



File Code – Principal Life Use Only

Mailing Address:
Des Moines, IA 50392-0001

Principal Life Insurance Company | **Death Notification Form**
CTD 01306

Instructions

Please complete this form when a plan participant dies. Note: A beneficiary is required to make a decision by 9/30 of the year following a participant's death. In most situations, if a distribution were not made by 12/31 of the year following a participant's death, the beneficiary's minimum distribution would be subject to the 50% federal excise tax.

Mail this form **and** a certified copy of the death certificate to your Client Service Associate.

Section 1 – Special Instructions

Hours: (Only needed if your plan uses Hours Method for vesting). Please indicate total hours worked from the beginning of the vesting service period (usually plan year) through the date of death or benefit event, which ever occurred first.

Marital Status: **M** = Married
(on date of death) **S** = Single
L = Spouse cannot be located

QDRO: (**Qualified Domestic Relations Order.**) Please indicate in QDRO box and fill out the QDRO section on the back of this form.

State Taxation: If all Elective Deferral contributions have been taxed by the participant's state of residence, check this box. If a portion of the elective deferrals have been taxed by the participant's state of residence, record the dollar amount that has been taxed in the State Taxation box.

Benefit Event: If a benefit event date had not been previously reported, please indicate date of original benefit event and reason code.
T = Termination
R = Retirement
D = Disability. Include copy of verification letter (award or benefit) from Social Security Administration.

Section 2 – Employer or Plan Sponsor Signature

Note: The law requires a beneficiary to receive a written description of their benefit choices. In addition, the beneficiary is required to let us know their decision on payment of benefits no later than 9/30, of the year following the death of the participant. Based on this notification, Principal Life Insurance Company (Principal Life) will provide the beneficiary with the benefit choices information. Retirement funds placed in a Personal Retirement Account (PRA) or vested deferred status remain in the plan and the plan/trustee retains fiduciary responsibility for the account balance.

On behalf of the plan fiduciary, I authorize Principal Life or its affiliates to make benefit payments to the beneficiaries listed on this form. This authorization applies to beneficiaries who make a distribution election, and also to distributions made in accordance with the small amounts provisions of the plan. In addition, this notification authorizes Principal Life or its affiliates to make benefit payments to beneficiaries in the PRA or vested deferred status when they elect a distribution. This authorization remains in effect unless subsequently cancelled by a plan fiduciary, such cancellation being effective upon actual receipt by Principal Life or its affiliates. The plan fiduciary hereby releases Principal Life and its affiliates from any and all liability arising in any way from any payment pursuant to this authorization and prior to its termination.

For deceased participants with an outstanding loan balance, this authorization directs Principal Life or its affiliates to make the loan taxable. If the loan is not repaid by the beneficiary within the number of days required in your plan, Principal Life or its affiliates will produce a Form 1099-R the following January and notify the IRS as required. If a beneficiary requests a distribution, the loan will be made taxable at that time, even if the repayment period has not expired.

Plan Representative Signature _____ Title _____ Date _____
Print Plan Representative Name _____

Plan Trustee Signature (if applicable) _____ Date _____

Section 3 – Participant's Information

Contract or Plan ID _____ **Plan Sponsor** _____

Participant Name _____ Participant ID # _____ Date of Death _____ Hours _____ Marital Status _____ QDRO (See Section 5)
Address _____ Apt. No. City _____ State ZIP Code _____ Yes No
State Taxation _____

Original Term Date (if applicable) _____ Benefit Event Reason (if applicable) _____

Section 4 – Beneficiary Information (to be completed for each beneficiary)

Beneficiary Name	Relationship to Participant	Soc Sec No.	Date of Birth	Date Beneficiary Designation Signed
Address	Apt. No.	City	State	ZIP Code

Beneficiary Name	Relationship to Participant	Soc Sec No.	Date of Birth	Date Beneficiary Designation Signed
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Section 5 – Alternate Payee Information

If there's an outstanding domestic relations order that affects the benefits held under the plan for the participant, please provide alternate payee information

Alternate Payee Name (first)	(middle initial)	(last)
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Alternate Payee Address	City	State	ZIP
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Alternate Payee Social Security Number	[Alternate Payee ID Number]
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