Mailing Address:
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) (mi) | Social security number

Mailing address (street) | Birth date (month/day/year) | male female

(city) (state) (ZIP code) | Do you have an eligible spouse or child? yes no

Date employed full-time (month/day/year) | Hrs worked per week | Job occupation/class | Location

Salary amount | Salary mode yr wk hr mo bi-wkly | What is your payroll mode? mthly bi-mnthly wkly bi-wkly

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
	In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? yes no					
Vision	elect	decline	elect	decline	elect	decline
Short Term Disability	elect	decline				
If STD Buy-up option is available, check one:	elect	decline				
Long Term Disability	elect	decline				
If LTD Buy-up option is available, check one:	elect	decline				
Group Term Life	elect	decline	elect	decline	elect	decline
Supplemental Term Life	elect	decline				
	$ ______ or ______ x annual salary		$ ______			
Voluntary Term Life	elect	decline	elect	decline	elect	decline
	$ ______ or ______ x annual salary		$ ______		$ ______	

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

spouse's group coverage   individual insurance

other ______

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.

Important – Complete Page 1 and Page 2.

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

Spouse's name	Birth date	male / female	Social security number

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 below.)*

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/or my dependents may enroll later but this will affect the level of benefits. If I refuse life and/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 I refuse coverage, I cannot enroll after retirement.
- If the group policy does not require my contributions, 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.
- 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/or 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.

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.

Applies to Accident and Health insurance only: Any person who knowingly and with intent to defraud any insurance company or other person files an application for 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 Page 1 only
- Employee – copy of Page 1 and Page 2