Employee Enrollment & Waiver-MA

Principal Life Insurance Company
Des Moines, IA 50392-0002

PLEASE USE BLACK INK
PLEASE ENTER DATES AS MM/DD/YYYY

Company name	Division level	Account number/unit number
UPTACK PLUMBING	ALL MEMBERS	1090848-10001

Employee information

Name			Social security number	
Mailing address (street)			Birth date	☐ male ☐ female
(City)		(State)		(ZIP code)
Date employed full-time	Hours worked per week	Job occupation/class		Location
Email address			Home number	Mobile number
Employer ZIP code		Employer county		

Eligible dependent information (Complete if you are electing benefits for your spouse [1] or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ domestic partner[1]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]

[1]Spouse will include Domestic Partners if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership / Enrollment Form Addendum (GP60456).

[2]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

[3]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[1] employed by this company?
☐ yes ☐ no

If you and your spouse[1] are both employed at the same company, and eligibile for benefits, you are not eligible to have benefits as both a Member and a Dependent.
If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.

Coverage	Employee	Spouse[1]	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

Employee agreement (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.
- If I refuse dental, I cannot enroll until the next open enrollment.
- 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.
- Any person who, with intent to defraud or knowing that they are 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.
- I understand collection of social security numbers for myself and/or my dependents will be used by Principal Life Insurance Company only as allowed by law.
- 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 coverage. Information will not be used for any purposes prohibited by law.
- 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:

- Employee retains a copy of the form, and
- Enrollment is submitted to Principal Life:
  - Use eService to submit enrollment information at www.principal.com. Employer retains the original form.
  - Or, email the form to groupbenefitsadmin@principal.com.
  - Or, send the original form to Principal Life Insurance Company. Employer retains a copy of the form.