Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver – NY

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.)*

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*

* Foster child coverage is not available for life insurance. 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) ☐ 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

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Any current symptoms or problems

Names and addresses of doctors, hospitals or other providers

Print

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 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 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.
- 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. This data may include age, medical history, claims information, job, income, habits, and other personal characteristic and identifying information. 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 an authorization for information at any time. I understand data obtained will be used by Principal Life to administer and underwrite 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. I understand an agent or broker cannot guarantee coverage, revise rates, benefits, or provisions without written approval from Principal Life.

Applies to Accident and Health Insurance only: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

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, 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 administer and underwrite your request for coverage, 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, claims information, job, income, habits and other personal characteristic and identifying 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.