Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-2412

Principal Life Insurance Company

Adjustment Application for Group Universal Life Insurance

Employee's name		Social security number		Certificate number
Insured's name		**Social security number**		**Certificate number**
Mailing address	**City**	**State**	**ZIP code**	**Home phone**
Employer name				**Work phone**

Adjustment in Coverage Amount	Employee: ☐ change multiple of salary to: ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ change monthly contribution to Certificate Account to: $ _____ Other: ☐ change coverage amount to: $ _____ ☐ change monthly contribution to Certificate Account to: $ _____ Complete health statement for increase in coverage. Note: Insureds no longer on payroll deductions see Continuation of Coverage in your Certificate for adjustment procedures.
Optional Benefits	Accidental Death Benefit: ☐ add (complete statement of health) ☐ cancel Automatic Benefit Increase: ☐ cancel Dependent Children Coverage ☐ add (separate statement of health must be submitted for each child over age 45 days) children name(s) and birthdates _____ _____ _____ ☐ cancel
Reclass-ification	☐ Request rating reclassification from smoker to nonsmoker. I have not used any type of tobacco in the past 12 months. Complete statement of health.
Reinstate-ment	☐ Request coverage to be reinstated. Complete statement of health.

Complete this Section if applying for increase in coverage amount, Accidental Death Benefit or Reinstatement.

Occupation _____

Do you plan to fly or have you, within the last five years, flown as a pilot or crew member? ☐ yes ☐ no

Have you, or do you plan to engage in hang gliding; scuba or sky diving; stock, modified sports car, drag strip, motorcycle, motor boat, snowmobile or other type of amateur or professional racing on an ongoing basis? ☐ yes ☐ no

If "yes", please circle which sports.

Statement of Health

Employee height		Weight	Spouse/Child height		Weight
ft.	inches	lbs	ft.	inches	lbs.

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☐ yes ☐ no 1. Has any Applicant been advised to receive or is any applicant receiving medical treatment, taking any medicine, drugs, pills, shots, etc.?

2. In the past 10 years has any applicant been treated for, diagnosed as having, or had any known indication of:

☐ yes ☐ no a. chest pains, heart trouble, heart attack, or heart murmur?
☐ yes ☐ no b. high blood pressure, cancer, or tumors?
☐ yes ☐ no c. nervous, respiratory, circulatory, liver, digestive, urinary or genitourinary problems?
☐ yes ☐ no d. venereal disease or other infectious disease?
☐ yes ☐ no e. diabetes, pneumonia, or disorder of the lymph system?
☐ yes ☐ no f. acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), or any immune disorder?

☐ yes ☐ no 3. In the last five years has any Applicant seen a doctor, been hospitalized, had surgery, or had blood or other diagnostic tests?

This Section Must be Fully Completed for All "Yes" answers above (If additional space is needed, please attach a separate piece of paper)

Question number	Name	Nature of illness or injury, treatment, testing or medical attention, etc.	Date		Duration	Diagnosis, results, findings or remaining effects	Names and addresses of physicians or hospitals
			mo.	yr.			

Statement of Understanding and Authorization

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. These representations are to be relied upon in evaluating my request for insurance.

No contribution is being submitted with this application. I agree that no adjustment shall take effect unless approved by Principal Life Insurance Company. If approved it shall become effective on the first of the month next following the date we approve proof of good health as defined in the certificate, provided (1) any required premiums are paid, and (2) there has been no change since the date of this form in the health affecting the insurability of the Insured.

I authorize any doctor, health care provider, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to Principal Life or its reinsurers any such information. I authorize Principal Life to release any such data as required by law.

A photocopy of this authorization shall be as valid as the original. I understand I may revoke this authorization. This revocation must be in writing and will be effective when received at Principal Life home office.

I understand that, as the Employee, the insurance I and my dependents have applied for will begin on the Effective Date identified in the Schedule of Benefits, provided that I am Actively at Work on that date. If I am not Actively at Work on such date, coverage will not go into effect untill after my return to work. Futhermore, I understand that no insurance will become effective for any member of my family, while he/she is in a Period of Limited Activity. Period of Limited Activity means any period of time which a person is confined in a health care facility or, whether confined or not, is unable to carry on the regular and usual activities of a healthy person of the same age and sex.

Insured's signature Date signed

Owner signature Date signed

Assignee and/or irrevolcable beneficiary signature Date signed