



Mailing Address: Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - CT

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 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.)

Table with columns: Coverage, Employee, Spouse, Children. Rows include Dental, Vision, Short Term Disability, Long Term Disability, Group Term Life, Supplemental Term Life, Voluntary Term Life, and nicotine product usage questions.

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 | male | female | Social security number
Name(s) of child(ren) | Birth date | male | female | Social security number | 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 Page 1, Page 2, and Page 3.

**Health Information Questions** (Read the Notice of Information Practices prior to answering.)

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 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 \_\_\_\_\_ )?

2. yes no In the past 5 years, has anyone had surgery, been hospitalized or consulted with a doctor, 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
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Diagnosis of illness or condition	Type of treatment/names of all medications
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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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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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Diagnosis of illness or condition	Type of treatment/names of all medications
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Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

**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, 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/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 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 and/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, insurance company, consumer reporting agency or employer 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.

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 to the best of my knowledge and belief. 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:

- Employer – copy of Page 1 only
- Employee – copy of Page 1, Page 2, and Page 3

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**Notice of Information Practices** *(To be read before completing the Health Information Section.)*

In order to properly underwrite, we must collect information. We will do this by having you complete the Health Information Section. In addition, we may contact sources besides yourself for personal data about any proposed insured, including spouse, employer, medical professionals or institutions, and insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to governmental agencies, attending physicians, insurance organizations without identification, and the employer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

- to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
- to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

- the nature and scope of personal data in our records;
- the types of disclosures which may be made; and
- rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact Group Operations, Medical Underwriting, Principal Life Insurance Company, Des Moines, IA 50392-0432.

*Please keep this notice for your records.*