Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-2992

Principal Life Insurance Company

Group Life Conversion Application

Principal Life Insurance Company is a member of the Principal Financial Group®.

You may purchase an individual life insurance policy if your group term insurance ends and you qualify for individual purchase (conversion) as described in your booklet or certificate. **YOU MUST APPLY AND PAY THE FIRST PREMIUM WITHIN 31 DAYS AFTER THE DATE YOUR GROUP COVERAGE ENDS.**

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (first, middle, last)	Sex ☐ male ☐ female	Date of birth
Street address		Social security number
City, state, ZIP code		Home phone number

2. BENEFICIARY/OWNER INFORMATION (If no owner is named, the owner will be the proposed insured.)

Beneficiary	Relationship to proposed insured
Owner (if other than insured)	Relationship to proposed insured
Owner address	Owner social security number

3. BASIC COVERAGE APPLIED FOR

Amount of coverage requested $ _____

THE FIRST PREMIUM MUST BE ENCLOSED WITH THIS APPLICATION.

Premium amount $ _____

Mode of payment: ☐ annual ☐ semi-annual ☐ quarterly

4. SMOKING STATUS OF PROPOSED INSURED

Smoking Status: ☐ smoker ☐ nonsmoker

5. SIGNATURE OF PROPOSED INSURED/OWNER

I represent that all statements in this application are true and complete to the best of my knowledge and belief. I understand these statements are the basis of any insurance issued. If issued, the new policy will be effective on the 32nd day after the termination of group insurance.

Warning: It is a crime to provide false, misleading or incomplete information to an insurance company for the purpose of defrauding the company or any other person. Penalties include imprisonment and/or fines and denial of insurance benefits.

_____ (Signature of proposed insured)

_____ (date)

_____ (Signature of owner if other than proposed insured)

_____ (date)

Mail completed application (pages 1 & 2) along with premium to:
Principal Life Insurance Company, Life Conversions, Des Moines, IA 50392-2992

6. EMPLOYER TO COMPLETE

Applicant's name			
Employer's name	Group account number	Unit number	
Employer's address			
City	State	ZIP	Phone number
Date applicant last worked	Date insurance terminated (if different from date last worked)		
If date last worked differs from date insurance terminated, explain:			
If applicant ceased work due to illness or injury, has he or she been offered any applicable continuation rights due to disability? ☐ yes ☐ no (Please consult your group policy or administrative instructions.)			
Maximum amount eligible for conversion on termination date $ _____			
_____ (Signature of planholder)	_____ (title)	_____ (date)	

Print