



Mailing Address: Des Moines, IA 50392-0002

Principal Life Insurance Company Employee Enrollment & Waiver - AZ

Company name | Division level | Account number/unit number

Employee Information

Your name (last, first, middle initial) | Social security number | Mailing address (street) | Birth date | (city) | (state) | (ZIP code) | Do you have an eligible spouse or child? | Date employed full-time | Hours worked per week | Job occupation/class | Location | Salary amount | Salary mode | What is your payroll mode? | Employer ZIP | Employer county

Benefit Options (You can only elect those coverages offered by your employer.)

Table with columns: Coverage, Employee, Spouse, Children. Rows include Medical, Dental, Vision, Group term life, Voluntary term life (VTL), Supplemental term life, Short term disability (STD), Long term disability (LTD). Includes 'Important!' section for declining coverage.

Nicotine Products

Have you used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months? | Has your spouse used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?

Important – Complete Page 1, Page 2, Page 3, Page 4, and Page 5.

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

The right to make future changes is reserved. If two or more beneficiaries are named, the proceeds shall be paid to the named beneficiaries, or to the survivor or survivors, in equal shares, unless specified otherwise.

If any beneficiary is designated as trustee, it is understood and agreed that Principal Life Insurance Company shall not be a party to nor bound by the conditions of any trust and payment of the net proceeds of said policy on the death of the insured to the then designated beneficiary shall be a complete discharge as to Principal Life.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form.

NOTE: If you are covered by both group term life and voluntary term life coverage and only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children.)

Spouse's name		Birth date	male female	Social security number
Name(s) of child(ren)	Birth date		male female	Social security number 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.

Is your spouse employed by this company? yes no

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. I have read and understand the Preexisting Condition Exclusion and the Special Enrollment Rights and know if I refuse medical coverage, I and my dependents must wait for the next open enrollment unless I become eligible during a Special Enrollment. If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits. If I refuse life 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. 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 or material 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.

- I authorize Principal Life to release data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, from the date shown below, this form shall be valid for two years for all information except Human Immunodeficiency Virus (HIV) information for which the form shall be valid for 180 days. 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 my dependents will be sent to my home address. I also understand collection of social security numbers for myself and my dependents will be used by Principal Life only as allowed by law.
- For life coverage, 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.

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 Pages 1, 2, 3, and 4
- Employee – copy of Pages 1, 2, 3, and 4

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

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 service 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; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you or your dependents were covered under a prior health plan. You and your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life Insurance Company 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 or your dependents.

Special Enrollment Rights

If you and your dependents decline coverage because you have other health coverage, you may enroll within 31 days following:

- **Loss of eligibility**

Loss of eligibility includes:

- death, divorce, legal separation, or cessation of dependent status
- reduction in work hours or termination of employment
- if the other health coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area (and if the other health coverage is provided in the group market, no other benefit package is available to the individual)
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- if the other health coverage no longer offers any benefits to a class of similarly situated individuals

- **Employer contributions have terminated**

- **COBRA or state continuation has exhausted**

Exhaustion of COBRA or state continuation includes:

- failure of the employer or other responsible entity to remit premiums timely
- if continued coverage is offered through an HMO, or other similar arrangement, and does not provide benefits to individuals who no longer reside, live, or work in the service area and no other benefit package is available to the individual
- an incurred claim that would meet or exceed a lifetime limit on all benefits
- completion of the maximum continuation period

Special Enrollment Rights (continued)

If you 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 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 or your dependent child have declined coverage, you and your dependent child may enroll if coverage is requested after the date of a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN).

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

Additional Information

To obtain additional information or assistance, contact:

Principal Life Insurance Company
Des Moines, IA 50392-0002

Attn: Group Call Center
Telephone: 1-800-843-1371

Please keep this notice for your records.