

Principal
Financial Group

Principal Life Insurance Company

Mailing Address
Des Moines, IA
50392-0002

Employee Enrollment & Waiver-CA

Company name	Division level	Account number/unit number
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Employee Information

Name		Social security number	
Mailing address (street)		Birth date	<input type="checkbox"/> male <input type="checkbox"/> female
(city)	(state)	(ZIP code)	
Do you have an eligible spouse or state registered domestic partner or nonregistered domestic partner or child(ren)? <input type="checkbox"/> yes <input type="checkbox"/> no			
Date employed full-time	Hours worked per week	Job occupation/class	Location
Email address		Phone number	
Salary amount	Salary mode <input type="checkbox"/> yearly <input type="checkbox"/> weekly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly		
What is your payroll mode? <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly		Employer ZIP	Employer county

Eligible Dependent Information (Complete if you are electing benefits for your spouse or state registered domestic partner or nonregistered domestic partner or children)

Dependent name	Birth date	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Relationship <input type="checkbox"/> spouse <input type="checkbox"/> state registered domestic partner <input type="checkbox"/> nonregistered domestic partner <input type="checkbox"/> child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> spouse <input type="checkbox"/> state registered domestic partner <input type="checkbox"/> nonregistered domestic partner <input type="checkbox"/> child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**

* If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court? yes no

** When your child, who is developmentally or physically disabled, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or state registered domestic partner or nonregistered domestic partner employed by this company?
 yes no

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner*	Child(ren)
Dental	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? <input type="checkbox"/> yes <input type="checkbox"/> no			
Vision	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Group Term Life	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Voluntary Term Life	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____
Short Term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
Long Term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
Critical Illness	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____

Important: You must elect Employee coverage in order to elect the coverage for your dependent(s).

If you are applying for critical illness coverage, do you or your other eligible dependents have other benefits from an individual or group policy or contract that arranges for or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans in force as of the date of this application for critical illness coverage?

NOTE: Critical Illness coverage cannot be issued to a person who does not have such insurance in force.

employee: yes no spouse or state registered domestic partner or nonregistered domestic partner: yes no

* If enrolling a Nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60603).

Nicotine Products

Has any person used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?

Employee: yes no

Spouse or state registered domestic partner or nonregistered domestic partner: yes no

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

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 by the employee. 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 .

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