

Principal Life Insurance Company

Mailing Address: Des Moines, IA 50392-0002

Employee Change Form -

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

Company name		Ac	Account/unit number			
Employee Informat	ion (Change of name and addr		Conial conviety number			
rour name (last, lirst, l	middle miliar)	Date of Birth	Social security number			
New name (last, first, r	niddle initial)		1			
Your new address (street) (city)		(state)	(ZIP code)			
Home phone number	Email address		<u> </u>			
		a Coverage. If this is initial erust be elected to elect any depende				
Coverage	Employee	Spouse or State Registered Domestic Partner of Nonregistered Domesti Partner*	r			
Dental	Add	Add	Add			
	Cancel	Cancel	Cancel			
	Change to:	Change to:	Change to:			
	Change to date:	Change to date:	Change to date:			
	In the past twelve months, (for yourself or your depend	l have you, the applicant, had continud dents) with a prior carrier? yes	ous group orthodontia coverage no			
Vision	Add	Add	Add			
	Cancel	Cancel	Cancel			
	Change to:	Change to:	Change to:			
	Change to date:	Change to date:	Change to date:			
Group Term Life	Add	Add	Add			
	Cancel	Cancel	Cancel			
	Change to:	Change to:	Change to:			
	Change to date:	Change to date:	Change to date:			
Supplemental	Add					
Term Life	Cancel					
	Change to:					
	Change to date:					
						

Coverage	Employee	Spouse or State Registered Comestic Partner or Nonregistered Domestic Partner*	child(ren)
Voluntary Term Life	Add	Add	Add
(VTL)	Cancel	Cancel	Cancel
,	Change to:	Change to:	Change to:
	Change to date:	Change to date:	Change to date:
	Change to date.	Change to date.	Change to date.
	\$	\$	
	or X salary		
Short Term Disability	Add		
-	Cancel		
	Occupation:		
	Change to:		
	Change to.		
	Change to date:		
	\$		
Long Term Disability	Add		
	Cancel		
	Occupation:		
	Change to:		
	Change to date:		
	\$		
Critical Illness	Add	Add	Add
	Cancel	Cancel	Cancel
	Change to:	Change to:	Change to:
	Change to date:	Change to date:	Change to date:
	\$	\$	
Accident	Add	Add	Add
Accident	Cancel	Cancel	Cancel
	Change to:	Change to:	Change to:
	Change to date:	Change to date:	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 ac	lding or changing	is based on you	ur salary.		
Salary \$ yea	arly bi-weekly	monthly	weekly	hourly	
* Nonregistered Domestic Partners of Domestic Partner, please attach a (GP60603).					
Nicotine Products					
Has any person used nicotine products	s (including cigarett	e, pipe, cigar or o	chewing to	obacco) in tl	he past 12 months?
Employee: yes no Spouse or	State registered do	mestic partner or	Nonregist	ered domest	tic partner: yes no
Reason for Adding a Coverage or D	ependent				
marriage loss of other gr		open enrollment*			Date of event
birth/adoption court order (attach a copy) change in job st annual enrollment (if available) other			tus		
*For loss of other group coverage and Name of prior dental carrier	open enrollment, y	ou must complet	e the follo	wing:	Date coverage ended
Name of prior life carrier					Date coverage ended
Name of prior vision carrier		Date coverage ended			
Reason for Canceling a Coverage o	r Dependent				
divorce age limit individual insurance					Date of request/ineligibility
spouse's or state registered dome coverage other	estic partner's or no	onregistered dom	nestic part	ner's group	_
Beneficiary Designation					
Complete Beneficiary Designation/Chabeneficiary.	ange (GP34795) if a	adding life covera	age, accid	lent coveraç	ge with AD&D, or changing
Complete for Adding or Canceling a	Dependent (Inclu	de last name if di			
Dependent name	Birth date	Gender	Socia		mber Relationship
		male fema	_		spouse state registered domestic partner

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.

male

male

male

female

female

female

domestic partner

foster child*

foster child*

foster child*

child

child

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

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.