***Employee Enrollment & Waiver-OH***

**Principal Life Insurance Company**
Des Moines, IA 50392-0002

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

| Company name | Division level | Account number/unit number |
|---|---|---|
| IMPERIAL MANUFACTURING LLC | ALL MEMBERS | 1031538-10001 |

## 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 |
| Salary (for owners, include business income) | Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly | | |
| Employer ZIP code | Employer county | | |

## Eligible dependent information (Complete if you are electing benefits for your spouse [1] or children)

| Dependent name | Birth date | Gender | Social security number | Relationship |
|---|---|---|---|---|
| | | ☐ male ☐ female | | ☐ spouse ☐ domestic partner[1] |
| | | ☐ male ☐ female | | ☐ child ☐ foster child[2] ☐ disabled child[3] |
| | | ☐ male ☐ female | | ☐ child ☐ foster child[2] ☐ disabled child[3] |
| | | ☐ male ☐ female | | ☐ child ☐ foster child[2] ☐ disabled child[3] |
| | | ☐ male ☐ female | | ☐ child ☐ foster child[2] ☐ disabled child[3] |

[1]Spouse will include Domestic Partners if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership / Enrollment Form Addendum (GP60472).

[2]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

[3]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.



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Is your spouse[1] employed by this company?
☐ yes ☐ no

If you and your spouse[1] are both employed at the same company, and eligibile for benefits, you are not eligible to have benefits as both a Member and a Dependent.
If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

| Coverage | Employee | Spouse[1] | Child(ren) |
|---|---|---|---|
| **NOTE: Employee coverage must be elected to elect any dependent coverage.** | | | |
| **Dental** | ☐ Elect ☐ Decline | ☐ Elect ☐ Decline | ☐ Elect ☐ Decline |
| **Vision** | ☐ Elect ☐ Decline | ☐ Elect ☐ Decline | ☐ Elect ☐ Decline |
| **Group term life** | ☒ Elect | | |
| **Voluntary term life benefit amount:** | ☐ Elect ☐ Decline $_____ | ☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election** | ☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election** |
| **Short term disability** | ☐ Elect ☐ Decline | | |
| An amount in an increment of $50. The minimum amount you can elect is $100. Your maximum election cannot exceed 60% of your weekly earnings or $1,500 per week. [5] | | | [4]$ |

[4]May be reduced by income from other income sources.
[5]If you elect an amount higher than allowed, you will be enrolled for 60% of your weekly earnings rounded to the next lower increment.

| | | |
|---|---|---|
| **Long term disability** | ☐ Elect ☐ Decline | |
| An amount in an increment of $100. The minimum amount you can elect is $500. Your maximum election cannot exceed 60% of your monthly earnings or $6,000 per month. [5] | | [4]$ |

[4]May be reduced by income from other income sources.
[5]If you elect an amount higher than allowed, you will be enrolled for 60% of your monthly earnings rounded to the next lower increment.

**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. Additional beneficiaries can be added as an attachment.**

**Primary beneficiaries:**

| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |
|---|---|---|---|---|---|
| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |


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**Contingent beneficiaries:**

| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |
|---|---|---|---|---|---|
| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |

**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. Additional beneficiaries can be added as an attachment.**

**Primary beneficiaries:**

| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |
|---|---|---|---|---|---|
| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |

**Contingent beneficiaries:**

| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |
|---|---|---|---|---|---|
| Name | SSN | Date of birth | Relationship | Check here if a minor ☐ | Percentage |

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

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

**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 or vision, I cannot enroll until the next open enrollment.
- If I refuse life, disability, or critical illness 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.
- 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 person who, with intent to defraud or knowing that they are facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, is guilty of insurance fraud.


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- 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 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 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:

- 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.


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