Principal® Financial Group

Mailing Address:
711 High Street
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - NY

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 _____

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**

* Foster child coverage is not available for life insurance. 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 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 and belief. 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.
- I authorize Principal Life to release data as required by law. This data may include age, medical history, claims information, job, income, habits, and other personal characteristic and identifying information. 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 an authorization for information at any time. I understand data obtained will be used by Principal Life to administer and underwrite 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.

Print

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

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.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for **accident and health** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

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