



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee
Enrollment &
Waiver - CA

Company name City of Redlands	Division level	Account number/unit number 1006942
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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/domestic partner or child? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Dental

Employee: Elect Decline Cancel Spouse/Domestic Partner: Elect Decline Cancel Children: Elect Decline Cancel

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

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

spouse's or domestic partner's group coverage individual insurance
 other _____ other coverage offered by my employer

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

Spouse/Domestic partner'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, do you provide principal support and does the child(ren) live with you at least 50% of the time? 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/domestic partner employed by this company? Yes No

Employee Signature (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, 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 be guilty of insurance fraud.
- 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 only as allowed by law.

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** _____