Principal® Financial Group

Mailing Address
Des Moines, IA 50392-0002

**Principal Life Insurance Company**

***Employee Enrollment & Waiver - OR***

| Company name | Division level | Account number/unit number |
|---|---|---|
| PORTLAND VA RESEARCH FOUNDATION | | H37655 |

## Employee Information

| Name | | | Social security number | |
|---|---|---|---|---|
| Mailing address (street) | | | Birth date | ☐ male ☐ female |
| (city) | (state) | (ZIP code) | Do you have an eligible spouse or child? ☐ Yes ☐ No | |
| Date employed full-time | Hours worked per week | | Job occupation/class | Location |
| Salary amount | Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly | | | |
| What is your payroll mode? ☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly | | | Employer ZIP | Employer county |

## Group Term Life

Employee: ☐ Elect

## Voluntary Term Life

| **Employee Benefit Election** | $10,000 | $20,000 | $40,000 | $60,000 | | Decline o |
|---|---|---|---|---|---|---|
| Bi-Weekly Premium* | | | | | | |
| Benefit Election – Check Box | ☐ | ☐ | ☐ | ☐ | | |

* Actual premium amount may be slightly different due to rounding.

| **Spouse Benefit Election** Can not exceed 100% of the employee election | Amount | Cost | | Decline o |
|---|---|---|---|---|
| | | | | |

Has your spouse used nicotine products in the past 12 months? o Yes o No

| **Child Benefit Election** | | | | | | Decline o |
|---|---|---|---|---|---|---|
| Bi-Weekly Premium* | | | | | | |
| Benefit Election – Check Box | | | | | | |

## Beneficiary Designation

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below.

**Primary Beneficiaries:**

| Name | Relationship | Address | Social security number |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Contingent Beneficiaries:**

| Name | Relationship | Address | Social security number |
|---|---|---|---|
| | | | |
| | | | |

| | | | |
|---|---|---|---|
| | | | |

The right to make future changes is reserved. 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 said company.

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

## Dental

Employee ☐ Elect ☐ Decline

Spouse ☐ Elect ☐ Decline

Children ☐ Elect ☐ Decline

In the past 12 months, have you, the applicant, had continuous group orthodontia coverage (for yourself and/or your dependents) with a prior carrier? ☐ Yes ☐ No

## Short Term Disability

Employee: ☐ Elect

## Long Term Disability

Employee: ☐ Elect

**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 _____

## Eligible Dependent Information (Complete if you have elected benefits for your spouse and/or children)

| | | | | |
|---|---|---|---|---|
| Spouse's name | Birth date | ☐ male<br>☐ female | Social security number | |
| Name(s) of child(ren) | Birth date | ☐ male<br>☐ female | Social security number | ☐ foster child*<br>☐ disabled or handicapped child ** |
| | | ☐ male<br>☐ female | | ☐ foster child*<br>☐ disabled or handicapped child ** |
| | | ☐ male<br>☐ female | | ☐ foster child*<br>☐ disabled or handicapped child ** |

* If you checked foster child, do you provide principal support and does the child(ren) live with you at least 50% of the time? ☐ Yes ☐ No

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

## **Employee Signature** (Read and sign below.)

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/or 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 and/or disability 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 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, false statements, omissions, and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowingly is facilitating a fraud against an insurer, submits an application or files a claim with false or deceptive statements, may be guilty of insurance fraud.
- 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 life and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments for myself and/or 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 only as allowed by law.
- For life coverage, 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, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer