



Mailing Address:  
 Marsh Affinity Group Service  
 P.O. Box 9356  
 Des Moines, IA 50306-9356

**Principal Life  
 Insurance Company**

**Adjustment Application for  
 Group Universal Life Insurance**

Employee's name		Social security number		Certificate number
Insured's name		Social security number		Certificate number
Mailing address	City	State	ZIP code	Home phone
Employer name				Work phone

Adjustment in Coverage Amount	Employee:	<input type="checkbox"/> change multiple of salary to:	<input type="checkbox"/> 1x	<input type="checkbox"/> 2x	<input type="checkbox"/> 3x	<input type="checkbox"/> 4x	<input type="checkbox"/> 5x
		<input type="checkbox"/> change monthly contribution to Certificate Account to: \$	_____				
	Other:	<input type="checkbox"/> change coverage amount to: \$	_____				
		<input type="checkbox"/> change monthly contribution to Certificate Account to: \$	_____				
Complete health statement for increase in coverage.							
Note: Insureds no longer on payroll deductions see Continuation of Coverage in your Certificate for adjustment procedures.							

Optional Benefits	Accidental Death Benefit:	Dependent Children Coverage
	<input type="checkbox"/> add (complete statement of health)	<input type="checkbox"/> add (separate statement of health must be submitted for each child over 45 days)
	<input type="checkbox"/> cancel	children name(s) and birthdates _____ _____
	Automatic Benefit Increase:	
	<input type="checkbox"/> cancel	<input type="checkbox"/> cancel

Reclassification	<input type="checkbox"/> Request rating reclassification from smoker to nonsmoker. I have not used any type of tobacco in the past 12 months. Complete statement of health.
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Reinstatement	<input type="checkbox"/> Request coverage to be reinstated. Complete statement of health.
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**Complete this Section if applying for increase in coverage amount, Accidental Death Benefit or Reinstatement.**

Occupation \_\_\_\_\_

Do you plan to fly or have you, within the last five years, flown as a pilot or crew member?  yes  no

Have you, or do you plan to engage in hang gliding; scuba or sky diving; stock, modified sports car, drag strip, motorcycle, motor boat, snowmobile or other type of amateur or professional racing on an ongoing basis?  yes  no

If "yes", please circle which sports.

**Statement of Health**

Employee height		Weight	Spouse/Child height		Weight
ft.	inches	lbs.	ft.	inches	lbs.

- yes     no    1. Has any Applicant been advised to receive or is any applicant receiving medical treatment, taking any medicine, drugs, pills, shots, etc.?
- yes     no    2. In the past 10 years has any applicant been treated for, diagnosed as having, or had any known indication of:
- yes     no    a. chest pains, heart trouble, heart attack, or heart murmur?
- yes     no    b. high blood pressure, cancer, or tumors?
- yes     no    c. nervous, respiratory, circulatory, liver, digestive, urinary or genitourinary problems?
- yes     no    d. venereal disease or other infectious disease?
- yes     no    e. diabetes, pneumonia, or disorder of the lymph system?
- yes     no    f. acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC, or any immune disorder?
- yes     no    3. In the last five years has any Applicant seen a doctor, been hospitalized, had surgery, or had blood or other diagnostic tests?

**This Section Must be Fully Completed for All "Yes" answers above** (if additional space is needed, please attach a separate piece of paper)

Question number	Name	Nature of illness or injury, treatment, testing or medical attention, etc.	Date		Duration	Diagnosis, results, findings or remaining effects	Names and addresses of physicians or hospitals
			mo.	yr.			

**Statement of Understanding and Authorization**

I represent that the statements and answers in this application are true and complete to the best of my knowledge and belief. These representations are to be relied upon in evaluating my request for insurance.

No contribution is being submitted with this application. I agree that no adjustment shall take effect unless approved by Principal Life Insurance Company. If approved it shall become effective on the first of the month next following the date we approve proof of good health as defined in the certificate, provided (1) any required premiums are paid, and (2) there has been no change since the date of this form in the health affecting the insurability of the Insured.

I authorize any doctor, health care provider, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person that has any records or knowledge of me or my health to give to Principal Life or its reinsurers any such information. I authorize Principal Life to release any such data as required by law.

A photocopy of this authorization shall be as valid as the original. I understand I may revoke this authorization. This revocation must be in writing and will be effective when received at Principal Life home office.

I understand that, as the Employee, the insurance I and my dependents have applied for will begin on the Effective Date identified in the Schedule of Benefits, provided that I am Actively at Work on that date. If I am not Actively at Work on such date, coverage will not go into effect until after my return to work. Furthermore, I understand that no insurance will become effective for any member of my family, while he/she is in a Period of Limited Activity. Period of Limited Activity means any period of time which a person is confined in a health care facility or, whether confined or not, is unable to carry on the regular and usual activities of a healthy person of the same age and sex.

Insured's signature	Date signed
Owner signature	Date signed
Assignee and/or irrevocable beneficiary signature	Date signed