid. You must make full payment within the required time period, including a grace period, to prevent cancellation. **If you submit any premium payment after the required postmark date, or if you submit any premium payment and you are otherwise ineligible for coverage, these payments will be refunded to you. Refunds of \$5.00 will be sent automatically and no action on your part is required. To receive refunds for amounts below \$5.00, please contact CONEXIS. Acceptance of premium payments by CONEXIS is not an indication that coverage is in force. If your coverage is canceled for non-payment of premium, you cannot reinstate it.**

†See next page for individual plan termination dates

‡See next page for individual plan continuation start dates



**COBRA COVERAGE ELECTION FORM**

**Participant Name:** JAMIE N BRYANT  
**Plan:** Wal-Mart Associates' Health and Welfare Plan ("Plan")  
**Form Number:** CLC02

**Election Deadline:** 6/27/2016  
**Account Number:** 0121966997  
**Document ID:** 63914842

**Section A. Plan Alternatives if Electing**

Place an "X" in the box beside the monthly cost of the coverage(s) you are selecting. Please note that you may not elect a tier of coverage higher than what was in effect on the date of your qualifying event. **Please note that the amount below represents the full COBRA premium for one calendar month of COBRA coverage.**

|   |                                    |                                  |                                  | Date of Coverage Loss | COBRA Coverage Start Date if Electing |
|---|------------------------------------|----------------------------------|----------------------------------|-----------------------|---------------------------------------|
| <b>Dental - * Delta Dental of Arkansas 2016</b>                       |                                    |                                  |                                  | 04/13/2016            | 04/14/2016                            |
| Associate + Children  | Associate Only                     | Child Only                       | Children                         |                       |                                       |
| <input type="checkbox"/> \$42.99                                      | <input type="checkbox"/> \$18.39   | <input type="checkbox"/> \$18.39 | <input type="checkbox"/> \$42.99 |                       |                                       |
| <b>Medical - * HRA High:+Dependent(s) United Health Care PPO 2016</b> |                                    |                                  |                                  | 04/13/2016            | 04/14/2016                            |
| Associate + Children  | Children                           |                                  |                                  |                       |                                       |
| <input type="checkbox"/> \$1145.89                                    | <input type="checkbox"/> \$1145.89 |                                  |                                  |                       |                                       |
| <b>Medical - * HRA High:Individual United Health Care PPO 2016</b>    |                                    |                                  |                                  | 04/13/2016            | 04/14/2016                            |
| Associate Only  | Child Only                         |                                  |                                  |                       |                                       |
| <input type="checkbox"/> \$763.93                                     | <input type="checkbox"/> \$763.93  |                                  |                                  |                       |                                       |
| <b>Vision - * Vision 2016</b>   |                                    |                                  |                                  | 04/13/2016            | 04/14/2016                            |
| Associate + Children  | Associate Only                     | Child Only                       | Children                         |                       |                                       |
| <input type="checkbox"/> \$12.23                                      | <input type="checkbox"/> \$6.12    | <input type="checkbox"/> \$6.12  | <input type="checkbox"/> \$12.23 |                       |                                       |

**Section B. Participant Information**

Please verify our records are accurate and make changes as necessary. You MUST select the coverage type for each individual you intend to cover.

| Participant Name                | Relationship                     | Birth Date                      | Gender |
|---------------------------------|----------------------------------|---------------------------------|--------|
| JAMIE BRYANT                    | Self                             | 04/02/1982                      | F      |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Medical | <input type="checkbox"/> Vision |        |
| PERRY M SYLVAIN III             | Child                            | 07/23/2006                      | M      |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Medical | <input type="checkbox"/> Vision |        |

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|                                 |                                  |                                 |   |
|---------------------------------|----------------------------------|---------------------------------|---|
| JAYAC                           | Child                            | 12/01/2010                      | F |
| BRYANT                          |                                  |                                 |   |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Medical | <input type="checkbox"/> Vision |   |

**Section C. Medicare Entitlement**

Please note that you are "entitled" to Medicare when you are eligible for and **enrolled** in Medicare.

Is the covered associate entitled to Medicare ?  Yes  No

If yes, please provide the date of entitlement as shown on the Medicare card: \_\_\_\_\_

**If you are enrolled in Medicare, Medicare will be, in most cases, your primary insurance provider. This may affect how your benefits are paid. Also, Covered Dependents of an Associate who was enrolled in Medicare prior to COBRA eligibility may be eligible for extended COBRA coverage.**

**If you are eligible for Medicare Parts A and/or B and terminate employment (or lose coverage under the Plan), you should be aware that if you do not enroll in Medicare Part A and/or B during the Medicare special enrollment period, you may have to wait to enroll in Medicare Part A and/or B (i.e., until the next Medicare annual enrollment period) and may have to pay a higher premium when you do enroll. The eight month special enrollment period runs from the date that you are no longer employed by the Company (or lose coverage under the Plan, whichever occurs first), even if you elect COBRA continuation coverage (e.g., following termination of employment). For additional information, please refer to Medicare's *Medicare & You* handbook, published annually. The handbook can be obtained directly from Medicare by calling 800-633-4227 or from the Medicare website at medicare.gov.**

**Applicant's Authorization and Agreement**

By my signature below, I:

- elect COBRA continuation coverage as checked in Section A under the Plan; and,
- attest that I have read and understand the information provided to me in this COBRA Election Notice, COBRA Election Form, and "IMPORTANT INFORMATION: Your COBRA Coverage Rights and Other Health Coverage Alternatives" enclosure.

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Important Information About Your COBRA Continuation Coverage Rights**

COBRA (and the description of COBRA continuation coverage contained in this notice) generally applies only to health and dental benefits offered under the Plan and not to any other benefits.

**What is continuation coverage?**

Federal law requires that most group health plans, including the Walmart Associates' Health and Welfare Plan ("Plan") give associates 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 the Plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the associate (or former associate) covered under the Plan, the covered associate's spouse, and the dependent children of the covered associate. In addition, a child born to, adopted by, or placed for adoption with a covered associate during the period in which the associate is receiving COBRA continuation coverage, becomes a qualified beneficiary even though they were not covered under the Plan on the day before the qualifying event. A child of the covered associate receiving benefits pursuant to a qualified medical child support order (QMCSO), to the extent that such child is enrolled in accordance with the terms of the Plan, is entitled to the same rights to elect COBRA continuation coverage as an eligible dependent child of the covered associate.

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.

**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 generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an associate's death, divorce or legal separation, the associate's becoming entitled to Medicare Part D or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the associate's hours of employment, and the associate became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the associate lasts until 36 months after the date of Medicare entitlement. This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary (NOTE: there are limitations on plans' imposing a preexisting condition exclusion and such exclusions will become prohibited beginning in 2014 under the Affordable Care Act);
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA continuation coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate), or
- the employer ceases to provide any group health plan for its associates.

You must notify CONEXIS in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes covered under other group health plan coverage or becomes entitled to Medicare.

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).

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If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify CONEXIS 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 determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The disability extension will be available only if all the following conditions are met:

- The Social Security Administration determines that you or your eligible dependent is disabled;
- The disability exists at any time during the first 60 calendar days of COBRA coverage; or
- You and your eligible dependent(s) notify CONEXIS of the Social Security Administration's disability determination by submitting a copy of the Social Security Administration Disability Determination Notice of Award letter to CONEXIS within your initial 18 month COBRA period and within 60 days of the later of:
  - The date of your qualifying event;
  - The date of your Social Security Administration Disability Determination Notice of Award letter; or
  - The date on which you and/or your eligible dependent(s) loses coverage under the Plan as a result of the qualifying event.

In the absence of an official Notice of Award from Social Security, the Plan may accept other correspondence from the Social Security Administration if that correspondence explicitly includes all information the Plan needs in order to grant the extension and is submitted to CONEXIS within the time frames listed above.

Each qualified beneficiary who has elected COBRA coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the CONEXIS of that fact within 30 days after SSA's determination.

A request for the disability extension should be sent to CONEXIS as specified in the section *How to Contact CONEXIS*. It must include the associate's name, the name of the disabled individual as well as copy of the Social Security Administration Disability Determination award letter.

### Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered associate, divorce or separation from the covered associate, the covered associate's becoming entitled to Medicare Part D, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. You must notify CONEXIS within 60 days after a second qualifying event occurs if you want to extend continuation coverage. **If notice is not provided during this 60-day notice period, COBRA coverage will not be extended beyond the initial 18 months.**

The notice of a second qualifying event should be sent to CONEXIS as specified in the section *How to Contact CONEXIS*. It must include the associate's name, the name of the spouse and/or each dependent child, the nature of the second qualifying event (e.g., divorce or child's loss of dependent status.)

### How can you elect COBRA continuation coverage?

To elect COBRA continuation coverage, you must complete the COBRA Coverage Election Form and submit it to CONEXIS according to the instructions and by the date specified on that form. Failure to do so will result in a loss of the right to elect COBRA coverage under the Plan. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the associate's spouse may elect continuation coverage even if the associate does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent

### How much does COBRA 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 (or, in the case of an extension of continuation coverage due to disability, 150 percent) of the cost to the group health plan (including both employer and associate contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in this notice.

**When and how must payment for COBRA continuation coverage be made?**

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed, or the date on which your election is successfully submitted electronically on mybenefits.conexis.com.) Your first premium payment must cover the cost of COBRA continuation coverage from the date of the qualifying event to the end of the month in which the election is made. If you do not make your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact CONEXIS to confirm the correct amount of your first payment.

Monthly payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make monthly payments for each subsequent coverage period. The amount due for each monthly coverage period for each qualified beneficiary is shown in this notice. Under the Plan, each of these monthly payments for continuation coverage is due on the first day of each month for that coverage period. If you make a monthly 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. CONEXIS will send monthly notices of payments due for these coverage periods. You are responsible for paying the full premium on time even if you do not receive an invoice.

Grace periods for monthly payments

Although monthly payments are due on the dates shown above, you will be given a grace period of 30 days after the first day of the coverage period in which to make each monthly payment. Continuation coverage will be provided for each coverage period as long as payment is made before the end of the grace period for that coverage period.

IMPORTANT: If you make your payment after the first day of the month, any claims incurred, including pharmacy benefits, will not be paid until coverage is paid through the current month. Your continuation coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) only after the monthly payment is received. Any claims will have to be resubmitted once your account is current. Depending on the timing of receipt of a payment, it may take several days to process and update eligibility.

You will not be considered to have made any payment if your payment is returned due to insufficient funds or if there is otherwise a discrepancy with your payment (e.g., funds are not immediately available or verifiable, invalid banking account number, unsigned checks, incorrect payment amounts.) Any deposit of payment by CONEXIS will not constitute an acceptance of the premium payment. If mailed, your payment is considered to have been made on the date it is postmarked, given that it is received by CONEXIS.

If you fail to make a monthly payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

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

CONEXIS  
P.O. Box 660212  
Dallas, TX 75266-0212

To pay online, log on to [mybenefits.conexis.com](http://mybenefits.conexis.com), or to pay by phone, call (800) 570-1863.

**COBRA Continuation Coverage for Associates on Leave Performing Military Service**

If a covered associate takes a leave of absence to perform services in the Uniformed Services (as addressed in the Uniformed Services Employment and Reemployment Act (USERRA) that is expected to last 31 days or more, the covered associate may be able to continue health coverage for the associate and any covered dependents until the earlier of 24 months from the date the leave began or the date that the associate fails to return to or apply for work as required under USERRA. The USERRA continuation period will run concurrent with the COBRA period described herein. The rights described in this notice apply only to the COBRA continuation period. Notwithstanding anything to the contrary in this notice, continuation of coverage under a military leave of

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**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](http://www.HealthCare.gov).

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA 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 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](http://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 coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA 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." NOTE: If you terminate your COBRA coverage early without another qualifying event, you will 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 coverage and the coverage expires, you will 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 coverage, you cannot switch to COBRA coverage after your election period ends 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 coverage instead of enrolling in another group health plan for which you are eligible, you will have another opportunity to enroll in the other group health plan within no less than 30 days of losing your COBRA coverage.

**What factors should I consider when choosing coverage options?**

When considering your options for health coverage, you may want to think about the following: (1) PREMIUMS: Your previous plan can charge up to 102 percent of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. (2) PROVIDER NETWORKS: If you are currently receiving 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. (3) DRUG FORMULARIES: If you are 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. (4) SEVERANCE PAYMENTS: If you lost your job and received a severance package from your former employer, your former employer may have offered to pay some or all of your COBRA premium 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. (5) 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. (6) 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.

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

**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 Associate Benefits Book.

If you have any questions concerning the information in this notice or your rights to coverage, you should contact CONEXIS at (800) 570-1863. To request a copy of your Associate Benefits Book, you should contact Walmart Benefits at (800) 421-1362.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), 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](http://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 Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

**How to Contact CONEXIS**

All required notices should be sent to CONEXIS at P.O. Box 226101 Dallas, TX 75222 or by fax to (877) 353-2948. You may also call (800) 570-1863.

00264240030005



JS 44 (Rev. 11/15)

### 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><b>I. (a) PLAINTIFFS</b><br/>                 JAMIE BRYANT</p> <p><b>(b) County of Residence of First Listed Plaintiff</b> Miami-Dade<br/> <i>(EXCEPT IN U.S. PLAINTIFF CASES)</i></p> <p><b>(c) Attorneys (Firm Name, Address, and Telephone Number)</b><br/>                 Brandon J. Hill, Wenzel Fenton Cabassa, P.A., 1110 N. Florida Ave.,<br/>                 Ste. 300, Tampa, FL 33602, 813-224-0431</p> | <p><b>DEFENDANTS</b><br/>                 WAL-MART STORES, INC.</p> <p>County of Residence of First Listed Defendant<br/> <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)</p> |
|--|--|

|   |  |                            |   |                            |                            |            |            |                       |                            |                            |   |                            |                            |                          |                            |                            |   |                            |                            |   |                            |                            |                |                            |                            |
|---|--|----------------------------|---|----------------------------|----------------------------|------------|------------|-----------------------|----------------------------|----------------------------|---|----------------------------|----------------------------|--------------------------|----------------------------|----------------------------|---|----------------------------|----------------------------|---|----------------------------|----------------------------|----------------|----------------------------|----------------------------|
| <p><b>II. BASIS OF JURISDICTION</b> <i>(Place an "X" in One Box Only)</i></p> <p><input type="checkbox"/> 1 U.S. Government Plaintiff</p> <p><input checked="" type="checkbox"/> 3 Federal Question <i>(U.S. Government Not a Party)</i></p> <p><input type="checkbox"/> 2 U.S. Government Defendant</p> <p><input type="checkbox"/> 4 Diversity <i>(Indicate Citizenship of Parties in Item III)</i></p> | <p><b>III. CITIZENSHIP OF PRINCIPAL PARTIES</b> <i>(Place an "X" in One Box for Plaintiff and One Box for Defendant)</i></p> <table style="width:100%; border-collapse: collapse;"> <tr> <td style="width:30%;"></td> <td style="width:10%; text-align: center;"><b>PTF</b></td> <td style="width:10%; text-align: center;"><b>DEF</b></td> <td style="width:40%;"></td> <td style="width:10%; text-align: center;"><b>PTF</b></td> <td style="width:10%; text-align: center;"><b>DEF</b></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> |                            | <b>PTF</b>  | <b>DEF</b>                 |                            | <b>PTF</b> | <b>DEF</b> | 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 |
|   | <b>PTF</b>   | <b>DEF</b>                 |   | <b>PTF</b>                 | <b>DEF</b>                 |            |            |                       |                            |                            |   |                            |                            |                          |                            |                            |   |                            |                            |   |                            |                            |                |                            |                            |
| 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)*

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| <b>CONTRACT</b>   | <b>TORTS</b>   | <b>FORFEITURE/PENALTY</b>  | <b>BANKRUPTCY</b>  | <b>OTHER STATUTES</b>  |  |
| <input type="checkbox"/> 110 Insurance<br><input type="checkbox"/> 120 Marine<br><input type="checkbox"/> 130 Miller Act<br><input type="checkbox"/> 140 Negotiable Instrument<br><input type="checkbox"/> 150 Recovery of Overpayment & Enforcement of Judgment<br><input type="checkbox"/> 151 Medicare Act<br><input type="checkbox"/> 152 Recovery of Defaulted Student Loans (Excludes Veterans)<br><input type="checkbox"/> 153 Recovery of Overpayment of Veteran's Benefits<br><input type="checkbox"/> 160 Stockholders' Suits<br><input type="checkbox"/> 190 Other Contract<br><input type="checkbox"/> 195 Contract Product Liability<br><input type="checkbox"/> 196 Franchise | <p><b>PERSONAL INJURY</b></p> <input type="checkbox"/> 310 Airplane<br><input type="checkbox"/> 315 Airplane Product Liability<br><input type="checkbox"/> 320 Assault, Libel & Slander<br><input type="checkbox"/> 330 Federal Employers' Liability<br><input type="checkbox"/> 340 Marine<br><input type="checkbox"/> 345 Marine Product Liability<br><input type="checkbox"/> 350 Motor Vehicle<br><input type="checkbox"/> 355 Motor Vehicle Product Liability<br><input type="checkbox"/> 360 Other Personal Injury<br><input type="checkbox"/> 362 Personal Injury - Medical Malpractice <p><b>PERSONAL INJURY</b></p> <input type="checkbox"/> 365 Personal Injury - Product Liability<br><input type="checkbox"/> 367 Health Care/Pharmaceutical Personal Injury Product Liability<br><input type="checkbox"/> 368 Asbestos Personal Injury Product Liability <p><b>PERSONAL PROPERTY</b></p> <input type="checkbox"/> 370 Other Fraud<br><input type="checkbox"/> 371 Truth in Lending<br><input type="checkbox"/> 380 Other Personal Property Damage<br><input type="checkbox"/> 385 Property Damage Product Liability | <input type="checkbox"/> 625 Drug Related Seizure of Property 21 USC 881<br><input type="checkbox"/> 690 Other   | <input type="checkbox"/> 422 Appeal 28 USC 158<br><input type="checkbox"/> 423 Withdrawal 28 USC 157   | <input type="checkbox"/> 375 False Claims Act<br><input type="checkbox"/> 376 Qui Tam (31 USC 3729(a))<br><input type="checkbox"/> 400 State Reapportionment<br><input type="checkbox"/> 410 Antitrust<br><input type="checkbox"/> 430 Banks and Banking<br><input type="checkbox"/> 450 Commerce<br><input type="checkbox"/> 460 Deportation<br><input type="checkbox"/> 470 Racketeer Influenced and Corrupt Organizations<br><input type="checkbox"/> 480 Consumer Credit<br><input type="checkbox"/> 490 Cable/Sat TV<br><input type="checkbox"/> 850 Securities/Commodities/Exchange<br><input checked="" type="checkbox"/> 890 Other Statutory Actions<br><input type="checkbox"/> 891 Agricultural Acts<br><input type="checkbox"/> 893 Environmental Matters<br><input type="checkbox"/> 895 Freedom of Information Act<br><input type="checkbox"/> 896 Arbitration<br><input type="checkbox"/> 899 Administrative Procedure Act/Review or Appeal of Agency Decision<br><input type="checkbox"/> 950 Constitutionality of State Statutes |  |
| <p><b>REAL PROPERTY</b></p> <input type="checkbox"/> 210 Land Condemnation<br><input type="checkbox"/> 220 Foreclosure<br><input type="checkbox"/> 230 Rent Lease & Ejectment<br><input type="checkbox"/> 240 Torts to Land<br><input type="checkbox"/> 245 Tort Product Liability<br><input type="checkbox"/> 290 All Other Real Property  | <p><b>CIVIL RIGHTS</b></p> <input type="checkbox"/> 440 Other Civil Rights<br><input type="checkbox"/> 441 Voting<br><input type="checkbox"/> 442 Employment<br><input type="checkbox"/> 443 Housing/Accommodations<br><input type="checkbox"/> 445 Amer. w/Disabilities - Employment<br><input type="checkbox"/> 446 Amer. w/Disabilities - Other<br><input type="checkbox"/> 448 Education   | <p><b>PRISONER PETITIONS</b></p> <p><b>Habeas Corpus:</b></p> <input type="checkbox"/> 463 Alien Detainee<br><input type="checkbox"/> 510 Motions to Vacate Sentence<br><input type="checkbox"/> 530 General<br><input type="checkbox"/> 535 Death Penalty <p><b>Other:</b></p> <input type="checkbox"/> 540 Mandamus & Other<br><input type="checkbox"/> 550 Civil Rights<br><input type="checkbox"/> 555 Prison Condition<br><input type="checkbox"/> 560 Civil Detainee - Conditions of Confinement | <p><b>LABOR</b></p> <input type="checkbox"/> 710 Fair Labor Standards Act<br><input type="checkbox"/> 720 Labor/Management Relations<br><input type="checkbox"/> 740 Railway Labor Act<br><input type="checkbox"/> 751 Family and Medical Leave Act<br><input type="checkbox"/> 790 Other Labor Litigation<br><input type="checkbox"/> 791 Employee Retirement Income Security Act | <p><b>SOCIAL SECURITY</b></p> <input type="checkbox"/> 861 HIA (1395ff)<br><input type="checkbox"/> 862 Black Lung (923)<br><input type="checkbox"/> 863 DIWC/DIWW (405(g))<br><input type="checkbox"/> 864 SSID Title XVI<br><input type="checkbox"/> 865 RSI (405(g))  | <p><b>FEDERAL TAX SUITS</b></p> <input type="checkbox"/> 870 Taxes (U.S. Plaintiff or Defendant)<br><input type="checkbox"/> 871 IRS—Third Party 26 USC 7609 |

**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):*  
 Consolidated Omnibus Budget Reconciliation Act of 1985

Brief description of cause:  
 Violation of COBRA

**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: 11/17/2016    SIGNATURE OF ATTORNEY OF RECORD: /s/Brandon J. Hill

**FOR OFFICE USE ONLY**

RECEIPT # \_\_\_\_\_    AMOUNT \_\_\_\_\_    APPLYING IFP \_\_\_\_\_    JUDGE \_\_\_\_\_    MAG. JUDGE \_\_\_\_\_



AO 440 (Rev. 06/12) Summons in a Civil Action

# UNITED STATES DISTRICT COURT

for the

Southern District of Florida

JAMIE BRYANT

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)  
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\_\_\_\_\_  
*Plaintiff(s)*

v.

Civil Action No. \_\_\_\_\_

WAL-MART STORES, INC.

\_\_\_\_\_  
*Defendant(s)*

### SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* WAL-MART STORES, INC.  
C/O C T CORPORATION SYSTEM, RA  
1200 SOUTH PINE ISLAND ROAD  
PLANTATION, FL 33324

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff’s attorney, whose name and address are:

BRANDON J. HILL  
WENZEL FENTON CABASSA, P.A.  
1110 N. FLORIDA AVE.  
SUITE 300  
TAMPA, FL 33602

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: \_\_\_\_\_

\_\_\_\_\_  
*Signature of Clerk or Deputy Clerk*

Civil Action No. \_\_\_\_\_

**PROOF OF SERVICE**

*(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))*

This summons for *(name of individual and title, if any)* \_\_\_\_\_  
was received by me on *(date)* \_\_\_\_\_ .

I personally served the summons on the individual at *(place)* \_\_\_\_\_  
\_\_\_\_\_ on *(date)* \_\_\_\_\_ ; or

I left the summons at the individual's residence or usual place of abode with *(name)* \_\_\_\_\_  
\_\_\_\_\_, a person of suitable age and discretion who resides there,  
on *(date)* \_\_\_\_\_ , and mailed a copy to the individual's last known address; or

I served the summons on *(name of individual)* \_\_\_\_\_ , who is  
designated by law to accept service of process on behalf of *(name of organization)* \_\_\_\_\_  
\_\_\_\_\_ on *(date)* \_\_\_\_\_ ; or

I returned the summons unexecuted because \_\_\_\_\_ ; or

Other *(specify)*:

My fees are \$ \_\_\_\_\_ for travel and \$ \_\_\_\_\_ for services, for a total of \$ \_\_\_\_\_ 0.00 .

I declare under penalty of perjury that this information is true.

Date: \_\_\_\_\_

\_\_\_\_\_  
*Server's signature*

\_\_\_\_\_  
*Printed name and title*

\_\_\_\_\_  
*Server's address*

Additional information regarding attempted service, etc: