Principal®

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver-GA

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

Company name	Division level	Account number/unit number
Steppingblocks Inc	All Members	

Employee Information

Name		Social security number	
Mailing address (street)		Birth date	☐ male ☐ female
(city)	(state)		(ZIP code)

Date employed full-time	Hours worked per week	Job occupation/class	Location

Email address	Phone number

Do you have an eligible spouse or domestic partner or child(ren)?
☐ yes ☐ no

Payroll mode	Employer ZIP code	Employer county
☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly	30305	FULTON

Eligible Dependent Information (Complete if you are electing benefits for your spouse or domestic partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ Spouse ☐ domestic partner
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled 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 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 domestic partner employed by this company?
☐ yes ☐ no

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ 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			
Vision	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60448).

Declining Coverage

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

☐ spouse's or domestic partner's group coverage
☐ individual insurance
☐ other coverage offered by my employer
☐ other _____

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 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 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.
- 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, disability, and critical illness. 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 applying for critical illness coverage, I understand that it is not a replacement or substitute for any major medical coverage.

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 Insurance Company.

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