Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver – NH

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-wkdy | What is your payroll mode? ☐ mthly ☐ bi-mnthly ☐ wkly ☐ bi-wkdy

Employer ZIP | Employer county

Benefit Options (You can only elect those coverages offered by your employer. You cannot decline any coverage paid in full by your employer.)

Coverage	Employee		Spouse		Children	
Dental	☐ elect	☐ decline	☐ elect	☐ decline	☐ elect	☐ decline
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.

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*
		☐ male ☐ female		☐ foster child*
		☐ male ☐ female		☐ 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 and Page 2.

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 requires my contributions, 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.

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, send the original to Principal Life Insurance Company and make copies:

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