Principal Life
Insurance Company
Mailing Address:
711 High Street
Des Moines, Iowa 50392-0002

COBRA CONTINUATION OF GROUP HEALTH COVERAGE NOTIFICATION/ELECTION FORM

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Continuation of Group Health Coverage for Qualified Persons.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group plan allow qualified persons (described below) to continue group health coverage after it would otherwise end. The term "group health coverage" includes any medical, dental, vision care, and prescription drugs coverages that are included in the group health plan.

This form does not state:

(a) all of the terms of the plan.
(b) all of the terms of the plan which restrict coverage or benefits by condition or limitation.
(c) all of the terms required by law.

A complete description of plan provisions and benefits is outlined in the booklet certificate previously provided by the group planholder (employer).

A. **Qualified Persons/Qualifying Events.** Persons who qualify for COBRA continuation:

(1) A member (and any covered dependents) whose group health coverage ends due to: (a) termination of employment for a reason other than gross misconduct; or (b) a reduction in work hours. (Note: Taking a leave under the federal Family and Medical Leave Act (FMLA) is not a qualifying event under COBRA. A member qualifies for COBRA when the member does not return to work after completion of FMLA leave.)

(2) A member's former spouse (and any children) whose coverage ends due to divorce or legal separation.

(3) A member's surviving spouse and/or children whose coverage ends due to the member's death.

(4) A member's child whose coverage ends due to ceasing to be a dependent child under the terms of the plan.

(5) A member's spouse and/or children whose coverage ends if the member is enrolled under Medicare.

(6) A member's child who is born to or placed for adoption with the member who is on COBRA continuation due to termination of employment or reduction in work hours.

Exception: COBRA continuation is not available to any member or dependent who after the date of COBRA election becomes enrolled under Medicare or covered under another group health plan and has satisfied the preexisting exclusion provision.

Each qualified person (member or dependent) has independent COBRA election rights.

B. **Continuation Period.** Group health coverage can continue up to the maximum continuation period. The following are the maximum continuation periods:

(1) 18 months following a termination of employment or reduction in work hours for all qualified persons (members and their covered dependents).

Exception: Following a termination of employment or reduction in work hours, a qualified person may request an 11-month disabled extension of COBRA continuation. The maximum COBRA continuation will be 29 months (see section H for further information).

(2) 36 months for dependents following the death of the member, a loss of dependent status under the plan, or a divorce or legal separation.

Note: If coverage for a dependent was terminated in anticipation of a divorce or legal separation, the 36 months begins on the date of divorce or legal separation, provided the member or dependent notifies the planholder (employer) within 60 days of the qualifying event.

(3) When a member becomes enrolled under Medicare before employment terminates, work hours are reduced, or a decision to drop group coverage, the maximum continuation period for the dependents will be the longer of:

(a) 36 months dating back to the member's enrollment under Medicare; or

(b) 18 months from the date of the qualifying event (termination of employment, reduction in work hours, or decision to drop group coverage).

(4) For a member's child that is born to or placed for adoption with the member while on COBRA continuation, the maximum continuation period for that child will be the member's maximum continuation period.

(5) If any of the qualifying events described in A(2) through A(5) above occur during the 18-month continuation period (or 29 months for qualified persons on the disabled extension), such period may be extended for the qualified dependents to 36 months dating from the member's termination of employment or reduction in work hours. The extension is only available if the second qualifying event described in A(2) through A(5), absent the first qualifying event, results in a loss of coverage for dependents under the group health plan. A member's child who is born to or placed for adoption with the member who is on COBRA continuation may also be eligible for a second qualifying event that occurred prior to birth or placement for adoption. Requests for the extended continuation period must be sent to Principal Life Insurance Company within 60 days after the occurrence of any qualifying event.

C. **Termination of COBRA Continuation.** COBRA continuation ends the earliest of the following:

(1) The date the maximum continuation period ends.

(2) The date the qualified person becomes enrolled under Medicare.

(3) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan.

(4) The end of the last coverage period for which payment was made if payment is not made before the grace period ends (see item F below).

(5) The date the planholder's (employer's) group health plan is terminated. (The continuation period may be completed under the replacement plan, if any.)

D. **Monthly Cost.** Qualified persons who elect COBRA continuation are required to pay the entire cost for the continued coverage as well as an additional 2% billing fee as allowed by COBRA. Persons who qualify for the disabled extension and are not part of the family unit that includes the disabled person are required to pay the entire cost for the continued coverage as well as an additional 2% billing fee during the disability extension. Persons who qualify for the disabled extension and are part of the family unit that includes the disabled person are required to pay 148% of the entire cost plus the 2% billing fee for the 19th through the 29th month of coverage (or through the 36th month if a second qualifying event occurs during the disabled extension).

E. **Election Requirement.** Qualified person(s) must make written election within 60 days after the later of: (1) the date group health coverage would otherwise end; or (2) the date of the planholder's (employer's) notice. The election form must be returned to Principal Life within 60-day period; otherwise, the COBRA continuation option expires.

F. **Grace Period.** Qualified persons have 45 days after the initial election to remit the first payment. All other payments (except for the first payment) will be timely if made within 30 days following the due date (date of statement), or within the grace period of the plan if it is longer than 30 days. (Longer grace periods are not available in Nevada.) Claims will only be honored through the last date paid.

G. **Plan Changes.** Continued group health coverage(s) will be subject to the same benefit and rate changes that apply to the group plan. Principal Life will notify qualified persons of any plan changes by a notation on the statement on which the change is reflected. Contact the group planholder (employer) for details on these changes. Qualified persons have the same open enrollment rights offered to active members under the group health plan.

H. **Disabled Extension.** Following a termination of employment or reduction in work hours, a qualified person (member or dependent) who has been determined disabled by the Social Security Administration either before or within 60 days after a qualifying event may request an extension of COBRA continuation from 18 months to 29 months. A member's child who is born to or placed for adoption with the member who is on COBRA continuation may also qualify for the disabled extension if the Social Security Administration has determined the child disabled within 60 days after the date of birth or placement for adoption. The disabled extension applies to each qualified person (the disabled person or any family member), who is entitled to COBRA continuation as a result of termination of employment or reduction in work hours.

The new qualified person must submit a written request for the extension to the planholder (employer) within: (a) 60 days after receiving the Social Security determination; and (b) before the 18-month continuation period ends; otherwise the right to the 11-month extension expires. The 11-month extension for all qualified persons will end the earlier of: (a) 30 days following the date the disabled person is no longer determined by Social Security to be disabled; or (b) the date COBRA continuation would normally end (see item C).

I. **Newly Acquired Dependents.** A qualified person may elect coverage for a dependent acquired during COBRA continuation. All enrollment requirements that apply to dependents of active members apply to dependents acquired by qualified persons during COBRA continuation. Qualified persons must apply to Principal Life for coverage for newly acquired dependents. Refer to the booklet certificate for provisions regarding dependent eligibility and effective dates.

Coverage for newly acquired dependents will end on the same dates as described in Section C. Exception: Coverage for newly acquired dependents, other than a member's dependent child who is born to or placed for adoption with the member, will not be extended as a result of a second qualifying event described in B (5).

J. **Other Group Health Coverage or Medicare.** If during the continuation period, a qualified person becomes enrolled under Medicare or becomes covered by and has satisfied the preexisting exclusion provision of another group health plan, COBRA continuation will terminate. Any payment of benefit after COBRA continuation should have otherwise been terminated will be considered to be a benefit overpayment. Qualified persons are required to repay any benefit overpayment.

K. **Individual Purchase (Conversion).** When a qualified person is no longer eligible for COBRA continuation, he/she may apply for Individual Purchase if available under the group health plan. Persons who are eligible for similar benefits which would result in over-insurance or whose COBRA continuation ends because payment was not made timely may not purchase conversion. Application for Individual Purchase, and payment of the required premium, must be made within 31 days after COBRA continuation ends. Individual Purchase coverage may not duplicate your prior coverage.

Mailing Address:
711 High Street
Des Moines, IA 50392-0002

Principal Life Insurance Company

COBRA Continuation Election Form

Planholder (Employer) to Complete this Section Before Giving to Qualified Person.

Planholder's/employer's name ______________________ Account number ______________________

Planholder's/employer's address ______________________

Member's name ______________________ Social security number ______________________

Qualified person's name ______________________

Relationship to member: self spouse child(ren) former spouse

Qualifying event ______________________ Date of qualifying event ______________________
(Termination of employment, divorce, etc.)

If applicable, the date the member is enrolled under Medicare ______________________

Is termination of employment or reduction of work hours due to disability? yes no

If yes, has the qualified person applied for social security due to disability? yes no

If yes, please refer to item H of this form and advise the qualified person to notify you within 60 days of receiving the Social Security Notice of Determination and prior to the end of the 18-month continuation period in order to qualify for the 11-month extension of COBRA.

Date group health coverage would normally terminate for the qualified person based on plan provisions ______________________

Qualified person's coverage at time of qualifying event: (check boxes) Were dependents also covered?

medical dental vision prescription drugs yes no

If a state-mandated continuation applies to your group plan, the qualified person also needs to be offered the state-mandated continuation.

Your Monthly Cost is as Follows:

Member	Dependent(s)	Total	
$	$	$	Medical and/or prescription drugs
$	$	$	Dental
$	$	$	Vision
$	$	$	Subtotals
$	$	$	+ 2% COBRA administrative fee
		$	Total monthly cost

For single dependents electing COBRA continuation, the rate charged will be the member only rate.

Grace period for payments, other than your first payment, is 30 days (or your group plan's grace period, if longer).

The date the qualified person has been provided this form (notice) ______________________

______________________ ______________________
Authorized signature of planholder/employer Date signed

Qualified Person(s) Electing COBRA Continuation, Please Read this Section Carefully.

Election and Payment Schedule. If you decide to continue group health coverage, please sign this form and return it to Principal Life Insurance Company within 60 days after the later of: (a) the date group health coverage would otherwise end; or (b) the date of this form (notice). It is your responsibility to pay monthly payments (plus the 2% monthly billing fee) by check or money order made payable to Principal Life Insurance Company. It is suggested that you submit the full cost for the period from the date coverage would otherwise end through the current month with this form. **Claims will only be honored through the last date paid.** However:

1. You have 45 days after the initial election of COBRA to remit the first payment.
2. Payment for any following month of continued group health coverage must be paid no later than 30 days following the first day of each month, or within the group plan's normal grace period (whichever is greater).

Qualified Person to Complete this Section.

1. Coverage is to be continued: ☐ yes ☐ no

   If "yes" is checked, please complete the items below. If "no" is checked, please sign and date this form and return it to the planholder (employer).

   Note: If you are rejecting COBRA continuation for yourself and/or your family, your spouse must also sign where indicated.

2. Coverage is to be continued for (please check one): ☐ member only
☐ member and dependents (list below)
☐ dependent(s) only (list below)

3. Coverages to be continued: ☐ medical ☐ prescription drugs ☐ dental ☐ vision care

   Note: You must have been covered for these coverages before you became eligible for COBRA in order to continue them.

4. The coverage(s) checked above is (are) to be continued for the following person(s).

   Note: Current dependents may be continued only if they were covered under the group health plan. Dependents acquired during the continuation period may be eligible for coverage. Please refer to item I of this form.

Name	Date of birth	Sex	Relationship to member	Social security number

5a. Are you or any of your dependent listed above currently covered under another group health plan?

☐ yes ☐ no If yes, please list names. ______________________________

____

b. Are you or any of your dependents listed above currently enrolled under Medicare?

☐ yes ☐ no If yes, please list names. ______________________________

____

Name of person carrying the other group health plan or who is enrolled under Medicare ____________________

Name of group (employer, association, etc.) ____________________

Name of insurance company or plan ____________________

Policy or plan number ____________________

Effective date of other group health plan or enrollment under Medicare ____________________

Address of other insurance company's claim office ____________________

6. Have you or any of your dependents been determined disabled by the Social Security Administration? ☐ yes ☐ no

   If yes, please provide the following information:

   Name of person disabled ____________________

   Relationship to member ____________________

   Date of Social Security determination ____________________

   (Please attach copy of the Social Security Notice of Determination)

7. Qualified person's mailing address where statements should be mailed: ____________________

   Name ____________________

   Street ____________________

   City, state, and ZIP code ____________________

8. Home telephone number: ( ) ____________________
   Area code

   Work telephone number: ( ) ____________________
   Area code

I hereby certify that to the best of my knowledge the above statements are correct. I understand that omissions or misstatements regarding eligibility could cause an otherwise valid claim to be denied and void the contribution.

I have read and understand the COBRA guidelines as outlined at the beginning of this form.

Qualified person's signature ____________________ Date signed ____________________

If you are **rejecting** COBRA continuation for yourself and/or your family, please have your spouse sign below.

Qualified person's signature ____________________ Date signed ____________________

Please return this completed and signed election form (and initial payment) to:

Principal Life Insurance Company
Attn Group Operations
Mailing Address:
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Des Moines, Iowa 50392-0002