COBRA ELECTION FORM

Tuesday, February 01, 2008

Dear Elizabeth T Riley:

This notice contains important information about your right to continue your health care coverage in your company-provided medical (Kaplan Medical Group), vision, and dental plan (The Plan).

Please read the information contained in this notice very carefully.

To elect COBRA continuation coverage, follow the instructions on the next page to complete the enclosed Election Form and submit it to us.

If you do not elect COBRA continuation coverage, your coverage under the Plan will end on January 31, 2008 due to:

X___ End of employment
____ Death of employee
____ Entitlement to Medicare
____ Reduction in hours of employment
____ Divorce or legal separation
____ Loss of dependent child status

Each person ("qualified beneficiary") in the category(ies) checked below, who was covered under the Plan on the day before the qualifying event date, is entitled to elect COBRA continuation coverage, which will continue group health care coverage under the Plan for up to 18 months:

X___ 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

If elected, COBRA continuation coverage will begin on February 1, 2008 and can last until August 1, 2009. You may elect any of the following options for COBRA continuation coverage:

Health Plan	Coverage	Cost	Employee-Only
Blue Cross of California	Employee plus one dependent	$357.00	$255.00
Best Dental Group	Employee plus one dependent	$183.60	$122.40

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 this Election Form.

If you have any questions about this notice or your rights to COBRA continuation coverage, you should contact Sally H Administrator, 7560 Waterford Drive, Cupertino, CA, 95014, USA, 408-850-4975, support@auxillium.com.

COBRA CONTINUATION COVERAGE ELECTION FORM

INSTRUCTIONS: To elect COBRA continuation coverage, complete this Election Form and return it to us. Under federal law, you must 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: Sally H Administrator, 7560 Waterford Drive, Cupertino, CA, 95014, USA.

This Election Form must be completed and returned by mail, email or fax. If mailed, it must be postmarked no later than April 2, 2008.

If you do not submit a completed Election Form by the due date shown above, you will 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 furnish a completed Election Form before the due date. However, if you change your mind after first rejecting COBRA continuation coverage, your COBRA continuation coverage will begin on the date you furnish the completed Election Form.

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

I (We) elect COBRA continuation coverage in the Plan as indicated below:

	Name	Date of Birth	Relationship to Employee	SSN (or other identifier)	Coverage Option Elected
a.					
b.					
c.					
d.					

_______________________________________   _______________________________
Signature   Date

_______________________________________   _______________________________
Print Name   Relationship to individual(s) listed above

____

____

_______________________________________   _______________________________
Print Address   Telephone number

Prompt completion and return of this form will assure compliance with your request.