Principal Financial Group

Mailing Address:
Principal Life Insurance Company
Attn: Group Operations - Portability
PO Box 4934
Grand Island, NE 68802-9740

Principal Life Insurance Company

Group Term Life Insurance Portability Application

Account number _____

Employee & Dependent (if applicable) Information

I hereby apply for portability of my group term life insurance coverage issued by Principal Life Insurance Company in accordance with the provisions of the group policy.

Employee name (last, first, middle initial)

Street address	Home email address	Phone number

City	State	ZIP code

Name	Social security number	Date of birth	Sex	Relationship	Amount of coverage
			☐ male ☐ female	Self	$
			☐ male ☐ female		$
			☐ male ☐ female		$
			☐ male ☐ female		$

NOTE: Standalone dependent coverage is not available.

Have you or your spouse used nicotine products within the last 12 months?
Employee: ☐ yes ☐ no Spouse: ☐ yes ☐ no

Benefit Booklet election: I wish my benefit booklet to be provided by: ☐ Paper ☐ Electronic delivery

If you elect to receive your benefit booklet electronically, we will contact you with further information and directions for accessing your benefit booklet. Please be sure to include your current home e-mail address in the section above so we may contact you about electronic delivery of your portability benefit booklet.

Employee Beneficiary Designation

Full name	Relationship to insured

Employee Signature (Read and sign below.)

- **I understand coverage continuation will be effective only if this application and first month's premium are received by Principal Life Insurance Company within 60 days of the date my group term life insurance coverage terminates.** Confirmation of coverage will be sent to me by Principal Life Insurance Company.
- I hereby certify that the above information is true and complete to the best of my knowledge and belief. I understand my coverage can be ported as long as I:
  - do not meet the definition of actively at work which includes a reduction in work hours from full time to part time;
  - am less than 70 years of age;
  - am not currently on premium waiver due to disability;
  - am not receiving accelerated benefits;
  - am not exercising individual purchase rights.
- I understand initial rate calculation for me and my spouse, if covered, is based on our age as of prior policy anniversary. The member rate table and age used for our rate calculation is subject to change on May 1 of every year.

Print

Employee Signature (Read and sign below.) **(continued)** **161**

- I understand ported coverage amounts can be increased with proof of good health. Coverage can also be decreased or cancelled at any time. Coverage ends as specified in the portability policy or at the time premiums are no longer being paid. I do have conversion rights.
- I understand that if I consent to electronic delivery of my benefit booklet, I can withdraw my consent at any time or request a paper copy of the benefit booklet. In addition, if I change my e-mail address, I understand that I am responsible for notifying Principal Life in order to assure receipt of any changes to the benefit booklet. I understand that I may contact Principal Life regarding this matter at the address shown below.
- **I have read and understood the Fraud Notice Requirements on Page 2 and 3.**

Employee signature	Date signed
X	

Send completed form and check payable to:
Principal Life Insurance Company
Attn: Group Operations – Portability
PO Box 4934 Grand Island, NE 68802-9740

Employer to Complete this Section

Employer name	Contact for Questions	Phone

Was the above named employee on disability or receiving accelerated benefits when coverage ended? ☐ yes ☐ no

Amount of coverage upon termination

Employee $ _____ Dependent $ _____ Dependent children $ _____

Date last worked	Date coverage ended	Annual Salary
		$

Job/Benefit Class

Fraud Notice Requirements

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.

COLORADO FRAUD
It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA FRAUD
Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA FRAUD
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.

LOUISIANA FRAUD
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW MEXICO FRAUD
Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

OHIO FRAUD
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 is guilty of insurance fraud.

OKLAHOMA FRAUD
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PENNSYLVANIA FRAUD
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE FRAUD
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

VIRGINIA FRAUD
Any person who, with the 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 have violated state law.