Principal Life Insurance Company

Mailing Address
Des Moines, IA
50392-0002

Dental

Employee Enrollment & Waiver-CA

Company name	Division level	Account number/unit number
LITERACY FIRST CHARTER SCHOOL	ALL MEMBERS	1054902

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	Phone number

Do you have an eligible spouse or State Registered Domestic Partner or Nonregistered Domestic Partner or child(ren)?
☐ yes ☐ no

Payroll mode	Employer ZIP code	Employer county
☐ monthly ☐ semi-monthly ☐ weekly ☐ bi-weekly	92021	SAN DIEGO

Eligible Dependent Information (Complete if you are electing benefits for your spouse or State Registered Domestic Partner or Nonregistered Domestic Partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ Spouse ☐ State Registered Domestic Partner ☐ Nonregistered Domestic partner
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled child**
		☐ male ☐ female		☐ Child ☐ foster child* ☐ disabled 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 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 State Registered Domestic Partner or Nonregistered Domestic Partner employed by this company?
☐ yes ☐ no

Coverage	Employee	Spouse or State Registered Domestic Partner or Nonregistered Domestic Partner*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	Choose from one of the following plans.		
Plan #1	Design Description: Dental POS - POS		
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Plan #2	Design Description: Dental EPO - EPO		
	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

*NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Nonregistered Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60603).

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 have designated a minor child(ren) as your beneficiary, you must complete the Uniform Transfers to Minors Act form (GP55229).

Declining Coverage

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

☐ spouse's or State Registered Domestic Partner's or Nonregistered Domestic Partner group coverage

☐ individual insurance

☐ other coverage offered by my employer

☐ other _____

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 the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires 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. 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 false statement made on this form will not bar the right to recovery under the group policy(ies) unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by Principal Life.
- Explanation of Benefits reflecting claims payments for myself and my dependents will be sent to my home address. I also understand collection of social security numbers for myself and/or my dependents will be used by Principal Life only as allowed by law.

- 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, disability, and critical illness. 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 Insurance Company.

If electing Critical Illness coverage, I declare that I and my eligible dependents have other coverage providing comprehensive health benefits from an insurance policy, an HMO plan, or an employer health benefit plan. NOTE: Critical Illness coverage cannot be issued to a person who does not have comprehensive health benefits coverage in place.

Your signature X_____ **Date Signed** _____

Instructions

After this form is completed and signed, make two copies and send the original to Principal Life Insurance Company:

- One for the employee
- One for the employer