Principal® Financial Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - WV

Company name	Division level	Account number/unit number

Employee Information

Name			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

Dental

Employee: ☐ Elect ☐ Decline

Spouse: ☐ Elect ☐ Decline

Children: ☐ 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 Dental Coverage Has Been Entered It Will Appear on the Following Page(s)

Vision

Employee: ☐ Elect ☐ Decline

Spouse: ☐ Elect ☐ Decline

Children: ☐ Elect ☐ Decline

Short Term Disability

Employee: ☐ Elect ☐ Decline

Long Term Disability

Employee: ☐ Elect ☐ Decline

Group Term Life

Employee: ☐ Elect ☐ Decline

Dependent Life: ☐ Elect ☐ Decline

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

Employee: ☐ Elect ☐ Decline	$_____	
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? ☐ Yes ☐ No		
Spouse: ☐ Elect ☐ Decline	$_____	Birth date
Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in past 12 months? ☐ Yes ☐ No		
Children: ☐ Elect ☐ Decline	$ _____	

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: 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.

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)

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

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ 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, was the child placed with you by an authorized state placement agency or by order of a court? ☐ 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.

Is your spouse employed by this company? ☐ Yes ☐ No

Employee Agreement (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.
- If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- 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 Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates

Employee Name: ______________________ Employee SSN: ______________________

Dependent Name	Birth date	Gender	Social security number	Relationship
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**
		☐ Male ☐ Female		☐ foster child* ☐ disabled child**

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, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- 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.
- Explanation of Benefits reflecting claims payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Principal Life only as allowed by law.
- 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.
- 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:

- One for the employee
- One for the employer