Employee Change Form – CA

Principal Life Insurance Company

Mailing Address:
Des Moines, IA 50392-0002

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	☐ Add ☐ Cancel	☐ Add ☐ Cancel

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.**

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 or accident 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 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** _____

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.