

# Principal Life Insurance Company



Des Moines, IA 50392-0002

PLEASE USE BLACK INK  
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Division level	Account number/unit number
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**Employee Information**

Name		Social security number		
Mailing address (street)		Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	
(City)	(State)	(ZIP code)		
Date employed full-time	Hours worked per week	Job occupation/class	Location	
Email address		Home number	Mobile number	
Salary (for owners, include business income)	Salary mode <input type="checkbox"/> yearly <input type="checkbox"/> weekly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly			
Employer ZIP code	Employer county			

**Eligible Dependent Information** (Complete if you are electing benefits for your spouse or state registered domestic partner or nonregistered domestic partner<sup>1</sup> or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> spouse <input type="checkbox"/> state registered domestic partner <input type="checkbox"/> nonregistered domestic partner <sup>1</sup>
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child <sup>2</sup> <input type="checkbox"/> disabled child <sup>3</sup>
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child <sup>2</sup> <input type="checkbox"/> disabled child <sup>3</sup>
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child <sup>2</sup> <input type="checkbox"/> disabled child <sup>3</sup>
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child <sup>2</sup> <input type="checkbox"/> disabled child <sup>3</sup>

<sup>1</sup>Nonregistered Domestic Partners are eligible only if your employer allows this coverage. If enrolling a Nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60603).

<sup>2</sup>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

<sup>3</sup>When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or state registered domestic partner or nonregistered domestic partner<sup>1</sup> employed by this company?  
 yes  no

If you and your spouse or state registered domestic partner or nonregistered domestic partner<sup>1</sup> are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.

If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner <sup>1</sup>	Child(ren)
<b>NOTE: Employee coverage must be elected to elect any dependent coverage.</b>			
Dental	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> 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? <input type="checkbox"/> yes <input type="checkbox"/> no		
Vision	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Group term life	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Voluntary term life benefit amount:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____ <b>Cannot exceed 100% of the employee election</b>	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____ <b>Cannot exceed 100% of the employee election</b>
Short term disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
Long term disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
Critical illness benefit amount:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	
Accident	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Hospital indemnity	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline

**Nicotine Products**

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

Employee:  yes  no

Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner<sup>1</sup>:  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. Additional beneficiaries can be added as an attachment.

**Primary beneficiaries:**

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

**Contingent beneficiaries:**

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

**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. Additional beneficiaries can be added as an attachment.

**Primary beneficiaries:**

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

**Contingent beneficiaries:**

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

**Accident Beneficiary Designation** (Complete if accident insurance includes Accidental Death and Dismemberment)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

**Primary beneficiaries:**

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

**Contingent beneficiaries:**

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

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 designated a minor child(ren) as your beneficiary, complete the Uniform Transfers to Minors Act form (GP55229).

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.

**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 or vision or accident or hospital indemnity coverage, I cannot enroll until the next open enrollment.
- If I refuse life, disability, or critical illness coverage, I may apply later but I must show evidence of insurability 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 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.
- **For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**
- I understand collection of social security numbers for myself and/or my dependents will be used by Principal Life Insurance Company 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 coverage. Information will not be used for any purposes prohibited by law.
- 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.

If electing Critical Illness or Hospital Indemnity coverage, I declare that I and my eligible dependents have other coverage providing comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan.

NOTE: Critical Illness or Hospital Indemnity coverage cannot be issued to a person who does not have comprehensive health benefits coverage in place.

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:

- Employee retains a copy of the form, and
- Enrollment is submitted to Principal Life:
  - Use eService to submit enrollment information at [www.principal.com](http://www.principal.com). Employer retains the original form.
  - Or, email the form to [groupbenefitsadmin@principal.com](mailto:groupbenefitsadmin@principal.com).
  - Or, send the original form to Principal Life Insurance Company. Employer retains a copy of the form.