Mailing Address:
Des Moines, IA 50392-0002

**Principal Life Insurance Company**

***Employee Change Form - CA***

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 ☐ domestic partner ☐ children
☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
☐ change to: ______

**Dental**
☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ 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 ☐ domestic partner ☐ children
☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
☐ change to: ______

**Term Life**
☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ children
☐ change to: ______

**Voluntary Life**
☐ add ☐ employee ☐ spouse ☐ domestic partner ☐ children
☐ cancel ☐ employee ☐ spouse ☐ domestic partner ☐ 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 or domestic partner used nicotine products within the last 12 months?
Employee ☐ yes ☐ no Spouse ☐ yes ☐ no Domestic partner ☐ yes ☐ no
Employee $______ or ______X salary Spouse $______

## Reason for Adding a Coverage or Dependent

☐ marriage ☐ domestic partnership ☐ loss of other group coverage*
☐ birth/adoption ☐ court order (attach a copy) ☐ open enrollment* (medical only)
☐ annual enrollment (if applicable) ☐ other ______

Date of event

*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.

## Reason for Canceling a Coverage or Dependent

☐ divorce ☐ dissolution of domestic partnership ☐ spouse's or domestic partner's group coverage

Date of request/ineligibility ______

☐ age limit ☐ individual insurance ☐ Medicare

☐ other ______

## Beneficiary Designation (Complete if adding life coverage or changing beneficiary)

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)

| Name of: ☐ spouse ☐ domestic partner | 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, 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 and 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.

For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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**