Principal Life Insurance Company

Mailing Address: Des Moines, IA 50392-0002

Employee Change Form - CA

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Account/unit number

Employee Information (Change of name and address)

Your name (last, first, middle initial)	Date of Birth	Social security number

New name (last, first, middle initial)

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

Home phone number	Email address

Complete for Adding, Canceling or Changing a Coverage. If this is initial enrollment, please complete an Enrollment Form. NOTE: Employee coverage must be elected to elect any dependent coverage.

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner*	Child(ren)
Dental	Add Cancel Change to: ____ Change to date: ____	Add Cancel Change to: ____ Change to date: ____	Add Cancel Change to: ____ Change to date: ____
	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 Cancel Change to: ____ Change to date: ____	Add Cancel Change to: ____ Change to date: ____	Add Cancel Change to: ____ Change to date: ____
Group Term Life	Add Cancel Change to: ____ Change to date: ____	Add Cancel Change to: ____ Change to date: ____	Add Cancel Change to: ____ Change to date: ____
Supplemental Term Life	Add Cancel Change to: ____ Change to date: ____		

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner*	Child(ren)
Voluntary Term Life (VTL)	Add Cancel Change to: ______ Change to date: ______ $ ______ or ______ X salary	Add Cancel Change to: ______ Change to date: ______ $ ______	Add Cancel Change to: ______ Change to date: ______
Short Term Disability	Add Cancel Occupation: ______ Change to: ______ Change to date: ______ $ ______		
Long Term Disability	Add Cancel Occupation: ______ Change to: ______ Change to date: ______ $ ______		
Critical Illness	Add Cancel Change to: ______ Change to date: ______ $ ______	Add Cancel Change to: ______ Change to date: ______ $ ______	Add Cancel Change to: ______ Change to date: ______
Accident	Add Cancel Change to: ______ Change to date: ______	Add Cancel Change to: ______ Change to date: ______	Add Cancel Change to: ______ Change to date: ______

If you are applying for critical illness coverage, do you or your eligible dependents have other benefits from an individual or group policy or contract that arranges for or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans in force as of the date of this application for critical illness coverage?
NOTE: Critical Illness coverage cannot be issued to a person who does not have such insurance in force.
employee: yes no spouse or state registered domestic partner or nonregistered domestic partner: yes no

Complete if the coverage you are adding or changing is based on your salary.

Salary $ ________________ yearly bi-weekly monthly weekly hourly

* Nonregistered Domestic Partners can only be added if your employer allows this coverage. If adding a Nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60603).

Nicotine Products

Has any person used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?

Employee: yes no Spouse or State registered domestic partner or Nonregistered domestic partner: yes no

Reason for Adding a Coverage or Dependent

Date of event

marriage loss of other group coverage* open enrollment*
birth/adoption court order (attach a copy) change in job status
annual enrollment (if available) other ________________

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

Name of prior dental carrier	Date coverage ended
Name of prior life carrier	Date coverage ended
Name of prior vision carrier	Date coverage ended

Reason for Canceling a Coverage or Dependent

Date of request/ineligibility

divorce age limit individual insurance
spouse's or state registered domestic partner's or nonregistered domestic partner's group coverage
other ________________

Beneficiary Designation

Complete Beneficiary Designation/Change (GP34795) if adding life coverage, accident coverage with AD&D, or changing beneficiary.

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

Dependent name	Birth date	Gender	Social security number	Relationship
		male female		spouse state registered domestic partner nonregistered domestic partner
		male female		child foster child*
		male female		child foster child*
		male female		child 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 disabled child(ren) (over the maximum age); see your employer for the required forms.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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 stepchild(ren), foster child(ren) 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 dental or vision coverage, I or my dependents may enroll at a later date; however, enrolling late will affect the level of benefits.
- If I cancel any type of life, disability, or critical illness coverage, I may apply at a later date; however, I must provide evidence of insurability 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.

Any false statement made on this form will not bar the right to recovery under the group policy(ies) unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Principal Life.

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

You must complete all pages of this form.