Principal® Financial Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Enrollment/Change Request - NJ

Employer Group Information - To be completed by employer.

Company name	Division level	Account number/unit number

A. Type of Activity - To be completed by employer. Refer to instructions in section J before completing this form. Print clearly.

	Effective date	Date of hire
1. Enrollment ☐ new employee		

2. Add - Check all that apply.	**Effective Date/ Date of Event**	**Reason for Change**
☐ add spouse/civil union partner		
☐ add domestic partner		
☐ add dependent child		

3. Remove - Check all that apply.	**Effective Date/ Date of Event**	**Reason for Change**
☐ employee withdrawal/termination		
☐ remove spouse/civil union partner*		
☐ remove domestic partner*		
☐ remove dependent child*		

NOTE: Employee must be enrolled for spouse/dependents to have coverage.
*Please complete Section D.

4. Other Change	**Effective Date/ Date of Event**	**Reason for Change**
☐ name change		
☐ change plan		
☐ other		

5. Coverage Continuation

☐ for employee
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 29 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

☐ for spouse/civil union partner*
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 36 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

* Civil union partners are eligible to make an election pursuant to NJSGC, if applicable.

☐ for dependent child
- ☐ COBRA/NJSGC
- ☐ Length of continuation (in months): ☐ 18 ☐ 36 Date of loss of coverage: _____
- ☐ Qualifying event number: _____ ** Date of qualifying event: _____

** Qualifying event numbers: see list in Instructions.

B. Employee Information - To be completed by the employee.

Name (last, first, middle initial)				Social security number
Home address (street/apartment)			(city)	
(state)	(ZIP code)	Birth date	☐ male ☐ female	Phone
E-mail			Do you have an eligible spouse or child? ☐ yes ☐ no	
Employer name				
Employer address			(city)	
(state)	(ZIP code)	Employer county		Employer phone
Job occupation/class	Location	Date employed full-time		Hours worked per week
Other health coverage ☐ yes ☐ no	If yes, payer name			Policy number
Previous coverage ☐ yes ☐ no	If yes, effective date	Termination date		

C. Plan Options - To be completed by the employee. (Check all you elect coverage for.)

Coverage	Employee	Spouse or Civil Union Partner or Domestic Partner	Child(ren)
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ yes ☐ no

If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits

Vision	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Group Term Life	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Voluntary Term Life	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____
Short Term Disability	☐ Elect ☐ Decline		
Long Term Disability	☐ Elect ☐ Decline		

Critical Illness	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____

If electing Critical Illness coverage, I declare that I and my eligible dependents have other coverage providing benefits for hospital and medical services and supplies. NOTE: Critical Illness coverage cannot be issued to a person who does not have hospital and medical services and supplies coverage in place.

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

☐ spouse's or civil union partner's or domestic partner's group coverage ☐ individual insurance

☐ other _____

If I refuse life, disability or critical illness 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.

Salary amount	Salary mode	What is your payroll mode?
	☐ yr ☐ wk ☐ hr ☐ mo ☐ bi-wkly	☐ mnthly ☐ bi-mnthly ☐ wkly ☐ bi-wkly

Nicotine Products

Has any person used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?

Employee: ☐ yes ☐ no Spouse or civil union partner or domestic partner: ☐ yes ☐ no

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

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 by the employee. 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: You are covered by both group term life and voluntary term life coverage and if you 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.

D. Other Individuals Covered - To be completed by the employee. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated. Attach proof if full-time college student.

1. Spouse, domestic or civil union partner

☐ add ☐ remove ☐ other ☐ continue spouse ☐ continue civil union partner (NJSGC)

Name (last, first, middle initial)		Birth date
☐ male ☐ female	Social security number	Employed ☐ yes ☐ no If yes, complete Section E1.

Home or billing address same as employee

☐ yes ☐ no If no, complete Section E2.

2. Child

☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial)		Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no If no, complete Section E2.

If last name is different from employee's, please explain

3. Child

☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial)		Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no If no, complete Section E2.

If last name is different from employee's, please explain

4. Child

☐ add ☐ remove ☐ other ☐ continue

Name (last, first, middle initial)		Birth date

☐ foster child* ☐ disabled**

☐ male ☐ female	Social security number	Living with employee ☐ yes ☐ no If no, complete Section E2.

If last name is different from employee's, please explain

* If you check foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time?

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

E. Additional Spouse/Civil Union Partner/Domestic Partner Information - To be completed by the employee. If not applicable, please mark as "N/A".

1. Employer name

Employer address

(city)	(state)	(ZIP code)	Employer phone

2a. Street/apartment

(city)	(state)	(ZIP code)

2b. Please explain why the address is different

F. Additional Child Information - To be completed by the employee. Provide information below about children listed in section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name(s)

Street/apartment

(city)	(state)	(ZIP code)

Reason

Name(s)

Street/apartment

(city)	(state)	(ZIP code)

Reason

G. Race/Ethnicity - To be completed by the employee, at his/her option. Note: your response is appreciated but NOT required!

Choose a category that most closely describes you:

☐ American Indian or Alaskan Native
☐ Asian or Pacific Islander
☐ Black, not of Hispanic origin
☐ White, not of Hispanic origin
☐ Hispanic

H. Employee Signature (If you have questions concerning the benefits and services provided by or excluded under this group policy, contact a Customer Service Representative at 1-800-843-1371 before signing this form.)

I represent that all the information supplied in this application is true and complete. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature	Date

I. Employer Verification

The requested activity is believed eligible and is approved by the employer.

Employer representative

Representative's title	Date

Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer.

J. Instructions

Employer - You must complete the Employer Group Information and Sections A and I in order for this application to be processed.

Employee - You must complete all sections in order for this application to be processed.

- Please PRINT except when a signature is requested.
- Complete your full name along with the name(s) of your dependent(s), if applicable. Indicate Sex, Birth date, and Social security number for each individual listed.
- If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select "Other" in Section A4, and attach proof of disability.
- If a dependent is a full-time college student, you must attach a current course schedule or a letter from the school confirming full-time student status (12 or more credits).
- Employee must sign and date the application in order for it to be processed.

Qualifying Events

COBRA and NJSGC

C1. termination of job or reduction in hours
C2. employee enrollment in Medicare (COBRA only)
C3. divorce (COBRA/NJSGC; civil union dissolution (NJSGC))
C4. death of employee
C5. loss of dependent child status under the plan
C6. disability (occurring subsequent to another qualifying event)

Conditions of Enrollment - Employee Acknowledgments and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer, reporting agency, and any employer to give Principal Life, or any consumer reporting agency acting on behalf of Principal Life, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Principal Life has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Principal Life will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my employer to withhold payments from my wages as contribution to the premium, as appropriate.
6. Enrollment of myself and of the listed dependents into the plan if effective on acceptance by Principal Life.

Misrepresentation

7. Any person who includes any false or misleading information on an Enrollment/Change form for a health benefits plan is subject to criminal and civil penalties.