Group Insurance ***Employee Enrollment & Waiver-NY***

Principal Life Insurance Company

Home Office Mailing Address
711 High Street
Des Moines, IA 50392-0002

Principal®

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

Company name	Division level	Account number/unit number
City of Lockport	ALL MEMBERS	1180460-10001

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
Employer ZIP code		Employer county		

Eligible dependent information (Complete if you are electing benefits for your spouse or Domestic Partner or children)

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

[1]Foster child coverage is not available for life insurance. If you checked foster child, was the child placed with you by an authorized state placement agency or by order of a court?

[2]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 Domestic Partner employed by this company?
☐ yes ☐ no

Coverage	Employee	Spouse or Domestic Partner[3]	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ 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		
Vision	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

The policy permits your employer to change, reduce, restrict, or terminate your rights or benefits under the policy without your consent and such change, reduction, restriction, or termination may occur at a time when your health status has changed and may affect your ability to obtain individual coverage.

[3]NOTE: 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 (GP60471).

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 are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse dental or vision coverage, I cannot enroll until the next open enrollment.
- If the group policy/certificate do not require my contribution, I cannot decline coverage unless the policy/certificate indicates otherwise.
- If the group policy/certificate require 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 and belief. 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/certificate provisions apply. I have read, or had read to me, the information and my answers on this form.
- I understand collection of social security numbers for myself and/or my dependents will be used by Principal Life Insurance Company only as allowed 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/certificate, 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 (confined at home or at a medical facility).
- 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 to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

The following statement does not apply to life insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For further information, about your file or rights, you may contact Group Operations, Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0432

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:
  - 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.