Principal® Financial Group

Mailing Address
Des Moines, IA 50392-0002

Principal Life Insurance Company

Employee Enrollment & Waiver-VA

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

Company name	Division level	Account number/unit number
Contemporary Nursing Solutions	All Eligible Members	

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			Phone number	
Salary amount (for owners, include business income)	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly			
Payroll mode ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly		Employer ZIP code 24504		Employer county LYNCHBURG CITY

Eligible Dependent Information (Complete if you are electing benefits for your spouse or domestic partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ Spouse ☐ domestic partner
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**

* 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

** When your child, who is intellectually disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

Is your spouse or domestic partner employed by this company?
☐ yes ☐ no

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)

NOTE: Employee coverage must be elected to elect any dependent coverage.

Dental	Choose from one of the following plans.		
Plan #1	Design Description: Dental PPO - Core		
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Plan #2	Design Description: Dental PPO - Enhanced		
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Voluntary Term Life (VTL) Benefit Amount:	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**	☐ Elect ☐ Decline $_____

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60482).

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Contingent Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

The right to make future changes is reserved by the employee. 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 Insurance Company.

If you have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form (GP55229).

Declining Coverage

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

☐ spouse's or domestic partner's group coverage ☐ individual insurance

☐ other coverage offered by my employer ☐ other _____

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 coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.

- If I refuse life, disability, or critical illness coverage, I may apply later but I must show proof of good health and coverage will be subject to approval by Principal Life Insurance Company.
- 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 Insurance Company is not liable for a claim before the effective date of coverage and all policy provisions apply. I certify that 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.
- Any person who, with the 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 have violated state law.
- Explanation of Benefits reflecting claims payments for myself and my dependents will be sent to my home address. I also 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 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.

Upon written request, Principal Life Insurance Company will furnish to you (or your dependent) or authorized representative, a copy of this form.

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:

- One for the employee
- One for the employer