Principal Financial Group

Mailing Address:
Des Moines, IA 50392-0002

Underwritten by:
Principal Life Insurance Company

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Enrollment Form – CA

Company Name _____ **Account Number** [ ]

A. Employee Information

Your name (last, first, middle initial) | Social security number

Address (street or P.O. Box) | City | State | ZIP code

Date of birth (mo/day/yr) | ☐ male ☐ female | ☐ single ☐ married | Phone number | County

Date of Full-Time employment | Job position/location

Present salary excluding overtime and bonuses | Hours per week

$ ☐ yr ☐ mo ☐ wk ☐ hr

B. Beneficiary Designation: Complete only if your coverages include group term life insurance.

Beneficiary for employee group term life insurance (Print as "Doe, Mary A.", not "Mrs. John Doe")

last name | first name | middle initial | relationship to you

Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. If no beneficiary has been designated, any proceeds will be payable as provided by the group policy.

C. Benefit Election: *Ask your employer what coverages the policy has. Check your election option(s) below.

From the coverage options available that apply, I elect the following coverage(s):*

☐ supplemental life amount _____ ☐ medical ☐ all coverages

☐ supplemental AD&D amount _____ ☐ dental

I elect medical coverage for:*

☐ myself ☐ spouse ☐ child(ren) ____ (indicate number of child(ren) to be covered)

I elect dental coverage for:*

☐ myself ☐ spouse ☐ child(ren) ____ (indicate number of child(ren) to be covered)

I elect vision coverage for:*

☐ myself ☐ spouse ☐ child(ren) ____ (indicate number of child(ren) to be covered)

*If you do not elect any/all coverage for yourself and any/all eligible Dependents, complete the next page.

D. Dependent Information: Please list your spouse and all eligible children.

Spouse's name | Social security number | Date of birth (mo/day/yr)

Full name of Dependent child(ren)	Social security number	Date of birth mo	day	yr	Full-Time student	Foster child	Step child	Handicapped child	Male	Female
1.										
2.										
3.										
4.										

Dependents must meet eligibility requirements. Foster child and stepchild eligibility is subject to approval by The Principal. Complete a Foster Child and Stepchild Questionnaire. If you have Developmentally Disabled/Physically Handicapped children over age 19 (over age 20 for Life Insurance), complete an Application to Continue Handicapped Child. Contact your employer for assistance with any questions.

E. Employee Signature

If the group policy requires that contributions be made by me, I authorize my employer to deduct them from my pay. I have read the notice regarding the Preexisting Condition Exclusion and Special Enrollment Rights, located on the back page of this form, and I understand these provisions. I declare that the information given on this enrollment form is complete and true. I understand an agent cannot guarantee coverage, revise rates, benefits, or provisions without written approval by an officer of The Principal.

Your signature (Do not print) | Date signed

F. The Principal to Complete

Employee effective date | Dependent effective date