Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Change Form - FL

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

Company name	Account/unit number

Employee Information (Change of name and address)

Your name (last, first, middle initial)	Date of Birth	Social security number

New name (last, first, middle initial)

Your new address (street)	(city)	(state)	(ZIP code)

Home phone number	Email address

Complete for Adding, Canceling or Changing a Coverage. If this is initial enrollment, please complete an Enrollment Form. NOTE: Employee coverage must be elected to elect any dependent coverage.

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
Dental	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ 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: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
Group Term Life	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
Supplemental Term Life	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____		

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
Voluntary Term Life (VTL)	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____ or _____ X salary	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
Short Term Disability	☐ Add ☐ Cancel Occupation: _____		
Long Term Disability	☐ Add ☐ Cancel Occupation: _____		
Critical Illness	☐ 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 (GP60447).

Nicotine Products

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

Employee: ☐ yes ☐ no Spouse or Domestic Partner: ☐ yes ☐ no

Reason for Adding a Coverage or Dependent

Date of event

☐ marriage ☐ loss of other group coverage* ☐ open enrollment*
☐ 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

Date of request/ineligibility

☐ divorce ☐ age limit ☐ individual insurance
☐ spouse's or domestic partner's group coverage
☐ other _____

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 ☐ 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 disabled 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 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 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.

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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Your signature X _____ **Date signed** _____

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

You must complete all pages of this form.

Print