Principal® Financial Group

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, middle initial) | Social security number

Mailing address (street) | Birth date | ☐ male ☐ female

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

Date employed full-time | Hours worked per week | Job occupation/class | Location

Salary amount | Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly

What is your payroll mode? ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly | Employer ZIP | Employer county

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

Coverage	Employee	Spouse	Children
Dental	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
	Dental options: _____ (e.g., deductibles, PPO, etc.)		
	In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself or your dependents) with a prior carrier? ☐ yes ☐ no		
Vision	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
Group term life	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
Voluntary term life (VTL)	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
	$_____ or _____ X annual salary	$_____	$ _____
	☐ VTL only ☐ VTL with AD&D	☐ VTL only ☐ VTL with AD&D	
Supplemental term life	☐ elect ☐ decline		
	$_____ or _____ X annual salary		
Short term disability (STD)	☐ elect ☐ decline	If STD Buy-up option is available, check one: ☐ elect ☐ decline	
Long term disability (LTD)	☐ elect ☐ decline	If LTD Buy-up option is available, check one: ☐ elect ☐ decline	

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's group coverage ☐ individual insurance ☐ other coverage offered by employer

☐ other _____

Nicotine Products

Have you used nicotine products in the past 12 months? ☐ yes ☐ no

Has your spouse used nicotine products in the past 12 months? ☐ yes ☐ no

Important – Complete Page 1, Page 2, Page 3, Page 4 and Page 5

Group Term Life Beneficiary Designation (Complete if covered for group term life coverage.) **110**

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write “same as above” in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: If you are covered by both group term life and voluntary term life coverage and only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

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

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

Name(s) of child(ren)	Birth date		Social security number	
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child**
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child**
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped 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

****** When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Handicapped Child form must be completed and reviewed to determine eligibility.

Health Information Questions (Read the Notice of Information Practices prior to answering.) **110**

To avoid delays, answer all questions fully and accurately for everyone electing coverage. You do not have to reveal genetic test results. Include full details for "yes" answers. If not enough space, attach additional paper.

Employee's height ___ft. ___in. weight _____lbs. Spouse's height ____ft. ___in. weight _____lbs.

1. ☐ yes ☐ no Is any person on whom coverage is requested currently using tobacco products, including cigarette, pipe, cigar or chewing tobacco? If so, how long? _____

Which applicant(s)? _____

2. ☐ yes ☐ no Is anyone planning or scheduled for hospitalization, surgery, medical treatment, therapy, counseling, tests or examinations or taking any medicine or is anyone pregnant (due date _____ complications _____)?

3. ☐ yes ☐ no In the past 5 years, has anyone had surgery, been hospitalized or consulted with a doctor, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment OR been diagnosed or received treatment for any of the following conditions or disorders? (Check ALL that apply.) If a condition is not noted, please list it.

☐ cancer ☐ alcohol/drug use ☐ arthritis/bone/joint/muscle ☐ skin/eye/ear/nose/throat
☐ tumor ☐ liver/hepatitis ☐ allergy/asthma/respiratory ☐ kidney/bladder/urinary
☐ infertility ☐ heart/circulatory ☐ digestive/intestinal/eating ☐ stroke/neurological/nervous system
☐ endocrine ☐ mental/nervous ☐ high blood pressure – last reading and date _____/_____
☐ diabetes – last HbA1c reading and date _____/_____ ☐ other _____
☐ Acquired Immune Deficiency Syndrome (AIDS)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder

Name | Date diagnosed/treated | Duration of illness or condition

Diagnosis of illness or condition | Type of treatment/names of all medications

Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Name | Date diagnosed/treated | Duration of illness or condition

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Any current symptoms or problems

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Name | Date diagnosed/treated | Duration of illness or condition

Diagnosis of illness or condition | Type of treatment/names of all medications

Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Print

Employee Signature (Read and sign below.) 110

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 my dependents may enroll later but this will affect the level of benefits. If I refuse life 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. 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 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.
- For life and disability coverages, I authorize any health care provider who has personal information, including physical, mental, drug or alcohol use history, regarding me or a dependent, to give such data to Principal Life agents and employees performing my business transactions. 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.
- Explanation of Benefits reflecting claim payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

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** _____

Spouse signature* **X** _____ **Date signed** _____

*Spouse signature only required if voluntary term life coverage is elected.

Instructions

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

- Employer – copy of Pages 1, 2, 3, and 5
- Employee – copy of Pages 1, 2, 3, 4, and 5

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Notice of Information Practices (To be read before completing the Health Information Section.)

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete the Health Information section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

Please keep this notice for your records.