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, Canceling 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: _____

In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no

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

Reason for Canceling a Coverage or Dependent

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

Date of request/ineligibility

You must complete Page 1 and Page 2 of this form.

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

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.

Complete for Adding or Canceling 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.
- 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.

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 Principal Life.

Your signature **X** _____ **Date signed** _____

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

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

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