Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver – PA

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	
Medical	elect	decline	elect	decline	elect	decline
	Medical options: ______ *(e.g., deductibles, PPO, etc.)*					
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 coverage offered by my employer

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, Page 2, and Page 3.

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

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

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

Health Information Questions (continued)

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

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 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 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 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 subjects such person to criminal and civil penalties.
- 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.
- 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.

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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Federal Regulations require an employee to receive the following notices for medical coverage offered in the state of Pennsylvania.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or services during the preexisting condition period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you and/or your dependents were covered under a prior health plan. You and/or your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you and/or your dependents.

Special Enrollment Rights

If you and/or your dependents decline coverage because you have other health insurance, you may enroll within 31 days following the loss of other insurance. Loss of coverage includes:

- COBRA or state continuation coverage exhausted
- reduction in work hours or termination of employment
- employer contributions have terminated
- death, divorce or legal separation

If you and/or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you and/or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll if coverage is requested within 31 days, of a court or administrative order to provide health coverage (and dental, if applicable).

Please keep this notice for your records.

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.