



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver-/A

Company name CITY OF NORWALK	Division level	Account number/unit number 1022998-10001
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Employee Information

Name		Social security number	
Mailing address (street)		Birth date	<input type="radio"/> male <input type="radio"/> female
(city)	(state)	(ZIP code)	Do you have an eligible spouse or child? <input type="radio"/> Yes <input type="radio"/> No
Date employed full-time	Hours worked per week	Job occupation/class	Location
Salary amount	Salary mode <input type="radio"/> yearly <input type="radio"/> weekly <input type="radio"/> hourly <input type="radio"/> monthly <input type="radio"/> bi-weekly		
What is your payroll mode? <input type="radio"/> monthly <input type="radio"/> semi-monthly <input type="radio"/> weekly <input type="radio"/> bi-weekly	Employer ZIP	Employer county	

Dental

Employee: <input type="radio"/> Elect <input type="radio"/> Decline	Spouse: <input type="radio"/> Elect <input type="radio"/> Decline	Children: <input type="radio"/> Elect <input type="radio"/> 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? <input type="radio"/> Yes <input type="radio"/> No		

Vision

Employee: <input type="radio"/> Elect <input type="radio"/> Decline	Spouse: <input type="radio"/> Elect <input type="radio"/> Decline	Children: <input type="radio"/> Elect <input type="radio"/> Decline
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Long Term Disability

Employee: <input type="radio"/> Elect
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Group Term Life

Employee: <input type="radio"/> Elect
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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.

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 _____

Voluntary Term Life

Employee: Elect Decline \$ _____

Spouse: Elect Decline \$ _____

Birth date _____

Children: Elect Decline \$ _____

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.

Primary Beneficiaries:

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

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.

NOTE: You are covered by both group term life and voluntary term life coverage and if you 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.

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:

spouse's group coverage

individual insurance

other

Do other coverage offered by my employer

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

Spouse's name	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	
Name(s) of child(ren)	Birth date	<input type="checkbox"/> male <input type="checkbox"/> female	Social security number	<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> foster child* <input type="checkbox"/> disabled or handicapped child **

* 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

**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 this company? 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 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 refuse dental coverage, I and my dependents may enroll later but this will affect the level of benefits.
- If I refuse coverage, I cannot enroll after retirement.
- If I refuse life or disability 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.