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 of employee entitled to Medicare
   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:

   medical dental prescription drugs 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: ______________________