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, middle initial) | Social security number

New name (last, first, middle initial)

Your new address (street) | (city) | (state) | (ZIP)

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 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: _____

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

Employee $ _____ or _____ X salary Spouse $ _____

Reason for Adding a Coverage or Dependent

Date of event

☐ marriage ☐ loss of other group coverage* ☐ court order (attach a copy)
☐ birth/adoption ☐ annual enrollment (if available) ☐ other _____

*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

Name of prior vision carrier | Date coverage ended

You must complete Page 1, Page 2 and Page 3 of this form.

(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, WA, WI, WV, WY)

Reason for Canceling a Coverage or Dependent 110

Date of request/ineligibility

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

Beneficiary Designation

Complete Beneficiary Designation/Change (GP 34795) if adding life coverage or changing beneficiary.

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, was the child placed with you by an authorized state placement agency or by order of a court? ☐ 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. (except for Florida)
- **If I cancel medical coverage for myself or my dependents, and then request coverage at a later date, I and my dependents will be considered a late enrollee. As a late enrollee, I or my dependents may not enroll until the next annual open enrollment period or may be subject to the preexisting condition exclusion. However, I will not be considered a late enrollee for employee 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 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 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.

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.

Ohio: 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 is guilty of insurance fraud.

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.

Print

Employee Signature (continued) **110**

Tennessee: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

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.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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.

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 York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for **accident and health** 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 **X** _____ **Date signed** _____

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