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
	change to: ______			
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
other ______

loss of other group coverage*
court order (attach a copy)

Date of event ______

**For loss of other group coverage 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 Page 1 and Page 2.

(AL, AR, DC, FL, GA, HI, ID, IL, KY, LA, MA, ME, MI, MS, NH, NJ, NM, NY, OH, OR, PA, RI, SD, TN, UT, VA, VT, WV, WA, WI, WY)

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 *(except for Florida)*

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. *(except for Florida)*
- **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. 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.
- 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. *(except for Virginia)*

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.

District of Columbia: Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Virginia: Any person who, with the 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 have violated state law.

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 Principal Life.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Your signature ______________________ **Date signed** ____________

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

(AL, AR, DC, FL, GA, HI, ID, IL, KY, LA, MA, ME, MI, MS, NH, NJ, NM, NY, OH, OR, PA, RI, SD, TN, UT, VA, VT, WV, WA, WI, WY)