Principal®

Mailing Address:
711 High Street
Des Moines, IA 50392

Principal Life Insurance Company

Application for Individual Life Insurance -- Group Conversion

Principal Life Insurance Company is a member of 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 by personal check or cashier's check 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 / /
Primary Residence Street Address		Social Security Number – –
City, State, Zip Code	Phone Number ( ) ☐ Cell ☐ Other	
Email Address:		

2. TOBACCO STATUS OF PROPOSED INSURED

Within the past 12 months, have you used cigarettes, cigars, pipe, chewing tobacco, snuff, nicotine gum/patch or other products containing nicotine? ☐ Yes ☐ No

3. BASIC COVERAGE APPLIED FOR

Amount of Universal Life coverage requested $ _____

Premium amount $ _____

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

Payor: Is someone other than the Proposed Insured or Owner going to be paying the premiums?
If yes, please provide:
Name and Address _____
Date of Birth _____ Tax ID Number _____

4. BENEFICIARY INFORMATION

Primary Beneficiary	SSN/TIN	Relationship to proposed insured
Address *(Street, City, State, Zip)*		
Primary Beneficiary	SSN/TIN	Relationship to proposed insured
Address *(Street, City, State, Zip)*		
Contingent Beneficiary	SSN/TIN	Relationship to proposed insured
Address *(Street, City, State, Zip)*		

5. OWNER INFORMATION (Complete if different than the Insured)

Owner Name (If trust, provide name of trust*)	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth (If trust, provide date of trust*)
Email Address	
Joint Owner Name	Relationship to Proposed Insured
Primary Residence Street Address	Taxpayer Identification Number
City, State, Zip Code	Date of Birth
Email Address	
Contingent Owner Name	Relationship to Proposed Insured

*** Submit copy of trust with this application.**

6. 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: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

As a proposed owner of this contract, I certify under penalty of perjury that:

1. The number shown on this form is my correct Taxpayer Identification Number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

   Exempt Payee code (if any):_____
3. I am a U.S. Citizen or other U.S. Person (as defined in the instructions to Form W-9), and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

   FATCA code (if any):_____

You must cross out item 2 above, if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

If any proposed owners are not a U.S. person or entity, submit a valid Form W-8BEN (foreign individual) or W-8BEN-E (foreign entity). If you are claiming treaty benefits, provide the required U.S. or foreign tax identifying number as required in the instructions. Failure to submit a valid Form W-8BEN or W-8BEN-E or to provide a required tax identifying number will result in mandatory withholding of 30% of the taxable portion of the payment.

The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

_____ (Signature of proposed insured)

_____ (Signature of owner if other than proposed insured)

_____ / ____ / _____ (Date)

_____ / ____ / _____ (Date)

Signed at _____ State

Mail completed application (pages 1 & 2) along with premium to:

Principal Life Insurance Company, Life Conversions, 711 High Street, Des Moines, IA 50392

7. EMPLOYER TO COMPLETE – PRINT OR TYPE

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:				
Reason for Conversion: ☐ Termination ☐ Retirement ☐ Sickness/Injury ☐ Other – Please specify				
Maximum amount eligible for conversion on termination date $ _____				
_____ (Signature of planholder)	_____ (Title)	_____ (Date)		

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