Principal®

Mailing Address:
Des Moines, IA 50392-2992

Principal Life Insurance Company

Group Life Conversion Application – NY

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.**

THIS APPLICATION IS TO BE ATTACHED TO AND MADE PART OF THE POLICY.

1. PERSONAL INFORMATION ABOUT THE PROPOSED INSURED

Name (First, Middle, Last)	Sex ☐ 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

Product applied for _____

Amount of coverage requested $_____

THE FIRST PREMIUM MUST BE ENCLOSED WITH THIS APPLICATION.

Policy Mode / Planned Premium amount $ _____

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

4. SMOKING STATUS OF PROPOSED INSURED

Smoking Status: ☐ 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 32nd day after the termination of group insurance.

(Signature of proposed insured)	(Signature of owner if other than proposed insured)
_____ / / _____ (Date)	_____ / / _____ (Date)

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

6. 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:				
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 $ _____				
_____ (Signature of planholder)	_____ (Title)	_____ (Date)		

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