

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Change Form - IA

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

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) change in job status
 other _____

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

| | |
|-------------------------------------|---|
| Name of prior medical carrier _____ | Date of event _____ / _____ / _____ |
| Name of prior dental carrier _____ | Date coverage ended _____ / _____ / _____ |
| Name of prior life carrier _____ | Date coverage ended _____ / _____ / _____ |

Reason for Cancelling a Coverage or Dependent

divorce spouse's group coverage individual insurance
 age limit other _____ 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 both sides of the form.

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

| Spouse's name | Birth date | <input type="checkbox"/> male <input type="checkbox"/> female | Social security number |
|-----------------------|------------|---|--|
| Name(s) of child(ren) | / / | <input type="checkbox"/> male <input type="checkbox"/> female | <input type="checkbox"/> foster child* |
| | / / | <input type="checkbox"/> male <input type="checkbox"/> female | <input type="checkbox"/> foster child* |
| | / / | <input type="checkbox"/> male <input type="checkbox"/> female | <input type="checkbox"/> foster child* |
| | / / | <input type="checkbox"/> male <input type="checkbox"/> female | <input type="checkbox"/> 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. 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 (The Principal®).
- 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.

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 The Principal.

Your signature **X** _____ Date signed ____ / ____ / ____

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