Principal® Financial Group

Return this form to:
Your Human Resources Office

Principal Life Insurance Company

Voluntary Term Life Employee Enrollment & Waiver - ID

Company name	Agency	Account number/unit number
State of Idaho		**H71129**

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(ren)? ☐ Yes ☐ No	
Date of Hire				

Voluntary Term Life

Employee Benefit Election **Minimum:$ 20,000** **Maximum:$500,000**	1 x salary	2 x salary	3 x salary
Monthly Premium			
Benefit Election – Check Box	☐	☐	☐

Spouse Benefit Election* **Minimum: $10,000** **Maximum:$50,000**	$10,000	$20,000	$30,000	$40,000	$50,000
Monthly Premium					
Benefit Election – Check Box	☐	☐	☐	☐	☐

Child(ren) Benefit Election*	$10,000
Monthly Premium	$2.00
Benefit Election – Check Box	☐

***Spouse or Child benefits cannot exceed 100% of Employee's coverage.**

Voluntary Term Life Beneficiary Designation

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

Primary Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number
Name	Percentage	Relationship
Address		Social security number

Contingent Beneficiaries:

Name	Percentage	Relationship
Address		Social security number
Name	Percentage	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 Principal Life.

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

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

Spouse's name	Birth date	☐ male ☐ female	Social security number	
Name(s) of child(ren)	Birth date	☐ male ☐ female	Social security number	☐ disabled or handicapped child *
		☐ male ☐ female		☐ disabled or handicapped child *
		☐ male ☐ female		☐ disabled or handicapped child *

* 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.

Is your spouse employed by The State of Idaho? ☐ Yes ☐ No

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 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 life 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.
- I authorize my employer to deduct contributions from my pay.
- I represent all information on this form and attachments are 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, fraud or intentional misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, 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 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, 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, please make a copy of it.

- Send the original form to your Human Resources Office
- Keep the copy for your records