

January 19, 2016

**SENT VIA EMAIL AND US MAIL**

Office of Regulations and Interpretations,  
Employee Benefits Security Administration  
Room M-5655  
U.S. Dept. of Labor  
200 Constitution Avenue NW  
Washington D.C. 20210

Re: Claims Procedure Regulations for Plans Providing Disability Benefits  
RIN No.: 1210-AB39  
Regulation: 29 C.F.R. §2560.503-1

Dear Assistant Secretary Borzi:

We write to offer comments on the proposed regulations for amending the claims procedure regulations applicable to disability benefit plans. As attorneys whose practice focuses on the representation of claimants and litigants with respect to ERISA-governed plans including disability plans, we are interested in the content of these regulations. Based on our experience, we are in a knowledgeable position to comment about the practical impact of the proposed regulations.

We have organized our comments as follows. First, we address what we believe are the most important substantive issues for the DOL to address as it finalizes the proposed regulations. These comments relate to where we believe the DOL should make substantive changes. Second, we have set out what we see as the most important technical issues in the proposed regulations. These are matters that do not change the substance of a proposed regulation but language changes for purposes of greater clarity or conformity with other regulations. Finally, we have set out other issues of concern we have with the regulations and suggestions on how the DOL might address them

**I. Comments on Substantive Matters in the Proposed Regulations**

**Comment on Notice for Applicable Statute of Limitations**

The DOL has invited comment on the statute of limitations issues that have developed since the Supreme Court's decision in *Heimeshoff v. Hartford Life & Acc. Ins Co.*, 134 S.Ct. 604 (2013). We agree that this is a crucial area for regulation as the *Heimeshoff* decision has created confusion and spawned much litigation. The DOL can assist by creating standards for what is a reasonable plan-based limitations provision in the same way that the DOL used its regulatory power to create timing deadlines for the claims process in prior versions of the regulations. Because *Heimeshoff* left open the possibility that an internal limitations period could run before the appeals process is complete (even where exhaustion is mandatory), the DOL is in a good position to clarify that such an approach would violate the full and fair review required by 29

U.S.C. §1133. Additionally, because contractual limitations periods are plan terms, the claimant should receive notice about the limitations period from the plan just as is the case with other plan terms. As the DOL aptly points out in the preamble to these proposed regulations, plan administrators are in a better position to know the date of the expiration of the limitations period and should not be hiding the ball from claimants if the plan administrator is functioning as a true fiduciary.

Some courts have interpreted the existing regulations to require notice of the expiration of limitations periods. For example in *Chappel v. Laboratory Corp. of America*, 232 F.3d 719, 726-27 (9th Cir. 2000), the Ninth Circuit found that it would be a breach of fiduciary duty for an ERISA plan to fail to give notice in an appeal denial of the deadline to commence arbitration where arbitration was mandatory under the terms of the Plan. The Court found that such notice was required in the claims regulations' requirements for reasonable claims procedures and stated in relevant part:

The regulations implementing § 1133 require that a plan's internal claims procedures be "reasonable." 29 C.F.R. § 2560.503-1(b). ...Although the existing ERISA regulations do not specifically address arbitration, we believe that they provide guidance for a fiduciary seeking to create "reasonable" arbitration procedures. See 29 C.F.R. § 2560.503-1(b). Just as a fiduciary must give written notice to a plan participant or beneficiary of the "steps to be taken" to obtain internal review when it denies a claim, *id.* § 2560.503-1(f), so also, we believe, should a fiduciary give written notice of steps to be taken to obtain external review through mandatory arbitration when it denies an internal appeal.

A plan administrator knows, or should know, that a claimant may not be aware, when his or her internal appeal is denied, of a mandatory arbitration clause and a time limit for seeking arbitration, even though the clause and its terms are part of the contract for benefits . . . Given the consequences of an untimely request for arbitration, if a plan administrator does not bring to the claimant's attention, at the time the internal appeal is denied, the plan's arbitration requirement and the steps necessary to invoke the arbitration clause, the administrator cannot claim to be acting "solely in the interest of the participants and beneficiaries."

We therefore hold that Lab Corp, as Plan administrator, breached its fiduciary duty to Chappel if, as Chappel alleges, it adopted a mandatory arbitration clause that set a 60-day time limit in which to demand arbitration and then relied, for notice of the clause and its terms, on a summary plan description contained in an employment manual. It would have been a simple matter, when the Plan administrator sent a letter to Chappel notifying him of its denial of his appeal, for the administrator to have notified Chappel in that same letter of the arbitration clause and its required procedures. If the administrator had done that, it would have fulfilled its fiduciary duty to Chappel.

*Id.*; see also *Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, No. 4:12CV53 HEA, 2014 WL 562557, at \*4 (E.D. Mo. Feb. 13, 2014), *aff'd sub nom. Munro-Kienstra v. Carpenters' Health & Welfare Trust Fund of St. Louis*, 790 F.3d 799 (8th Cir. 2015). These cases interpret the existing regulations to determine what constitutes a reasonable claims process

when a plan implements its own time limits. Here, the DOL should do more than interpret its own rules; it should re-write them to remove any ambiguity. We recommend an amendment to the regulations governing the manner and content of the notification of benefit determinations on review. 29 C.F.R. §2560.503-1(j) [proposed regulation]. The amended language should require the claims administrator to notify the claimant of the precise date of the expiration of any plan based limitations period and should include a definition of what is a reasonable limitations period. Because it is not uncommon for a plan to send multiple letters to a claimant following denial of a claim, it is important for the notice in an appeal denial to clearly set forth the actual deadline rather than, for example, a deadline “running from the denial of the appeal.” This too is a simple requirement that could save participants from confusion and uncertainty regarding any time limits. Such an alteration takes care of the different courts’ views on when claims “accrue” in that it will make clear that no limitations period can start before the internal claim and appeals process is complete. It will also make clear that there will be at least a one-year period after the completion of the plan’s appeals process in which a claimant may file suit. This rule would cut down on litigation devoted to the threshold issue of the running of the limitations period. In addition, it may well lead to a standardization of internal limitations periods that would be salutary for both claimants and plan administrators.

Accordingly, we propose amending the proposed regulation by adding a section as follows and renumbering accordingly (added language is indicated by bolding and underlining):

29 C.F.R. §2560.503-1 (j) [proposed regulation]

(6) In the case of an adverse benefit decision with respect to disability benefits—

(i) A discussion of the decision, including, to the extent that the plan did not follow or agree with the views presented by the claimant to the plan of health care professionals treating a claimant or the decisions presented by the claimant to the plan of other payers of benefits who granted a claimant’s similar claims (including disability benefit determinations by the Social Security Administration), the basis for disagreeing with their views or decisions; and

(ii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

**(7) Where the plan includes its own contractual limitations period, the contractual limitations period will not be reasonable unless:**

**a. it begins to run no earlier than the date of the claimant’s receipt of the final benefit determination on review including any voluntary appeals that are taken;**

**b. it expires no earlier than 1 year after the date of the claimant’s receipt of the final benefit determination on review including any voluntary appeals that are taken;**

**c. the administrator provides notice to the claimant of the actual date that the contractual limitations period will run; and**

**d. the contractual limitations period does not abridge any existing state limitations period that provides for a period longer than one year.**

(8) In the case of an adverse benefit determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner (as described in paragraph (p) of this section).

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**Comment on Timing of Right to Respond to New Evidence or Rationales**

The DOL clearly wishes to improve things for claimants who are confronted with new rationales or evidence during review on appeal. We commend this effort, as this practice has been a persistent problem in the ERISA appeals process and some courts have not appreciated how prejudicial this is to claimants. In *Abram v. Cargill*, 395 F.3d 882, 886 (8th Cir. 2005), the court articulated the problem as follows:

[w]ithout knowing what “inconsistencies” the Plan was attempting to resolve or having access to the report the Plan relied on, Abram could not meaningfully participate in the appeals process. . . This type of “gamesmanship” is inconsistent with full and fair review.

*Id.* Given that it is often very hard to supplement the record in litigation, the proposed change offers some assurance that a claimant can contribute his or her relevant evidence to the record that the court will review. Where the claimant, as a plaintiff, has the burden of proof on most issues, this only makes sense. In most litigation contexts, the party with the burden of proof is given the last word. Here, giving the last word to the claimant during the claims appeal process is, in effect, giving claimant the right of rebuttal in litigation.

There is, however, a countervailing concern that while this extra opportunity to submit proof to the plan exists, claimants will be extending their time without benefit payments. This is a problem that already exists and could be exacerbated. Plans have protested that giving the claimant the last word will make the internal appeals processes go on forever. This argument is out of touch with the reality of being an ERISA disability benefits claimant. These claimants, in our experience, would not continue the process *ad nauseum* while they are unable to pay their mortgages and feed their families.

The following suggestion places reasonable limits on both claimants and plan administrators and responds to the concern that claimants will have to wait too long for determinations on review. While claimants will want to make fast work of their responses because they are usually without income during this process, the type of evidence they often need to respond to new evidence or rationales by the plan may require hiring an expert such as another physician, psychologist, or vocational consultant. These professionals are not always readily available for quick turn-arounds and, depending on the new information such experts are responding to, they may need weeks to evaluate the new information. For this reason, claimants should have at least 60 days to respond to new evidence or rationales provided by the plan on appeal. Moreover, the period for the decision on review to be completed should be tolled during this 60-day period.

When the claimant has responded, the plan administrator should be allowed whatever time was left under the existing regulations or 30 days, whichever is longer, to issue its determination on review. This rule should apply whether the new information is a new “rationale” or new “evidence.”

Accordingly, we suggest the following amendment to the proposed regulation (new language indicated by bolding and underlining):

2560.503-1(h)(4)(ii) [proposed regulations]

(ii) Provide that, before the plan can issue an adverse benefit determination on review on a disability benefit claim, the plan administrator shall provide the claimant, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the plan (or at the direction of the plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under paragraph (i) of this section to give the claimant a reasonable opportunity to respond prior to that date. **Such new evidence or rationale must be provided to claimant before the decision on appeal is issued and the claimant must be afforded up to 60 days to respond. The time to render a determination on review will be suspended while the claimant responds to the new evidence or rationale. After receiving the claimant’s response to the new evidence or rationale or notification that the claimant will not be providing any response, the plan will have whatever time was left on the original appeal resolution time period or 30 days, whichever is greater, in which to issue its final decision.**

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### **Independence and Impartiality - Avoiding Conflicts of Interest**

The proposed regulation regarding the impartiality of claims personnel is essential and we applaud the DOL’s effort to minimize the effect that biased individuals have on the claims and appeals process. However, the proposed regulation needs clarification in three areas.

First, the proposed regulation should make clear that impartiality is ensured, even where the plan itself is not directly responsible for hiring or compensating the individuals involved in deciding a claim. This clarification is necessary because, as a practical matter, plans frequently delegate the selection of experts to third-party vendors who, in turn, employ the experts.

Second, clarification is needed concerning which individuals are “involved.” Claims administrators often protest that physicians, or other consulting experts, are not “involved in making the decision” but merely supply information (such as an opinion on physical restrictions and limitations) that is considered by the claims adjudicator. Under this logic, plans may argue that consulting experts are not affected by the impartiality regulation.

Finally, the proposed regulation should make clear that claims adjudicators and consulting physicians are not the only individuals who must be impartial; vocational experts and accountants are also frequently used in the claims process and should be included in the scope of the impartiality requirement.

In light of these concerns, we suggest that the proposed regulation language be amended as follows (added language is bolded and underlined):

29 C.F.R. §2560.503-1(b)(7) [proposed regulation]

In the case of a plan providing disability benefits, the plan **and its agents, contractors, or vendors (such as any entities who supply consulting experts to plans)** must ensure that all claims and appeals for disability benefits are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision **or who are consulted in the process of making the decision.** Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual, (such as a claims adjudicator, **vocational expert, accounting expert,** or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

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### **Opportunity to Supplement the Record**

Although the EBSA has not chosen to regulate this, it should. Many meritorious disability claims are denied and the courts affirm these determinations because of issues regarding the scope of the record on review in the court. For instance, Social Security Disability Insurance (“SSDI”) decisions, which are the focus of some of the proposed rules, are often crucial to proving disability claims. However, the Social Security Administration (“SSA”) takes time in issuing its decisions and the SSA’s ruling may sometimes come after the final denial on appeal of the disability plan. This is true as well for other kinds of evidence. Even where it would not be a problem to do so, plan administrators often refuse to consider this type of evidence, choosing instead to shut the door on a meritorious claim. Meanwhile, plans will often counterclaim to recover the offset that is provided by the SSA benefit. *Metropolitan Life Ins. Co. v. Glenn*, 554 U.S. 105 (2008). Sometimes a claims administrator may rush through an appeal decision simply to avoid the claimant being awarded SSDI and having that evidence in the claims file. There is a clear solution to this that would track the Fifth Circuit’s *en banc* holding in *Vega v. National Life Ins. Serv., Inc.*, 188 F.3d 287, 300 (5th Cir. 1999), where the Court wrote:

We hold today that the administrative record consists of relevant information made available to the administrator prior to the complainant's filing of a lawsuit and in a manner that gives the administrator a fair opportunity to consider it. Thus, if the information in the doctors' affidavits had been presented to National Life before filing this lawsuit in time for their fair consideration, they could be treated as part of the record. Furthermore, in restricting the district court's review to evidence in the record, we are merely encouraging attorneys for claimants to make a good faith effort to resolve the claim with the administrator before filing suit in district court; we are not establishing a rule that will adversely affect the rights of claimants.

*Id.* In light of this holding from *Vega*, we recommend a rule that would require the plan administrator to accept and review evidence and treat it as part of the record, so long as it is sent in time for the administrator to consider the evidence before litigation is commenced.

## II. Comments on Technical Matters in the Proposed Regulations

### Effective Date of Proposed Regulation

To avoid the application of the previous regulations to disability claims that are already in process before the effective date, we suggest the following text be added:

**The regulations shall apply to all claims pending with the plan fiduciary on or after the date that the regulations go into effect.**

The holding in *Abram v. Cargill*, 395 F.3d 882 (8th Cir. 2005), was seriously undermined when the Eighth Circuit later concluded that its decision in *Abram* was grounded in the pre-2000 version of the claims regulations and would not apply to cases decided under the post-2000 claims regulations. See *Midgett Washington Group Int'l LTD Plan*, 561 F.3d 887, 894-96 (8th Cir. 2009). To avoid this sort of problem occurring again, the above suggested language should be added to the proposed regulations.

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### Notice of Right to Request Relevant Documents

The regulation concerning notice of the right to request relevant documents contained in 29 C.F.R. §2560.503-1(g)(1)(vii)(C) [proposed regulation] is an improvement since it was formerly missing from the regulation. However, it would be more helpful to claimants to use the words “claim file,” which is plain language and is consistent with the amendment at 29 C.F.R. §2560.503-1(h)(4)(i) [proposed regulation]. Attorneys understand the language of (g)(1)(vii)(C), but lay persons, who are the actual participants and often not represented, may not realize what rights are given here.

Accordingly, we suggest the following amendment to the proposed regulation (added language is underlined and bolded):

29 C.F.R. §2560.503-1(g)(1)(vii)(C)[proposed regulation]

A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to **the claimant's claim file, including** copies of all documents, records, and other information relevant to the claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to paragraph (m)(8) of this section.

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### Deemed Exhaustion Drafting Issue

This regulation should be edited to clarify that the deemed exhausted provision applies to both claims and appeals, not just “claims.” Presumably, if there is a violation of the regulations, the claimant can seek review regardless of whether the claim is in the “claim” or the “appeal” stage. We suggest the following clarifying language (added language is bolded and underlined):

29 C.F.R. §2560.503-1(l)(2)(i) [proposed regulation]

In the case of a claim for disability benefits, if the plan fails to strictly adhere to all the requirements of this section with respect to a claim **or appeal**,

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### **Deemed Exhaustion of Claims and Appeals Processes**

We are pleased that the DOL has undertaken to clarify the consequences that will result when the plan does not comply with the procedural requirements of the regulations. The DOL has wisely separated the consequences into two categories, *i.e.*, for serious violations and for minor violations. We see four areas that could be improved in the proposal.

First, the standard of judicial review that will apply requires clarification because there is a potential conflict between language in the preamble and the proposed regulation. The preamble says: “in those situations when the minor errors exception does not apply, the proposal clarifies that the reviewing tribunal should not give special deference to the plan's decision, but rather should review the dispute de novo.” (emphasis supplied). The underscored language clearly contemplates that a court should exercise *de novo* review. However, the regulation itself says: “if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.” 29 C.F.R. §2560.503-1(l)(2)(i) [proposed regulation] (emphasis supplied). We anticipate that plans will argue that this underscored language does not go far enough to require a court to exercise *de novo* review. For example, this language could mean simply that the plan did not make a decision and another plan review would be ordered rather than *de novo* judicial review. To avoid a potential ambiguity on this point, we suggest the following amendment to the proposed regulation (added language is bolded and underlined):

29 C.F.R. 2560.503-1(l)(2)(i) [proposed regulation]

if a claimant chooses to pursue remedies under section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary, **and the reviewing tribunal should not give special deference to the plan's decision, but rather shall review the dispute de novo.**

Second, the portion of the proposed regulation concerning refiled appeals requires clarification. The claimant whose appeal is refiled may need to supplement the record for the refiled appeal, because it is possible that his or her attempt to communicate with the plan was thwarted in some way. We suggest amending the regulation to require the plan to give the claimant notice of his or her right to supplement the appeal.

Third, there could be uncertainty arising from how to interpret the phrase “reasonable time.” It would be better to specify a period of time. Ten (10) days seems reasonable.

Finally, for the same reasons as described above with regard to the appropriate standard of judicial review, it would be beneficial to specify the standard of judicial review is *de novo* when

the court does not remand. We suggest the following amendment (added language is bolded and underlined, deleted language shown by strikeout):

29 C.F.R. 2560-503-1(l)(2)(ii) [proposed regulation]

If a court rejects the claimant's request for immediate review under paragraph (l)(2)(i) of this section on the basis that the plan met the standards for the exception under this paragraph (l)(2)(ii), the claim shall be considered as re-filed on appeal upon the plan's receipt of the decision of the court. Within ~~a reasonable time~~ **ten (10) days** after the receipt of the decision, the plan shall provide the claimant with notice of the resubmission **and notify the claimant of the right to supplement the appeal if she chooses. If the court accepts the claimant's request for immediate review, the court will retain jurisdiction and decide the case applying de novo review.**

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#### **Right to Claim File and Meaning of Testimony**

There is a lack of clarity concerning what manner of "testimony" is contemplated by the new regulations.

In the preamble to the proposed regulations, the DOL has stated: "the proposal would also grant the claimant a right to respond to the new information by explicitly providing claimants the right to present evidence and written testimony as part of the claims and appeals process." (emphasis supplied). Note the underscored language refers to "written testimony." But the actual proposed regulation uses this phrasing: "[the processes for disability claims must] allow a claimant to review the claim file and to present evidence and testimony as part of the disability benefit claims and appeals process." 29 C.F.R. §2560.503-1(h)(4)(i)[proposed regulation] (emphasis supplied). Here the regulation refers to "testimony" without limiting the type of testimony to "written" testimony.

By comparison, the current regulation uses the following language: "[the process must] provide claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits." 29 C.F.R. 2560.503-1(h)(ii)(2) [current regulation] (emphasis supplied).

Hence, there is an inconsistency between the preamble and the proposed regulation in that the preamble specifies "written testimony" whereas the proposed regulation just says "testimony." This could lead to costly disagreements over whether the regulation contemplates actual live testimony, *i.e.*, a hearing.

Furthermore, under the current regulation claimants sometimes submit testimony in the form of an audio or video CD. This is particularly useful in cases where the claimant cannot read or write so that a written statement is impossible. It is also helpful in those cases where actually seeing the claimant might be important. As such, we are concerned that the reference to "written testimony" in the preamble might give plans the ammunition to disallow any audio or video submissions on the grounds that these forms of evidence do not represent "written evidence." If this were the interpretation given to the language in the proposed regulation, it would actually put claimants in a worse position than they face at present.

Further, the proposed regulation's verbiage, *i.e.*, "evidence and testimony" could be interpreted to impose courtroom evidentiary standards for claimants submitting proof of their claim – something that is not normally applied in the ERISA context. Plans are in a position to observe rules of evidence as they have in-house counsel and other legal resources to rely upon to assure compliance with the rules of evidence. But claimants, who are often representing themselves, are not equipped to understand, much less apply, the usual evidentiary standards suggested by the phrase "evidence and testimony." The agency needs to make clear that it is not curtailing or narrowing the types of information that claimants may submit to the administrator.

### III. Other Issues of Concern with the Regulations

#### **Adverse Benefit Determination to Include Rescission**

An addition to the regulation that an adverse benefit determination includes an adverse decision on coverage is necessary. However, we question whether the definition of "rescission" in 29 C.F.R. §2560.503-1(m)(4)(ii) [proposed regulation] is sufficient to cover the situation where the plan asserts that coverage never existed in the first place. Coverage disputes regarding disability benefits should be appealable by the claimant as a matter of full and fair review. We suggest the following amendment (added language indicated by bolding and underlining):

29 C.F.R. §2560.503-1(m)(4)(ii) [proposed regulation]

In the case of a plan providing disability benefits, the term "adverse benefit determination" also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage **or any other repudiation of coverage** that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

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#### **Disclosure of Internal Rules etc.**

The DOL's proposed regulation regarding disclosure of the internal rules or criteria used to make a disability benefit decision, 29 C.F.R. §2560.503-1(g)(1)(vii)(B) [proposed regulation], is helpful because internal rules, guidelines, protocols, standards, claims manuals, and similar materials often create hidden plan terms that the claimant is unable to learn of or discover in order to address them in the appeal. As is true in the healthcare context, plans sometimes argue that internal criteria are confidential or proprietary. But keeping the rules that are used to administer a plan a secret is inconsistent with the most basic premise of ERISA. Benefits must be administered "in accordance with the documents and instruments governing the plan." 29 U.S.C. §1104. In addition, much litigation would be avoided if the claimant could know what criteria he or she needed to meet in an appeal. *See, e.g., Cook v. New York Times Co. Long-Term Disability Plan*, 2004 WL 203111, at \*10 (S.D.N.Y. Jan. 30, 2004); *Craig v. Pillsbury*, 458 F.3d 748, 754 (8th Cir. 2006)(decrying the use of "double-secret" plan terms); *Samples v. First Health Group Corp.*, 631 F. Supp. 2d 1174, 1183 (9th Cir. 2007). Given that the regulations require adverse benefit determinations to include the reasons for the denial and the applicable plan terms, this additional requirement should not be onerous and would promote

Assistant Secretary Borzi

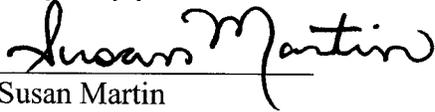
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the dialogue between claimant and plan that ERISA contemplates. *Booten v. Lockheed Med. Ben Plan*, 110 F.3d 1461, 1463 (9th Cir. 1997) (“in simple English, what this regulation calls for is a meaningful dialogue between ERISA plan administrators and their beneficiaries.”).

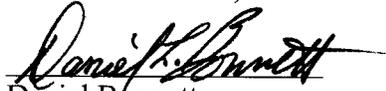
We appreciate the opportunity to comment on the proposed regulations and commend the DOL on its work.

Very truly yours,



Susan Martin

Martin & Bonnett, P.L.L.C.



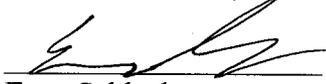
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