Principal Financial Group

Principal Life Insurance Company

Employee Enrollment & Waiver – CA

Company name | Division level | Account number/unit number

Employee Information

Your name (last, first, middle initial) | 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 (STD)	☐ elect	☐ decline				
If STD Buy-up option is available, check one:	☐ elect	☐ decline				
Long Term Disability (LTD)	☐ 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 (VTL)	☐ elect	☐ decline	☐ elect	☐ decline	☐ elect	☐ decline
	$ _____ or _____ X annual salary		$ _____		$ _____	
	☐ VTL only	☐ VTL with AD&D	☐ VTL only	☐ VTL with AD&D		

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 and Page 2.

Print

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**

*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.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and/or my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. 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.
- 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 and Page 2

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

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 6 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, due to a court or administrative order to provide health coverage (and dental, if applicable).

If you are already enrolled for coverage, and your spouse has declined coverages, your spouse 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.