

Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - CT

Company name _____ Division level _____ Account number/unit number _____

Employee Information

Your name (last) _____ (first) _____ (mi) _____ Social security number _____

Mailing address (street) _____ Birth date (month/day/year) _____ male
 female

(city) _____ (state) _____ (ZIP code) _____ Do you have an eligible spouse or child?
 yes no

Date employed full-time (month/day/year) _____ Hrs worked per week _____ Job occupation/class _____ Location _____

Salary _____ What is your payroll mode?
 yr wk hr mo bi-wkly mthly bi-mnthly wkly bi-wkly

Employer ZIP _____ Employer county _____

Benefit Options (You can only elect those coverages offered by your employer.)

Coverage	Employee		Spouse		Children	
Dental	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline
Vision	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline
Short Term Disability	<input type="checkbox"/> elect	<input type="checkbox"/> decline				
If STD Buy-up option is available, check one:		<input type="checkbox"/> elect	<input type="checkbox"/> decline			
Long Term Disability	<input type="checkbox"/> elect	<input type="checkbox"/> decline				
If LTD Buy-up option is available, check one:		<input type="checkbox"/> elect	<input type="checkbox"/> decline			
Group Term Life	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline
Supplemental Term Life	<input type="checkbox"/> elect	<input type="checkbox"/> decline				
	\$ _____ or _____ x annual salary		\$ _____			
Voluntary Term Life	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline	<input type="checkbox"/> elect	<input type="checkbox"/> decline
	\$ _____ or _____ x annual salary		\$ _____			
Have you used nicotine products in the past 12 months?		<input type="checkbox"/> yes	<input type="checkbox"/> no			
Has your spouse used nicotine products in the past 12 months?		<input type="checkbox"/> yes	<input type="checkbox"/> no			

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:
 spouse's group coverage individual insurance
 other _____

Beneficiary Designation (Complete if life coverages are elected.)

Full name _____ Relationship _____

If two or more beneficiaries are named, proceeds shall be paid in equal shares to the surviving beneficiaries, unless specified otherwise. If no beneficiary has been named, any proceeds will be payable as provided by the group policy.

Eligible Dependent Information (Complete if you have elected benefits for your spouse and/or children.)

Spouse's name _____ Birth date _____ male female Social security number _____

Name(s) of child(ren) _____ Birth date _____ male female Social security number _____ foster child*

_____ male female _____ foster child*

_____ male female _____ foster child*

*If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time?
 yes no

If your child is over the maximum age and handicapped, see your employer for the necessary form.
Important - Complete Page 1 and Page 2.

Employee Signature (Read and sign below)

I understand and agree with the following statements:

- My dependents are not eligible for coverages I don't have. My dependents, including step and foster children and any over the maximum age, are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed. If I refuse dental coverage, I and/or my dependents may enroll later but this will affect the level of benefits. If I refuse life and/or disability coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company. If I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contribution, I cannot decline any coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. During the first two years coverage is in force, false statements, omissions and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date. Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- I authorize Principal Life to release data as required by law. If signed in connection with an application, reinstatement or a change in benefits, this form will be valid two years from the date below. I may revoke authorization for information not yet obtained. I understand data obtained will be used by Principal Life for claims administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law.

A copy of this form will be as valid as the original.

I declare that the information I have completed on this enrollment form is complete and true to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Principal Life.

Your signature X Date signed _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- Employer – copy of Page 1 only
- Employee – copy of Page 1 and Page 2