Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - IA

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:

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

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		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.

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, medical 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 (other than for AIDS), 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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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

Employee Name: ______________________________ Employee SSN: ____________________

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**
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		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child**
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Employee Name: ______________________________ Employee SSN: ___________________

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		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child**
		☐ male ☐ female		☐ foster child* ☐ disabled or handicapped child**

Employee Signature (Read and sign.) **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. 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, 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.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0302. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.
- For Wellness PPO Program Medical Coverage: I understand and authorize Principal Life to disclose information to my employer indicating the level of benefits for which I am qualified, but Principal Life will not disclose why I am qualified for the particular level of benefit.

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** _____