Principal Financial Group

Company Name _____

Account & Unit Number _____ – _____

Employee Enrollment & Waiver - CA

Employee Information

Your Name (Last) (First) (MI) Social Security Number

Mailing Address (Street) Date Employed Full-Time (Month, Day, Year)

(City) (State) (ZIP) Birth Date (Month, Day, Year)

Hrs Wrkd Per Wk Job Occupation/Class Location

☐ Male ☐ Female

Do you have an eligible spouse or child? ☐ Yes ☐ No What is your payroll mode? ☐ Mnthly ☐ Bi-mnthly ☐ Wkly ☐ Bi-wkly

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

Coverage	Employee		Spouse		Children	
Dental	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
Vision	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
Short Term Disability	☐ Elect	☐ Decline				
Long Term Disability	☐ Elect	☐ Decline				
Group Term Life	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline

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

If Waiving Coverage, Information Will Appear on the Following Page(s)

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 Social Security Number ☐ Male ☐ Female

Name(s) of Child(ren) Birth Date Social Security Number

☐ Male ☐ Female ☐ 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 both sides of this form ==>>

Employee Name: _____ Employee SSN: _____

Name(s) of child(ren)	Birth date		Social security number	
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*
		☐ Male ☐ Female		☐ foster child*

Employee Signature *(Read and sign below.)*

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including step and foster children and those over the maximum age, are eligible for coverage based on plan provisions. Eligibility for my dependents, over the maximum age, will be verified when claims are submitted.
- If I decline dental coverage, I and/or my dependents may enroll at a later date. However, enrolling late will affect the level of dental benefits.
- If I decline any type of life and/or disability coverages, I may apply at a later date. However, I must provide proof of good health at my own expense and coverage will only become effective subject to approval from Principal Life.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

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:

- *One for the employer*
- *One for the employee*

Underwritten by:
Principal Life Insurance Company

Mailing Address:
Des Moines IA 50392-0002