



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**

<b>Medical</b>	add	employee	spouse	children	<b>Supplemental Term Life</b>	add
	cancel	employee	spouse	children		cancel
	change to: _____					change to: _____

<b>Dental</b>	add	employee	spouse	children	<b>Short Term Disability</b>	add
	cancel	employee	spouse	children		cancel
	change to: _____					occupation: _____

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

<b>Vision</b>	add	employee	spouse	children	<b>Long Term Disability</b>	add
	cancel	employee	spouse	children		cancel
	change to: _____					occupation: _____

<b>Term Life</b>	add	employee	spouse	children	Complete if the coverage you are adding or changing is based on your salary:	Salary \$ _____
	cancel	employee	spouse	children		yr    bi-wkly
	change to: _____					mo    wkly    hr

<b>Voluntary Life</b>	add	employee	spouse	children	*If "change to" is elected, provide the date: _____
	cancel	employee	spouse	children	
	change to: _____				

Have you or your spouse used nicotine products within the last 12 months?    Employee    Spouse

Employee \$ _____ or _____ X salary	yes	no	yes	no
Spouse \$ _____				

**Reason for Adding a Coverage or Dependent**

marriage	loss of other group coverage*	open enrollment* (medical only)	Date of event _____
birth/adoption	court order (attach a copy)	annual enrollment (if available)	other _____

\*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 _____
Name of prior vision carrier _____	Date coverage ended _____

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)

**Reason for Canceling a Coverage or Dependent**

**110**

divorce spouse's group coverage Medicare  
age limit individual insurance other \_\_\_\_\_

Date of request/ineligibility \_\_\_\_\_

**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	male	female	Social security number
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 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. (Exception: in 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 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.

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**