Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Change Form

Company name | Account/Unit number

Employee Information *(Change of name and address)*

Your name (Last) (First) | Social security number

New name (Last) (First)

New address* (Street) (City) (State) (ZIP)

**New address information is only needed if you have medical, dental or vision*

Complete for Adding, Cancelling or Changing* a Coverage

Medical → ☐ add ☐ employee ☐ spouse ☐ children
☐ cancel ☐ employee ☐ spouse ☐ children
☐ change to: ______

Dental → ☐ add ☐ employee ☐ spouse ☐ children
☐ cancel ☐ employee ☐ spouse ☐ children
☐ change to: ______

Vision → ☐ add ☐ employee ☐ spouse ☐ children
☐ cancel ☐ employee ☐ spouse ☐ children
☐ change to: ______

Term Life → ☐ add ☐ employee ☐ spouse ☐ children
☐ cancel ☐ employee ☐ spouse ☐ children

Voluntary Life → ☐ add ☐ employee ☐ spouse ☐ children
☐ cancel ☐ employee ☐ spouse ☐ children
☐ change to: ______

Supplemental Term Life → ☐ add
☐ cancel
☐ change to: ______

Short Term Disability → ☐ add ☐ cancel
occupation: ______

Long Term Disability → ☐ add ☐ cancel
occupation: ______

Complete if the coverage you are adding or changing is based on your salary → Salary $ ______
☐ yr ☐ bi-wkly
☐ mo ☐ wkly ☐ hr

* If "change to" is elected provide the date → Date of change __/__/__

Have you or your spouse used nicotine products within the last 12 months? Employee ☐ yes ☐ no Spouse ☐ yes ☐ no

Employee $ ______ or ____ X salary Spouse $ ______

Reason for Adding a Coverage or Dependent

☐ marriage
☐ birth/adoption
☐ loss of other group coverage*
☐ court order (attach a copy)
☐ open enrollment* (medical only)
☐ other ______

Date of event __/__/__

**For Loss of other group coverage and open enrollment, you must complete the following*

Name of prior medical carrier ______ Date coverage ended __/__/__

Name of prior dental carrier ______ Date coverage ended __/__/__

Name of prior life carrier ______ Date coverage ended __/__/__

Reason for Cancelling a Coverage or Dependent

☐ divorce
☐ age limit
☐ spouse's group coverage
☐ other ______
☐ individual insurance
☐ Medicare

Date of request/ineligibility __/__/__

Beneficiary Designation *(Complete if adding life coverage or changing beneficiary)*

Full name | Relationship

If two or more beneficiaries are named, proceeds will be paid in equal shares to the surviving beneficiaries unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the Group Policy.

You must complete both sides of the form.

(AK, AZ, CA, CO, CT, DE, IN, KS, MD, MN, MO, MT, NE, NV, NC, ND, OK, SC, TX)

Complete for Adding or Cancelling a Dependent *(Include last name if different from the employee)*

Spouse's name	Birth date		Social security number	
	/ /	☐ male ☐ female		
Name(s) of child(ren)	/ /	☐ male ☐ female		☐ foster child*
	/ /	☐ male ☐ female		☐ foster child*
	/ /	☐ male ☐ female		☐ foster child*
	/ /	☐ male ☐ female		☐ foster child*

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time?
☐ yes ☐ no

To determine eligibility for handicapped children (over the maximum age), see your employer for the required forms.

Employee Signature *(Read and sign below)*

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including stepchildren, foster children and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- **If I cancel medical coverage for myself and/or my dependents, and then request coverage at a later date, I and/or my dependents will be considered a late enrollee. As a late enrollee, I and/or my dependents may not enroll until the next annual open enrollment period and/or may be subject to the preexisting condition exclusion. (Exception: in MD and MN, the annual open enrollment period does not apply. Late enrollees will be subject to the preexisting condition exclusion.) However, I will not be considered a late enrollee for employee and/or dependent coverage (and will not have to wait until the next annual open enrollment period) if: (a) enrollment is requested under one of the special enrollment rights; (b) request is made within the time period specified for that special enrollment right; and (c) any required information or proof is furnished. Refer to your booklet for more details.**
- If I cancel dental coverage, I and/or my dependents may enroll at a later date; however, enrolling late will affect the level of dental benefits.
- If I cancel any type of life and/or disability coverage, I may apply at a later date; however, I must provide proof of good health at my own expense and coverage will only become effective subject to approval from Principal Life Insurance Company (The Principal®).
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the Group Policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- If I knowingly provide false or misleading information, I may be guilty of insurance fraud, which is punishable by law.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

California: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

I declare that the information I have completed on this change form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from The Principal.

Your signature X ______________________ **Date signed** ___/___/___

Note - Make two copies: one for employer and one for employee

(AK, AZ, CA, CO, CT, DE, IN, KS, MD, MN, MO, MT, NE, NV, NC, ND, OK, SC, TX)