

Enrollment/Change Request - NJ

Principal Life Insurance Company
Des Moines, IA 50392-0002



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

Employer Group Information – To be completed by employer.

Company name	Division level	Account number/unit number
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A. Type of Activity – To be completed by employer. Refer to Instructions section before completing this form. Print clearly.

1. Enrollment	<input type="checkbox"/> new employee	Effective date	Date of hire
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2. Add – Check all that apply.	Effective Date/ Date of Event	Reason for Change
<input type="checkbox"/> add spouse/Civil Union Partner	_____	_____
<input type="checkbox"/> add domestic partner	_____	_____
<input type="checkbox"/> add dependent child	_____	_____

3. Remove – Check all that apply.	Effective Date/ Date of Event	Reason for Change
<input type="checkbox"/> employee withdrawal/termination	_____	_____
<input type="checkbox"/> remove spouse/Civil Union Partner ¹	_____	_____
<input type="checkbox"/> remove domestic partner ¹	_____	_____
<input type="checkbox"/> remove dependent child ¹	_____	_____

NOTE: Employee must be enrolled for spouse/dependents to have coverage. The term “Civil Union Partner” wherever used includes partners in a legally recognized union of the same sex which provides substantially all of the rights and benefits of marriage. The term “domestic partner” wherever used includes partners in relationships defined in the group policy which provide some, but not all of the rights and obligations of marriage.

¹Please complete Section D.

4. Other Change	Effective Date/ Date of Event	Reason for Change
<input type="checkbox"/> name change	_____	_____
<input type="checkbox"/> change plan	_____	_____
<input type="checkbox"/> other	_____	_____

5. Coverage Continuation

for employee

COBRA/NJSGC

Length of continuation (in months): 18 29 Date of loss of coverage: _____

Qualifying event number: _____² Date of qualifying event: _____

for spouse/Civil Union Partner¹

COBRA/NJSGC

Length of continuation (in months): 18 36 Date of loss of coverage: _____

Qualifying event number: _____² Date of qualifying event: _____

¹Civil Union Partners are eligible to make an election pursuant to NJSGC, if applicable.

for dependent child

COBRA/NJSGC

Length of continuation (in months): 18 36 Date of loss of coverage: _____

Qualifying event number: _____² Date of qualifying event: _____

² Qualifying event numbers: see list in Instructions.

B. Employee Information – To be completed by the employee.

Name (last, first, middle initial) _____ 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 _____

Employer name _____

Employer address _____ (City) _____

(State) _____ (ZIP code) _____ Employer phone _____ Employer county _____

Other dental or vision coverage _____ If yes, payer name _____ Policy number _____
 yes no

Salary (for owners, include business income) _____ Salary mode _____
 yearly weekly hourly monthly bi-weekly

C. Plan Options – To be completed by the employee. (Check all you elect coverage for.)

Coverage	Employee	Spouse or Civil Union Partner or Domestic Partner ³	Child(ren)
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NOTE: Employee coverage must be elected to elect any dependent coverage.

Dental	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
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In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself or your dependents) with a prior carrier? yes no

If I refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.

If your dental coverage includes Pediatric Dental Essential Benefits, please refer to GP61845 for information about free language services that may be available to you.

Vision	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
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If I refuse vision coverage, I and my dependents may enroll later but this will affect the level of benefits.

Group Term Life	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
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Voluntary Term Life Benefit amount: _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____ Cannot exceed 100% of the employee election	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____ Cannot exceed 100% of the employee election
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Short Term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
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Long Term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
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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.

Critical Illness Benefit amount: _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	
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Critical Illness – Please complete the following question if enrolling for critical illness coverage.

Do you or your eligible dependents have other hospital and medical services and supplies insurance in force as of the date of this enrollment for critical illness coverage? NOTE: Critical Illness coverage cannot be issued to a person who does not have hospital and other medical services and supplies insurance in force.

employee: yes no spouse or Civil Union Partner or domestic partner³: yes no

Accident	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Hospital Indemnity	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline

³NOTE: 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 (GP60468).

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 Civil Union Partner or Domestic Partner³: yes no

Group Term Life Beneficiary Designation (Complete if covered for group 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 <input type="checkbox"/>	Percentage

Contingent Beneficiaries:

Name	SSN	Date of Birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage. If you want to use the same beneficiary designation as indicated for group term life coverage above, write "same as above" in the beneficiary section below.)

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 <input type="checkbox"/>	Percentage

Contingent Beneficiaries:

Name	SSN	Date of Birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

Accident Beneficiary Designation (Complete if Accident Insurance includes Accidental Death and Dismemberment)

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 <input type="checkbox"/>	Percentage

Contingent Beneficiaries:

Name	SSN	Date of Birth	Relationship	Check here if a minor <input type="checkbox"/>	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.

If you designated a minor child(ren) as your beneficiary, complete the Uniform Transfers to Minors Act form (GP55229). NOTE: You are covered by both group term life and voluntary term life coverage and only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

D. Other Individuals Covered – To be completed by the employee. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated.

1. Spouse, domestic or Civil Union Partner

add remove other continue spouse continue Civil Union Partner (NJSGC)

Name (last, first, middle initial) | Birth date

male female | Social security number | Employed yes no | If yes, complete Section E1.

Home or billing address same as employee yes no | If no, complete Section E2.

add remove other continue ^{2. child}

Name (last, first, middle initial) | Birth date

foster child⁷ disabled⁸

D. Other Individuals Covered – To be completed by the employee. Identify individuals other than yourself for whom you are adding/changing/removing/continuing coverage. Attach additional pages if necessary, with your signature and dated – **continued.**

male female | Social security number | Living with employee yes no | If no, complete Section F.

If last name is different from employee's, please explain

add remove other continue ^{3. child}

Name (last, first, middle initial) | Birth date

foster child⁷ disabled⁸

male female | Social security number | Living with employee yes no | If no, complete Section F.

If last name is different from employee's, please explain

add remove other continue ^{4. child}

Name (last, first, middle initial) | Birth date

foster child⁷ disabled child⁸

male female | Social security number | Living with employee yes no | If no, complete Section F.

If last name is different from employee's, please explain

⁷ If you checked foster child, was the child placed with you by an authorized state placement agency or by a court? yes no

⁸ When your child, who is developmentally disabled or physically handicapped, reaches/exceeds the maximum age, an Application to Continue Disabled Child form must be completed and reviewed to determine eligibility.

E. Additional Spouse/Civil Union Partner/Domestic Partner Information – To be completed by the employee. If not applicable, please mark as “N/A”.

1. Employer name

Employer address

(city)	(state)	(ZIP code)	Employer phone
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2a. Street/apartment

(city)	(state)	(ZIP code)	
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2b. Please explain why the address is different

F. Additional Child Information – To be completed by the employee. Provide information below about children listed in ‘Section D, if they have a different address from the employee. If multiple children are at an address, you may list them together. Attach additional pages as necessary, signed and dated.

Name (s)			
Street/apartment			
(city)	(state)	(ZIP code)	
Reason			
Name (s)			
Street/apartment			
(city)	(state)	(ZIP code)	
Reason			

G. Employee Signature

I represent that all the information supplied in this application is true and complete to the best of my knowledge and belief. I hereby agree to the Conditions of Enrollment set forth in this Enrollment/Change Request form. I authorize deductions from my earnings for any contributions required from me.

Signature	Date
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H. Employer Verification

The requested activity is believed eligible and is approved by the employer.

Employer representative

Representative’s title	Date
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Instructions

- Employer** – You must complete the Employer Group Information and Sections A and H in order for this application to be processed.
- Employee** – You must complete all other sections in order for this application to be processed.
- Please PRINT except when a signature is requested.
 - Complete your full name along with the name(s) of your dependents(s), if applicable. Indicate Sex, Birth date, and Social security number for each individual listed.
 - If a dependent is disabled and you want to continue his or her coverage beyond the limiting age, you do not have to make a COBRA/NJSGC election. Instead, select “Other” in Section A4, and attach an Application to Continue Disabled Child form.

Instructions - continued

- Employee must sign and date the application in order for it to be processed.

Qualifying Events - COBRA and NJSGC

- C1. termination of job or reduction in hours
- C2. employee enrollment in Medicare (COBRA only)
- C3. divorce (COBRA/NJSGC); civil union dissolution (NJSGC)
- C4. death of employee
- C5. loss of dependent child status under the plan
- C6. disability (occurring subsequent to another qualifying event)

Conditions of Enrollment – Employee Acknowledgments and Agreements

On behalf of myself and the dependents listed in this Enrollment/Change Request form, I acknowledge that:

1. I authorize any physician or medical professional, hospital, clinic or other medical care institution, carrier, consumer, reporting agency, and any employer to give Principal Life, information pertaining to employment, other health coverage, and medical advice, treatment or supplies for any physical or mental condition relevant to me or a minor dependent applying for coverage. I agree that this authorization shall be valid for 30 months from the date I sign this Enrollment/Change Request form, unless revoked at an earlier date.
2. I agree that, if I revoke this authorization before it expires, such revocation shall not affect any action that Principal Life has taken in reliance on the authorization.
3. I understand I may receive a copy of this authorization if I request one.
4. I agree Principal Life will provide coverage in accordance with the terms of the contract for the group policy.
5. I agree that the provision of coverage and benefits is contingent upon payment of premiums and may be terminated in accordance with the terms of the group policy if premiums are not paid timely. I authorize my employer to withhold payments from my wages as contribution to the premium, as appropriate.

Misrepresentation

6. Any person who includes any false or misleading information on an Enrollment/Change Form for a health benefits plan is subject to criminal and civil penalties.