Print

150

Principal® Financial Group

Mailing Address:
Des Moines, IA 50309-0002

Principal Life Insurance Company

Foster Child and Stepchild Questionnaire

Instructions

- This questionnaire must be completed for us to determine if a Member's foster child or stepchild is an eligible Dependent.
- Complete a separate form for each foster child or stepchild.
- Date and sign the form.
- If this is an employer-sponsored group plan, return the completed form to your employer.
- After receipt of this completed form, we will review the information and notify the planholder regarding coverage.

Account Number X

A. Member Information

Your name (last, first, middle initial) | Address | Social security/I.D. number

Name of child | Social security number | Relationship | Sex ☐ male ☐ female | Date of birth / / | If age 19 or over, is child a Full-Time Student? ☐ yes ☐ no

1. Do you have full care and custody of this child? ☐ yes ☐ no If "no", please explain: _____

2. Does this child reside in your home permanently? ☐ yes ☐ no If "no", please explain: _____

3a. Under what circumstances did you undertake the care and custody of this child? _____

3b. When did this care and custody begin? (show date) _____

3c. Have care and custody been continuous since this date? ☐ yes ☐ no If "no", please explain: _____

4. Do you regularly provide more than one-half of the financial support of this child? ☐ yes ☐ no If "no", please explain: _____

5. Is this child claimed as a Dependent by you for federal income tax purposes? ☐ yes ☐ no If "no", please explain: _____

6. Is there any other pertinent information not covered above? ☐ yes ☐ no If "yes", please explain: _____

I hereby acknowledge that the above statements are true to the best of my knowledge.

Your signature _____ Date signed _____

B. Employer to complete if this is an Employer-Sponsored Group Plan

Company name as it appears on your billing

X

Authorized planholder signature | Title | Date signed

C. Principal Life Insurance Company to Complete

Child meets eligibility of plan ☐ yes ☐ no | Date | Signature | ☐ Letter mailed ☐ Message sent to Claims

Claim office number | Claim office name | Claim office telephone number | Age limits _____ to _____