Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

COBRA Continuation of Group Health Coverage Notification/Election Form

When applicable, 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 or by contacting the plan administrator.

(A) Qualified Persons/Qualifying Events. Continuation of group health coverage must be offered to the following persons if they would otherwise lose that coverage as a result of the following qualifying events:

(1) A member (and any covered dependents) whose group health coverage ends due to the member's: (a) termination of employment for a reason other than gross misconduct; or (b) a reduction in work hours.

Reduction in work hours includes, but is not limited to, leave of absence, layoff, continuation due to sickness or injury, or when applicable, retirement.

(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 the end of FMLA leave.)

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

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

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

(5) A member's dependent 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.

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

(1) From the date of the qualifying event, 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 from the date of the qualifying event (see section H for further information).

(2) From the date of the qualifying event, 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.

(3) For a member's dependent 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.

(4) If any of the qualifying events described in A(2) through A(4) 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(4), absent the first qualifying event, would result 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.

(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; however, this does not apply to a person who is already enrolled in Medicare on the date he/she elects COBRA.

(3) The date the qualified person becomes covered by and has satisfied the preexisting exclusion provision of another group health plan; however, this does not apply to a person who is already covered by the other group health plan on the date he/she elects COBRA.

(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 E below).

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

Note: Persons who, after the date of COBRA continuation election, become entitled to Medicare or become covered under another group health plan and have satisfied the preexisting exclusion provision, are not eligible for continued coverage.

(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) Grace Period. Qualified persons have 45 days after the initial election to remit the first payment. The first payment must include all payments due when sent. All other payments (except for the first payment) will be timely if made within 30 days following the due date (date of monthly statement), or within the grace period of the plan if it is longer than 30 days. (Longer grace periods are not available in Nevada.) Qualified persons are responsible for making sure premium is paid timely and correctly. The amount due for the initial monthly payment is reflected in this notice. Claims will be honored through each coverage period as long as payment is received before the end of the grace period. If payment is received after the due date, but before the end of the grace period, claims will be suspended as of the due date until payment is received. Coverage will be retroactively reinstated when payment is received.

If payment is not received before the end of the grace period, the right to COBRA continuation ends.

(F) Qualified Person Notice and Election Requirements. Qualified persons must notify the plan administrator of a qualifying event within 60 days after: (a) the date of a qualifying event (i.e., divorce, legal separation, a child ceases to be a dependent child under the terms of the group health plan); (b) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (c) the date the qualified person is first informed of this notice obligation; otherwise the right to COBRA continuation period ends. This 60-day notice period applies to initial and second qualifying events.

Qualified person must make written election within 60 days after the later of: (1) the date group health coverage would normally end; or (2) the date of the plan administrator's election notice. The election notice must be returned to the plan administrator within this 60-day period; otherwise the right to elect COBRA continuation ends.

If you initially reject COBRA, qualified persons may elect COBRA if written election is made to the plan administrator within the 60-day election period.

Each qualified person has an independent right to elect COBRA. A covered member may elect COBRA continuation on behalf of his/her covered spouse. A covered member, parent, or legal guardian may elect COBRA continuation on behalf of is/her covered dependent children.

Qualified persons who request an extension of COBRA due to disability must submit a written request to the plan administrator before the 18-month COBRA continuation period ends and within 60 days after the latest of the following dates: (a) the date of disability determination by the Social Security Administration; (b) the date of the qualifying event; (c) the date the qualified person would otherwise lose coverage as a result of a qualifying event; or (d) the date the qualified person is first informed of the notice obligation; otherwise the right to the disabled extension (described in item H on this page) ends. Qualified persons must also notify the plan administrator within 30 days after the date the Social Security Administration determines the qualified person is not longer disabled.

Notification of a qualifying event must be in writing and must include the following information: (a) name and identification number of the member and each qualified beneficiary; (b) type and date of the qualifying event; (c) if the notice is for an extension due to disability, a copy of any letters from the Social Security Administration and the Notice of Determination; and (d) the name, address and daytime phone number of the qualified person (or legal representative) that the plan administrator may contact if additional information is needed to determine COBRA rights.

To protect COBRA rights, the plan administrator must be informed of any address changes for covered members and dependents. Retain copies of any notices sent to the plan administrator.

(G) Plan Changes. Continued group health coverage(s) will be subject to the same benefit and rate changes that apply to the group plan. Qualified persons may elect different plan offerings available under the group health plan during the open enrollment period (i.e., switch from an indemnity plan to an HMO 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 the 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 also applies to each qualified person (the disabled person or any family member), who is not disabled and who is on COBRA continuation as a result of termination of employment or reduction in work hours.

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 and notification 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 B. Exception: Coverage for newly acquired dependents, other than a member's dependent child who is born to or placed for adoption with the member under A(5), will not be extended as a result of a second qualifying event described in B (4).

(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) Health Insurance Portability and Accountability Act (HIPAA) Rights. Failure to elect COBRA continuation will affect the following future rights and protections under HIPAA: (1) Preexisting condition exclusions may be applied by other group health plans if there is more than a 63-day gap in coverage; and (2) Guarantee issue of an individual policy without a preexisting condition exclusion will not be available if the qualified person does not maintain COBRA through the maximum continuation period. Under HIPAA, qualified persons may also have special enrollment rights under another group health plan for which he/she is otherwise eligible. Requests for special enrollment rights must be made within 30 days of the date group health coverage ends due to a qualifying event or when the maximum COBRA continuation period ends.

(L) Contact Information. To notify the plan administrator of a second qualifying event, request for disability extension, request termination of COBRA, change of address, or request additional information concerning the group health plan, COBRA, or HIPAA, contact the following:

Group health plan: _____

Contact name/area: _____

Address: _____

Phone number: _____

Plan Administrator to Complete this Section Before Giving to Qualified Person.

Plan administrator's name | Account number

Plan administrator's address

Contact name/area | Phone number

Member's name | Social security number

Qualified person's name

Relationship to member: ☐ self ☐ spouse ☐ children ☐ 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.

If COBRA is not elected, the date group health coverage would normally terminate for the qualified person based on plan provisions _____.*

* *(If group health coverage ends ON THE DATE the member and/or dependent ceases to be eligible for coverage as outlined on the plan provisions, this date is also the date of the qualifying event. Please refer to your booklet certificate for this information.)*

Qualified person's coverage at time of qualifying event: (check boxes)

☐ dental ☐ vision

Were dependents also covered?

☐ 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	
$	$	$	Dental
$	$	$	Vision
$	$	$	Subtotals
$	$	$	+ 2% 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 plan administrator | date signed

Date election for COBRA is due _____

Print

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

Please read carefully the information contained in this Notification/Election Form. Important information concerning your rights, notice obligations, election and payment requirements under COBRA are provided in this form. Failure to comply with the information contained in this Notification/Election Form will affect your right to elect COBRA.

If you decide to continue group health coverage, please sign this form and return it to the plan administrator prior to the date election for COBRA is due (listed in this form). If you do not submit a completed Election Form by the COBRA election due date, you will lose the right to elect COBRA. If you reject COBRA before the due date, but later wish to elect, you must furnish a completed Election Form to the plan administrator before the COBRA election due date.

It is your responsibility to pay monthly payments (plus the 2% monthly billing fee) by check or money order made payable to the plan administrator (employer). The first payment must include all payments due when sent. 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 plan administrator (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: ☐ 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

5.a 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:

   _____

8. Home telephone number: (____) _____ Work telephone number (____) _____
   area code 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 the plan administrator's address listed at the beginning of the Election Form.