Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - PA

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
Medical	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
	Medical options: _____ (e.g., deductibles, PPO, etc.)		
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, and Page 4

Beneficiary Designation (Complete if life coverages are elected.) **110**

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

Primary Beneficiaries:

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

Contingent Beneficiaries:

Name	Relationship
Address	Social security number
Name	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.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children.) **110**

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

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.

Employee Signature (Read and sign.)

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. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. 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 knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
- 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.

Print

Employee Signature (Read and sign below.) (continued) **110**

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

Federal Regulations require an employee to receive the following notices for medical coverage offered in the state of Pennsylvania.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or service during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

  Loss of eligibility includes:

  - death, divorce, legal separation, or cessation of dependent status
  - reduction in work hours or termination of employment
  - if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
  - an incurred claim that would meet or exceed a lifetime limit on all benefits
  - if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

  Exhaustion of COBRA or state continuation includes:

  - failure of the employer or other responsible entity to remit premiums timely
  - if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
  - an incurred claim that would meet or exceed a lifetime limit on all benefits
  - completion of the maximum continuation period

Special Enrollment Rights (continued)

If you or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days of a court or administrative order to provide health coverage.

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

Please keep this notice for your records.