

Mailing Address:  
Des Moines, IA 50392-0002

**Principal Life Insurance Company**

**Employee Enrollment & Waiver – CA**

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

Your name (last)	(first)	(mi)	Social security number
Mailing address (street)		Birth date (month/day/year)	
(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		What is your payroll mode?	
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. You cannot decline any coverage paid in full by your employer.)*

Coverage	Employee	Spouse	Children
Medical	elect      decline	elect      decline	elect      decline
	Medical options: _____ <i>(e.g., deductibles, PPO, etc.)</i>		
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	
<b>Important!</b> If declining any coverage for yourself or any dependent, give reason. Covered under:			
spouse's group coverage		individual insurance	other coverage offered by my employer
other _____			

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

Full name	Relationship
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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	Social security number
		female	
Name(s) of child(ren)	Birth date	male	Social security number
		female	foster child*
		male	
		female	foster child*
		male	
		female	foster 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

If your child is over the maximum age and handicapped, see your employer for the necessary form.

**Important** – Complete Page 1 and Page 2.



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

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### **Preexisting Condition Exclusion**

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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 6 months and will exclude benefits for any treatment or services 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 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 and/or your dependents were covered under a prior health plan. You and/or your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life 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 and/or your dependents.

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### **Special Enrollment Rights**

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If you and/or your dependents decline coverage because you have other health insurance, you may enroll within 31 days following the loss of other insurance. Loss of coverage includes:

- COBRA or state continuation coverage exhausted
- reduction in work hours or termination of employment
- employer contributions have terminated
- death, divorce or legal separation

If you and/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 and/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 are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll, due to a court or administrative order to provide health coverage (and dental, if applicable).

If you are already enrolled for coverage, and your spouse has declined coverages, your spouse may enroll if coverage is requested within 31 days, of a court or administrative order to provide health coverage (and dental, if applicable).

*Please keep this notice for your records.*