



Mailing Address  
Des Moines, IA 50392-0002

**Principal Life  
Insurance Company**

**Employee  
Enrollment &  
Waiver - WI**

Company name	Division level	Account number/unit number
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**Employee Information**

Name			Social security number		
Mailing address (street)			Birth date		male female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? Yes      No		
Date employed full-time		Hours worked per week	Job occupation/class		Location
Salary amount	Salary mode yearly      weekly      hourly      monthly      bi-weekly				
What is your payroll mode? monthly   semi-monthly   weekly   bi-weekly			Employer ZIP 54914		Employer county

**Group Term Life**

Employee:

Elect

**Group Term Life Beneficiary Designation** (Complete if covered for group term life coverage.)

**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



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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 my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- 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 Insurance Company.
- 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, 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 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 claims payments for myself or my dependents will be sent to my home address. I also understand collection of social security numbers for myself or 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:

- One for the employee
- One for the employer