Principal® Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver - OK

Company name | Division level | Account number/unit number

Employee Information

Your name (last, first, middle initial) | 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 | Employer county

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

Coverage	Employee	Spouse	Children
Medical	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
	Medical options: _____ (e.g., deductibles, PPO, etc.)		
Dental	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
	Dental options: _____ (e.g., deductibles, PPO, etc.)		
	In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself or your dependents) with a prior carrier? ☐ yes ☐ no		
Vision	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
Group Term Life	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
Voluntary Term Life (VTL)	☐ elect ☐ decline	☐ elect ☐ decline	☐ elect ☐ decline
	$_____ or _____ X annual salary	$_____	$ _____
	☐ VTL only ☐ VTL with AD&D	☐ VTL only ☐ VTL with AD&D	
Supplemental Term Life	☐ elect ☐ decline		
	$_____ or _____ X annual salary		
Short Term Disability (STD)	☐ elect ☐ decline	If STD Buy-up option is available, check one:	☐ elect ☐ decline
Long Term Disability (LTD)	☐ elect ☐ decline	If LTD Buy-up option is available, check one:	☐ elect ☐ decline

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

☐ spouse's group coverage ☐ individual insurance ☐ other coverage offered by employer

☐ other _____

Nicotine Products

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

Beneficiary Designation (Complete if life coverages are elected.) **110**

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

Primary Beneficiaries:

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

Contingent Beneficiaries:

Name	Relationship
Address	Social security number
Name	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.

Eligible Dependent Information (Complete if you have elected benefits for your spouse or children.) **110**

Spouse's name	Birth date	☐ male ☐ female	Social security number

Name(s) of child(ren)	Birth date		Social security number	
		☐ male ☐ female		☐ 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.

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 any person on whom coverage is requested currently using tobacco products, including cigarette, pipe, cigar or chewing tobacco? If so, how long? _____

Which applicant(s)? _____

2. ☐ 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 _____)?

3. ☐ 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)/infection with HIV (Human Immunodeficiency Virus)/other immune disorder

Print

Health Information Questions (continued) **110**

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

Employee Signature (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 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.

Employee Signature (Read and sign below.) (continued) **110**

- For life and disability coverages, I authorize any health care provider 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. 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 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.
- For medical coverage, I authorize pharmacy benefit managers, "health care providers", and entities covered under the HIPAA Privacy Rule and their agents and employees, to disclose my personal health information to Principal Life, its agents, and employees, for purposes of underwriting my application for coverage, and making eligibility, premium rating, and enrollment decisions, relating to any coverage I have, have applied for, or may in the future apply for with Principal Life or other entities covered under the HIPAA Privacy Rule. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, and the use of alcohol, drugs, and tobacco. This authorization shall remain in force for two years following the date of my signature. I may revoke this authorization in writing at any time by sending the request for revocation to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0302. A revocation is not effective if Principal Life has relied on the protected health information disclosed to it. Any information disclosed under this authorization may no longer be covered by privacy provisions of HIPAA and may be subject to redisclosure. I understand that if I refuse this authorization, Principal Life may not make an eligibility determination, and I will not be considered for coverage with Principal Life. I have read and I understand this authorization.

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 Page 1 and Page 2 only
- Employee – copy of Page 1, Page 2, Page 3, Page 4 and Page 5

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

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. The preexisting exclusion period is: 12 months for individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; or 6 months for late enrollees. This preexisting period will exclude benefits for any treatment or service received during the preexisting exclusion 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 if coverage is requested within 31 days of birth, adoption or placement 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 coverages, your spouse or 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

Notice of Information Practices for Life and Disability Coverages

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life. We will do this by having you complete an application or health statement. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

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 (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, and (d) 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:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. 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 these notices for your records.