



Principal Life Insurance Company

Mailing Address:
Des Moines, IA
50392-0002

Employee Change Form - CA

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	State registered domestic partner	Nonregistered Domestic partner*	Child(ren)
Dental	Add Cancel Change to:	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:	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:	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:	Change to date:
	_____	_____	_____	_____	_____
Group Term Life	Add Cancel Change to:	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:	Change to date:
	_____	_____	_____	_____	_____
Supplemental Term Life	Add Cancel Change to:				

	Change to date:				

Coverage	Employee	Spouse	State registered domestic partner	Nonregistered Domestic partner*	Child(ren)
Voluntary Term Life	Add Cancel Change to:	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:	Change to date:
	\$ _____ or _____ X salary	\$ _____	\$ _____	\$ _____	
Short Term Disability	Add Cancel Occupation:				
Long Term Disability	Add Cancel Occupation:				
Critical Illness	Add Cancel Change to:	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:	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.

Nicotine Products

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

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

Reason for Adding a Coverage or Dependent

marriage	loss of other group coverage*	open enrollment*	Date of event
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

divorce age limit individual insurance dissolution of domestic partnership
 spouse's or state registered domestic partner's or nonregistered domestic partner's group
 coverage
 other _____

Date of request/ineligibility _____

Beneficiary Designation

Complete Beneficiary Designation/Change (GP34795) 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 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 handicapped 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 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 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.