

Policyholder: TOWN OF CLAY



Group term life insurance

Benefit summary for all non union members

Policy anniversary: January 1

The benefits shown below are the benefits available as of 11/29/2022.

What's available to me?

Protect what means the most to you – the people you love. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries.

	Benefit	Guaranteed issue ¹	Benefit reduction ²
You	\$50,000	If you're under 70: \$50,000 If you're 70 or older: The lesser of \$50,000 or the amount with the prior carrier	35% reduction at age 65, with an additional 15% reduction at age 70
Your spouse ³	\$10,000		
Your child(ren) ³	<ul style="list-style-type: none">• Up to 6 months old: \$1,000• 6+ months old: \$7,500		

¹Amount of coverage you may buy without answering medical questions.

²As you get older, your life insurance benefit amount decreases. Age reductions apply to the benefit amount after providing health information.

³Amount of coverage may not exceed 50% of your benefit.

Who receives coverage?

- You'll receive coverage if you're an active, full-time employee. Seasonal, temporary, or contract employees aren't eligible.
 - If you're on a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off, you're still considered actively at work, as long as you're fulfilling your regular duties and were working the day immediately prior to your time off.
- If you're covered, you may buy coverage for your dependents, if they're not confined at home, in a hospital or skilled nursing facility (this is referred to as Period of Limited Activity).
- If you were covered as an employee, you may be eligible as a retiree.

Additional eligibility requirements may apply.

Do I need to provide health information?

Benefit amounts over the guaranteed issue shown in the table above will require health information.

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

What benefits does Accidental Death and Dismemberment (AD&D) provide?

If you're accidentally injured on or off the job, you may receive a benefit equal to your life benefit.

Loss	AD&D Benefit
Loss of life, loss of both hands or both feet or one hand and one foot, or loss of sight of both eyes	100%
Loss of one hand, or one foot, or sight of one eye	50%
Loss of thumb and index finger on the same hand	25%
Seatbelt / airbag - If you die in a car accident while wearing a seat belt or protected by an airbag	10% of benefit, not to exceed \$10,000
Repatriation - If you die at least 100 miles from your home	Up to \$2,000
Loss of use or paralysis - total loss of movement for 12 consecutive months or permanent paralysis	
Quadriplegia	100%
Paraplegia, hemiplegia, or loss of use of both hands or both feet or one hand and one foot.	50%
Loss of use of one arm, one leg, one hand or one foot	25%
Loss of speech and/or hearing - total loss for 12 consecutive months	
Loss of speech and hearing in both ears	100%
Loss of speech or hearing in both ears	50%
Loss of hearing in one ear	25%

Additional benefits:

Accelerated death benefit	If you're terminally ill, you may be able to receive a portion of your life benefit.
Coverage during disability	If you're disabled, you may be able to continue your coverage and not pay premium for you and your covered dependents.
Conversion of terminated coverage	If coverage terminates, you may be able to convert coverage to an individual policy.

The benefit summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.



[principal.com](https://www.principal.com)

This is a summary of group term life coverage insured by or with administrative services provided by Principal Life Insurance Company. This outline is a brief description of your coverage. It is not an insurance contract or a complete statement of the rights, benefits, limitations and exclusions of the coverage. If there is a discrepancy between the policy and this document, the actual policy provision prevails. For complete coverage details, refer to the booklet.

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Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392

Group
Insurance
Employee
Enrollment &
Waiver-NY

Principal Life Insurance Company

Home Office Mailing Address
711 High Street
Des Moines, IA 50392-0002



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

Company name TOWN OF CLAY	Division level ALL NON UNION MEMBERS	Account number/unit number 1081841-10001
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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
Email address		Home number	Mobile number
Employer ZIP code		Employer county	

Eligible dependent information (Complete if you are electing benefits for your spouse or Domestic Partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> spouse <input type="checkbox"/> domestic partner
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child ¹ <input type="checkbox"/> disabled child ²

¹Foster child coverage is not available for life insurance. 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

²When 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 Domestic Partner employed by this company?
 yes no

Coverage	Employee	Spouse or Domestic Partner ³	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Group term life	<input checked="" type="checkbox"/> Elect	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline Cannot exceed the lesser of \$25,000 or 0% of the employee election

The policy permits your employer to change, reduce, restrict, or terminate your rights or benefits under the policy without your consent and such change, reduction, restriction, or termination may occur at a time when your health status has changed and may affect your ability to obtain individual coverage.

³NOTE: Domestic Partners can only be added if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60471).

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 <input type="checkbox"/>	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	

Contingent beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	
Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	

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/certificate 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).

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 are eligible based on plan provisions but those over the maximum age will be verified when a claim is filed.
- If I refuse coverage, I cannot enroll until the next open enrollment.
- If I refuse life, disability, or specified disease 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/certificate do not require my contribution, I cannot decline coverage unless the policy/certificate indicates otherwise.
- If the group policy/certificate require 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 and belief. 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/certificate provisions apply. I have read, or had read to me, the information and my answers on this form.
- 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 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/certificate, 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 (confined at home or at a medical facility).
- 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 to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

The following statement does not apply to life insurance: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For further information, about your file or rights, you may contact Group Operations, Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0432

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.