



Mailing Address  
Des Moines, IA 50392-0002

Principal Life  
Insurance Company

Employee  
Enrollment &  
Waiver - KY

Company name Roman Catholic Diocese of Lexington	Division level	Account number/unit number H33308
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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)		
Date employed full-time	Hours worked per week	Job occupation/class	Location	

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

**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

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.

## Short Term Disability

Employee:  Elect    Required

**Important!** You cannot decline any coverage paid in full by your employer

### Employee Signature (Read and sign below.)

I understand and agree with the following statements:

- My dependents are not eligible for coverage.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise..
- 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. All statements by or on behalf of the insured shall be deemed to be representations and not warranties. 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 and/or material misrepresentations can cause changes in my coverage, including cancellation back to the effective date.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.
- 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 and disability coverage. Information will not be used for any purposes prohibited by law.
- Explanation of Benefits reflecting claims payments will be sent to my home address. I also understand my social security numbers will be used by Principal Life only as allowed by law.
- For life coverage, I understand that as the employee, the insurance I 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.

A copy of this form will be as valid as the original.

**I represent** 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** \_\_\_\_\_