

Employee Information

Your Name (Last) (First) (MI) Social Security Number

Mailing Address (Street) Date Employed Full-Time (Month, Day, Year)

(City) (State) (ZIP) Birth Date (Month, Day, Year)

Male Hrs Wrkd Per Wk Salary Yr Wk Hr Job Occupation/Class

Female \$ Mo Bi-wkly

Location Employer ZIP Employer County

Do you have an eligible spouse or child? Yes No

Benefit Options

Coverage	Employee	Spouse	Children
Medical	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
	Medical Options: _____ (e.g., deductibles, PPO, etc.)		
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
Long Term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
Group Term Life	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		

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.

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

Spouse's Name Birth Date Social Security Number

Male
 Female

Name(s) of Child(ren) Birth Date Social Security Number

Male Foster Child *
 Female

Male Foster Child *
 Female

Male Foster Child *
 Female

* 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
 If your child is over the maximum age and handicapped, see your employer for the necessary form.

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

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. This preexisting exclusion period is 12 months and will exclude benefits for any treatment or services during the preexisting condition 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 Insurance Company 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).

If you have a change in employee status which results in a change of benefits, you may enroll within 63 days.

Please keep this notice for your records.