Employee Change Form – CA

Principal Life Insurance Company

Mailing Address:
Des Moines, IA 50392-0002

Principal®

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 number	Mobile 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 State Registered Domestic Partner or Nonregistered Domestic Partner [1]	Child(ren)
Dental	☐ Add ☐ Cancel ☐ Change to[2]: _____ 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	☐ Add ☐ Cancel	☐ Add ☐ Cancel
Vision	☐ Add ☐ Cancel ☐ Change to[2]: _____ Change to date: _____	☐ Add ☐ Cancel	☐ Add ☐ Cancel
Group Term Life	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
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: _____ $ _____

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner [1]	Child(ren)
Short Term Disability	☐ Add ☐ Cancel Occupation: _____ Change to: _____ Change to date: _____ $ _____		
Long Term Disability	☐ Add ☐ Cancel Occupation: _____ Change to: _____ Change to date: _____ $ _____		
Critical Illness	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	
Accident	☐ Add ☐ Cancel	☐ Add ☐ Cancel	☐ Add ☐ Cancel
Hospital Indemnity	☐ Add ☐ Cancel ☐ Change to[2]: _____ Change to date: _____	☐ Add ☐ Cancel	☐ Add ☐ Cancel

If you are applying for critical illness or hospital indemnity 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 or hospital indemnity coverage? NOTE: Critical Illness or Hospital Indemnity 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[1]: ☐ yes ☐ no

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

Salary $ _____ Salary mode ☐ yearly ☐ bi-weekly ☐ monthly ☐ weekly ☐ hourly

1 Spouse will include Nonregistered Domestic Partner if your employer allows this coverage. If adding a Nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60603).

2 Change will apply to all eligible dependents.

Nicotine Products

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

Employee: ☐ yes ☐ no Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner[1]: ☐ yes ☐ no

Reason for Adding or Increasing Coverage

Date of event

☐ marriage ☐ loss of other group coverage[3] ☐ change in job status
☐ birth/adoption ☐ court order (attach a copy) ☐ other _____
☐ open enrollment (if available)

[3]For loss of other group coverage 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
Name of prior critical illness carrier	Date coverage ended
Name of prior accident carrier	Date coverage ended
Name of prior hospital indemnity carrier	Date coverage ended

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[1]
		☐ male ☐ female		☐ child ☐ foster child[4] ☐ disabled child[5]
		☐ male ☐ female		☐ child ☐ foster child[4] ☐ disabled child[5]
		☐ male ☐ female		☐ child ☐ foster child[4] ☐ disabled child[5]

[4] 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

[5] When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

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.**

Beneficiary Designation

Complete Beneficiary Designation/Change (GP34795) if adding life coverage, accident coverage with AD&D, or changing beneficiary.

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, vision, accident, or hospital indemnity, coverage, I cannot enroll again until the next open enrollment period.
- 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 you and your spouse or state registered domestic partner or nonregistered domestic partner[1] are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.
- If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.
- 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.

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a 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** _____

After this form is completed and signed:

- Employee retains a copy of the form, and
- Enrollment is submitted to Principal Life:
    - Use eService to submit enrollment information at www.principal.com. Employer retains the original form.
    - Or, email the form to groupbenefitsadmin@principal.com.
    - Or, send the original form to Principal Life Insurance Company. Employer retains a copy of the form.