Employee Enrollment & Waiver-WA

Principal Life Insurance Company
Des Moines, IA 50392-0002

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

Company name	Division level	Account number/unit number
COLUMBIA SURGICAL	ALL MEMBERS	1057855-10001

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			Home number	Mobile number
Salary (for owners, include business income)	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly			
Employer ZIP code		Employer county		

Eligible dependent information (Complete if you are electing benefits for your spouse or State Registered Domestic Partner[1] or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ state registered domestic partner ☐ domestic partner[1]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled child[3]

[1]Spouse will include Domestic Partners if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60484).

[2]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

[3]When 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 state registered domestic partner or domestic partner[1] employed by this company?
☐ yes ☐ no

If you and your spouse or state registered domestic partner or domestic partner[1] are both employed at the same company, and eligibile for benefits, you are not eligible to have benefits as both a Member and a Dependent.

If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.

Coverage	Employee	Spouse or State Registered Domestic Partner or Domestic Partner[1]	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Voluntary term life benefit amount:	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**

Nicotine products

Has any person used nicotine products (including cigarettes, e-cigarettes, pipe, cigar or chewing tobacco) in the past 12 months?

Employee: ☐ yes ☐ no Spouse or State Registered Domestic Partner or Domestic Partner[1]: ☐ yes ☐ no

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

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 refusecoverage, I cannot enroll until the next open enrollment, unless I have a qualifying event as described in the group policy.
- If I refuse life, 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 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.
- It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
- I authorize Principal Life Insurance Company 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 Insurance Company 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, for dependent group term life, voluntary term life, accident, or critical illness, I understand that no insurance may become effective for any member of my family while he/she is confined in a hospital or skilled nursing facility or home confined.

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 insurance producer cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life Insurance Company.

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 Insurance Company:
  - 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.