



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<br>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 \$ _____                                                                        |
| <b>THE FIRST PREMIUM MUST BE ENCLOSED WITH THIS APPLICATION.</b>                                             |
| Premium amount \$ _____                                                                                      |
| Mode of payment:                      annual                      semi-annual                      quarterly |

**4. SMOKING STATUS OF PROPOSED INSURED**

|                                                              |
|--------------------------------------------------------------|
| <b>Smoking Status:</b> 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 32 <sup>nd</sup> 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.                                                       |                                                              |
| _____<br>(Signature of proposed insured)                                                                                                                                                                                                                                                                 | _____<br>(Signature of owner if other than proposed insured) |
| _____<br>(date)                                                                                                                                                                                                                                                                                          | _____<br>(date)                                              |

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

|                                                                                                                                                                                                                                                                                                         |                                                                |                      |              |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------|----------------------|--------------|
| 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 \$ _____                                                                                                                                                                                                                                     |                                                                |                      |              |
| <div style="display: flex; justify-content: space-between; margin-top: 20px;"> <div>_____</div> <div>_____</div> <div>_____</div> </div> <div style="display: flex; justify-content: space-between; margin-top: 5px;"> <div>(Signature of planholder)</div> <div>(title)</div> <div>(date)</div> </div> |                                                                |                      |              |