

**Employee Enrollment
& Waiver-DC**

**Principal Life Insurance
Company**
Des Moines, IA 50392-0002



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

Company name HIRE IT PEOPLE	Division level ACTIVE MEMBERS	Account number/unit number 1068862-10001
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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)	
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 or civil union partner or Registered Domestic Partner or Nonregistered Domestic Partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> spouse <input type="checkbox"/> civil union partner <input type="checkbox"/> registered domestic partner <input type="checkbox"/> nonregistered domestic partner
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²

¹If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court?

yes no

²When 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 civil union partner or Registered Domestic Partner or Nonregistered Domestic Partner employed by this company?

yes no

Coverage	Employee	Spouse or civil union partner or registered Domestic Partner or nonregistered Domestic Partner ³	Child(ren)
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NOTE: Employee coverage must be elected to elect any dependent coverage.

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
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

³NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60445).

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 or vision coverage, 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. During the first two years coverage is in force, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
- 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.

