Print

Principal®

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

COBRA and State – Continuation of Group Health Coverage for Qualified Persons

Complete this form on all transfer cases that currently insure any individual(s) under the COBRA or State Continuation provisions. Note: If the continuation began after the effective date of your group plan with Principal Life Insurance Company, this form should not be used. Please refer to your Administration Guide for further instructions. Please complete one form per continued individual or family.

Account number _____ (home office to complete)

1. Name of employer: _____

2. Prior carrier: _____

3. Continuee's relationship to employee: ☐ self ☐ spouse ☐ child

4. Continuee's name: _____

   Home address: _____

   _____

   _____

   Phone Number: ( ) _____ ☐ male ☐ female

   Date of birth: _____ Social security number _____

5. Reason for Continuation: (check one)

   ☐ employment termination
   ☐ disability
   ☐ reduction in work hours
   ☐ ex-spouse of employee
   ☐ surviving dependent(s) of employee
   ☐ dependent child's age exceeds eligibility
   ☐ other (explain) _____

   Note: Continuation is not available to any person who is covered under another group health plan. For COBRA (and under most State Continuation laws) continuation may not be available to any person who is entitled to Medicare. Are any of the persons listed for continuation currently covered under another group policy or Medicare? ☐ yes ☐ no

6. Date continuation started with prior carrier: month _____ day _____ year _____

7. Check coverages continued under the prior carrier:

   ☐ dental ☐ vision

8. Benefits were continued for: (check applicable boxes) ☐ employee ☐ spouse ☐ children

Dependent's name	Date of birth	Social security number

9. If State Continuation is applicable; please indicate the state: _____