Principal® Financial Group

Company Name _____

Account & Unit Number _____ – _____

Employee Enrollment & Waiver - CA

Employee Information

Your Name (Last) (First) (MI) Social Security Number

Mailing Address (Street) Date Employed Full-Time (Month, Day, Year)

(City) (State) (ZIP) Birth Date (Month, Day, Year)

☐ Male ☐ Female Hrs Wrkd Per Wk Salary $ ☐ Yr ☐ Mo ☐ Wk ☐ Bi-wkly ☐ Hr

Job Occupation/Class

Location

Do you have an eligible spouse or child? ☐ Yes ☐ No

Benefit Options *(You can not decline any coverage paid in full by your employer and can only elect those coverages being offered.)*

Coverage	Employee		Spouse		Children	
Dental	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline
Vision	☐ Elect	☐ Decline	☐ Elect	☐ Decline	☐ Elect	☐ Decline

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

☐ Spouse's Group Coverage ☐ Individual Insurance ☐ Other _____

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

Spouse's Name	Birth Date		Social Security Number
		☐ Male ☐ Female	

Name(s) of Child(ren)	Birth Date		Social Security Number	
		☐ Male ☐ 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 both sides of this form ==>>

Employee Signature *(Read and sign below.)*

I understand and agree with the following statements:

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including step and foster children and those over the maximum age, are eligible for coverage based on plan provisions. Eligibility for my dependents, over the maximum age, will be verified when claims are submitted.
- If I decline dental coverage, I and/or my dependents may enroll at a later date. However, enrolling late will affect the level of dental benefits.
- 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.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
- **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

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 Insurance Company.

Your Signature X _____ **Date Signed** _____

Instructions

After this form is completed and signed, send the original to Principal Life Insurance Company and make two copies:

- *One for the employer*
- *One for the employee*

Underwritten by:
Principal Life Insurance Company

Mailing Address:
Des Moines IA 50392-0002