



Mailing Address:  
Des Moines, IA 50392-0002

**Principal Life Insurance Company** | **Employee Change Form - MN**

Company name	Account/unit number
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**Employee Information (Change of name and address)**

Your name (last, first, middle initial)	Social security number
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New name (last, first, middle initial)

Your new address (street)	(city)	(state)	(ZIP)
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Home phone number	Email address
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**Complete for Adding, Canceling or Changing a Coverage. If this is initial enrollment, please complete an Enrollment Form.**

Coverage	Employee	Spouse	Domestic Partner*	Child(ren)
<b>Dental</b>	Add Cancel Change to: _____	Add Cancel Change to: _____	Add Cancel Change to: _____	Add Cancel Change to: _____
	Change to date: _____	Change to date: _____	Change to date: _____	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				
<b>Vision</b>	Add Cancel Change to: _____	Add Cancel Change to: _____	Add Cancel Change to: _____	Add Cancel Change to: _____
	Change to date: _____	Change to date: _____	Change to date: _____	Change to date: _____
<b>Group Term Life</b>	Add Cancel Change to: _____	Add Cancel Change to: _____	Add Cancel Change to: _____	Add Cancel Change to: _____
	Change to date: _____	Change to date: _____	Change to date: _____	Change to date: _____
<b>Supplemental Term Life</b>	Add Cancel Change to: _____			
	Change to date: _____			

Coverage	Employee	Spouse	Domestic Partner*	Child(ren)
<b>Voluntary Term Life</b>	Add Cancel Change to: _____ Change to date: _____ \$ _____ or _____ X salary	Add Cancel Change to: _____ Change to date: _____ \$ _____	Add Cancel Change to: _____ Change to date: _____ \$ _____	Add Cancel Change to: _____ Change to date: _____
<b>Short Term Disability</b>	Add Cancel Occupation: _____			
<b>Long Term Disability</b>	Add Cancel Occupation: _____			
<b>Critical Illness</b>	Add Cancel Change to: _____ Change to date: _____ \$ _____	Add Cancel Change to: _____ Change to date: _____ \$ _____	Add Cancel Change to: _____ Change to date: _____ \$ _____	Add Cancel Change to: _____ Change to date: _____

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

**Salary \$** \_\_\_\_\_ yearly bi-weekly monthly weekly hourly

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

**Nicotine Products**

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

Employee:    yes        no        Spouse:    yes        no        Domestic Partner:    yes        no

**Reason for Adding a Coverage or Dependent**

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

Date of event  
\_\_\_\_\_

\*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**

divorce      age limit      individual insurance  
 spouse's or domestic partner's group coverage  
 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)**

Dependent name	Birth date	Gender	Social security number	Relationship
		male		spouse
		female		domestic partner
		male		child
		female		foster child*
		male		child
		female		foster child*
		male		child
		female		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 handicapped child(ren) (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 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 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, disability, or critical illness 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.

I represent 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.