MISSED PREMIUM PAYMENT FORM

Please be sure the amount you are paying matches the full premium amount(s) due for your insurance coverage. Your payment must match the amount(s) due EXACTLY or the check will be returned to you.

We cannot accept overpayments or underpayments of premium.

INSTRUCTIONS

To make sure that your coverage is uninterrupted when a premium payroll deduction is missed:

1. Make copies of this form before filling it out so that you have a copy when needed.
2. Complete the form.
3. For each payroll deduction that was missed, you must attach a personal or cashier's check (or a money order) made payable to RSL Specialty Products Administration. If consecutive payroll deductions are missed, you must submit the total premium due for all missed payroll deductions.
4. Mail the form and your payment to the address below within 45 days from the date of the missed deduction.

IMPORTANT INFORMATION

- We will not accept a Missed Premium Payment if you are no longer part of the eligible group (for example: if your employment has been terminated).
- We will not accept a Missed Premium Payment after 45 days from the date of the missed deduction.
- If you have never had a premium payment deducted from your paycheck, you must submit a copy of your paycheck stub with your first Missed Premium Payment.
- We will not accept a Missed Premium Payment for more than eight (8) consecutive weeks of coverage, at which time your coverage will be canceled and you may be eligible for COBRA. See the topic "COBRA-Extended Coverage".
- We will not accept your Missed Premium Payment without a completed Missed Premium Payment Form and, when required, a copy of your paycheck stub.
- You may not select the coverage period. Premium will be applied to the earliest coverage period for which premium was not paid.

Remember: FAILURE TO PAY PREMIUMS, either through payroll deduction or by sending in a Missed Premium Payment, means that your insurance coverage is interrupted for that time period.

MISSED PREMIUM INFORMATION

Company Name: Craftwork's Holdings Inc

Employee Name:

Employee SSN:

Amount Enclosed: $

Please be sure the amount you are paying matches the full premium amount(s) due for your insurance coverage.

Employee Signature: _____ Date: _____

SEND THIS FORM along with your payment and a copy of your paycheck stub (when required) to:

RSL SPECIALTY PRODUCTS ADMINISTRATION
MISSED PREMIUM DEPARTMENT
505 S. LENOLA ROAD, SUITE 231
MOORESTOWN, NJ 08057