Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Declaration of Domestic Partnership/ Enrollment Form Addendum – AZ

Company name: _____ **Account/unit number:** _____

Employee Information

Employee name (last, first, middle initial) | Social security number | Date of birth

Address

Requested coverage:

☐ medical ☐ dental ☐ vision ☐ life ☐ voluntary life

Status

Your request for the coverage(s) shown above for a domestic partner is based on the criteria establishing that a domestic partnership exists and the provisions of the group policy. In order to properly evaluate your request and the eligibility for domestic partner coverage, you must complete the following information.

Domestic partner's name | Social security number | Date of birth

Address

Sex

☐ male ☐ female

On what date was the domestic partnership established?

Certification

We understand that in order for domestic partner coverage to become effective, a Declaration of Domestic Partnership must be submitted to and approved by Principal Life Insurance Company, and we must satisfy the following requirements.

We certify that:

1. We are at least 18 years old.
2. Neither of us is married to or legally separated from anyone else, nor have had another domestic partner within the prior six months.
3. We have shared the same residence for at least the number of months specified in the group policy, and continue to do so.
4. We are not blood relatives.
5. We are each other's sole life partner, and intend to remain so indefinitely.
6. We are jointly responsible for each other's financial welfare as evidenced by at least three of the following (need to checkmark all that apply):

   ☐ Common ownership of real property or a common leasehold interest in property

   ☐ Joint checking account

   ☐ Joint credit cards

   ☐ Designation of one another as primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under partner's will

   ☐ Joint ownership of a motor vehicle

   ☐ Designation of partner under power of attorney

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Enrollment of Domestic Partner's Dependent Children

We understand the children of _____ (domestic partner) are eligible for coverage under the group policy so long as they otherwise satisfy the group policy's definition of an eligible dependent child.

Domestic Partner's Eligible Dependent Children:

Name(s) of child(ren)	Date of birth		Social security number	
		☐ male ☐ female		☐ foster child*
		☐ male ☐ female		☐ foster child*
		☐ male ☐ female		☐ foster child*
		☐ male ☐ female		☐ foster child*

* If you checked foster child, do you provide principal support for the child and does the child live with you at least 50% of the time? ☐ yes ☐ no

If your child is over the maximum age and handicapped, see your employer for the necessary form. Dependents over the maximum age must meet eligibility requirements.

Acknowledgments

1. We understand domestic partners (and their eligible dependents) are subject to the same rules governing all other dependents who are covered by or applying for coverage under the group policy, including but not limited to those rules relating to enrollment periods.
2. We understand we have an obligation to notify Principal Life if there is any change in our domestic partnership status as certified in this Declaration.
3. We understand that termination of coverage issued to the domestic partner as a result of completion and approval of this Declaration will be effective on the date the domestic partnership ends, as provided under the group policy, providing coverage did not terminate earlier under other group policy provisions. We further understand the domestic partner and the children of the domestic partner will not be eligible for either continuation or conversion coverage should our domestic partnership terminate, unless the group policy indicates otherwise.
4. We understand that a lawsuit may be brought against one or both of us for any losses (including attorneys' fees and costs) due to any false statement contained in this Declaration, or for failure to notify Principal Life of a change in our domestic partnership status.
5. We understand this Declaration may have legal ramifications relating, for example, to our ownership of property or to the taxability of benefits provided, and that we are advised to seek competent legal advice regarding these matters before signing this Declaration.
6. We understand in the event that termination of this relationship is not due to death of my domestic partner I will mail my former domestic partner their Certificate of Creditable Coverage.
7. We understand once the employee terminates from the group his/her domestic partner and his/her dependents will not be able to continue coverage.

We represent that all statements and answers contained in this document are true, complete, and correctly recorded, to the best of our knowledge. We understand the completion of this Declaration in no way guarantees approval of the requested coverage.

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.

Your signature X _____ **Date signed** _____

Domestic partner's signature X _____ **Date signed** _____

Note: Make a copy for your records and distribute copy to employee.