

Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver – AK

Company name	Division level	Account number/unit number
--------------	----------------	----------------------------

Employee Information

Your name (last)	(first)	(mi)	Social security number
Mailing address (street)	Birth date (month/day/year)		male female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? yes no
Date employed full-time (month/day/year)	Hrs worked per week	Job occupation/class	Location
Salary amount	Salary mode yr wk hr mo bi-wkly	What is your payroll mode? mthly bi-mnthly wkly bi-wkly	
Employer ZIP	Employer county		

Benefit Options (You can only elect those coverages offered by your employer.)

Coverage	Employee	Spouse	Children
Medical	elect decline	elect decline	elect decline
	Medical options: _____ (e.g., deductibles, PPO, etc.)		
Dental	elect decline	elect decline	elect decline
	In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? yes no		
Vision	elect decline	elect decline	elect decline
Short Term Disability	elect decline	elect decline	elect decline
	If STD Buy-up option is available, check one: elect decline		
Long Term Disability	elect decline	elect decline	elect decline
	If LTD Buy-up option is available, check one: elect decline		
Group Term Life	elect decline	elect decline	elect decline
Supplemental Term Life	elect decline	elect decline	elect decline
	\$ _____ or _____ x annual salary \$ _____		
Voluntary Term Life	elect decline	elect decline	elect decline
	\$ _____ or _____ x annual salary \$ _____ \$ _____		
Have you used nicotine products in the past 12 months?	yes no	yes no	
Has your spouse used nicotine products in the past 12 months?	yes no	yes no	

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:
 spouse's group coverage individual insurance other coverage offered by my employer
 other _____

Beneficiary Designation (Complete if life coverages are elected.)

Full name	Relationship
-----------	--------------

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

Important – Complete Page 1 and Page 2.

Federal Regulations require an employee to receive the following notices for medical coverage offered in the state of Alaska.

Preexisting Condition Exclusion

Preexisting Conditions Exclusions apply to individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; and late enrollees.

A preexisting condition is a condition present before your enrollment date in any new health plan. If you or your dependents received, or were recommended to receive medical advice, diagnosis, care, or treatment for a condition (physical or mental), in the last six months, the preexisting exclusion will apply. The preexisting exclusion period is: 12 months for individuals covered on the policy issue date of a new group whose prior coverage was 12 months or less; or 6 months for late enrollees. This preexisting period will exclude benefits for any treatment or services received during the preexisting exclusion period.

Late enrollees may not enroll until the next annual open enrollment period at which time the preexisting condition exclusion period will apply. The preexisting exclusion will not apply to newborns or children under the age of 18 whom are adopted or placed for adoption if coverage is requested within 31 days of birth, adoption or placement for adoption; or pregnancy.

The preexisting exclusion period may be reduced by the number of days you and/or your dependents were covered under a prior health plan. You and/or your dependents have the right to demonstrate previous coverage by requesting a certificate of coverage from your prior health plan. If necessary, Principal Life will assist in obtaining a certificate. Once the amount of prior creditable coverage has been determined, you will receive a notice stating the length of any preexisting condition exclusion period that applies to you and/or your dependents.

Special Enrollment Rights

If you and/or your dependents decline coverage because you have other health insurance, you may enroll within 31 days following the loss of other insurance. Loss of coverage includes:

- COBRA or state continuation coverage exhausted
- reduction in work hours or termination of employment
- employer contributions have terminated
- death, divorce or legal separation

If you and/or your dependents have declined coverage, you may enroll within 31 days if there is a change in your family status. This includes:

- marriage
- birth of child
- adoption or placement for adoption

If you and/or your dependents do not enroll within 31 days, you will be considered a late enrollee and are subject to the Preexisting Condition Exclusion rules.

If you are already enrolled for coverage, and your dependents have declined coverages, your dependent child may enroll, due to a court or administrative order to provide health coverage (and dental, if applicable).

If you are already enrolled for coverage, and your spouse has declined coverages, your spouse may enroll if coverage is requested within 31 days, of a court or administrative order to provide health coverage (and dental, if applicable).

Please keep this notice for your records.