



Mailing Address  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Employee  
Enrollment &  
Waiver - VA

Company name <b>Anglican Church of North America</b>	Division level	Account number/unit number
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**Employee Information**

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

**Dental**

Employee:  Elect  Decline      Spouse:  Elect  Decline      Children:  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

**Group Term Life**

Employee:  
 Elect

**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: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	
Spouse: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	Birth date
Children: <input type="checkbox"/> Elect <input type="checkbox"/> Decline	\$ _____	

Does this life insurance replace existing life insurance or an annuity?     Yes     No  
 Does the agent know replacement is or may be involved in this life transaction?     Yes     No

**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

**Contingent Beneficiaries:**

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 Insurance Company.

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



- 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 Insurance Company is not liable for a claim before the effective date of coverage and all policy provisions apply.
- I certify that 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, false statements, omissions, or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may have violated state law.
- Principal Life Insurance Company may 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 understand data obtained will be used by Principal Life Insurance Company for administration and determining eligibility for life and disability coverage. Information will not be used for any purposes prohibited by law. A photocopy of this form shall be as valid as the original. This authorization shall remain valid for the term of the coverage when used for claim administration. This authorization shall remain valid for the duration of a life claim.
- 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 my dependents will be used by Principal Life Insurance Company only as allowed by law.
- For life coverage, 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.

Upon written request, Principal Life Insurance Company will furnish to you (or your dependent) or authorized representative, a copy of this form. 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.

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