



Group benefits

Understand your benefits.

SELECT PRODUCTS HOLDINGS LLC
ALL MEMBERS

Enroll in your benefits today. It's easy.

Congratulations! As part of your benefits package, you can enroll in insurance from Principal®. It takes just three easy steps:

1 Evaluate the insurance you need to help protect what's most important to you.

2 Get details about your coverage by reading the benefit summary.

3 Elect or decline coverage.

Get information about why the insurance may be beneficial to you by scanning the QR code in each product section. As you elect coverage, be sure to answer all questions. If left blank, your benefits could be delayed.

In the following pages, you'll find information about:

- Dental
- Vision
- Life
- Disability

Insurance products and plan administrative services issued by Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, Iowa 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 SELECT PRODUCTS HOLDINGS LLC	Division level ALL MEMBERS	Account number/unit number 1138553-10001
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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 or Domestic Partner or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ domestic partner
		☐ male ☐ female		☐ child ☐ foster child ¹ ☐ disabled child ²
		☐ male ☐ female		☐ child ☐ foster child ¹ ☐ disabled child ²
		☐ male ☐ female		☐ child ☐ foster child ¹ ☐ disabled child ²
		☐ male ☐ female		☐ child ☐ foster child ¹ ☐ 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.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ 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		
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 the lesser of \$25,000 or 100% of the employee election
Short term disability	☒ Elect		
Long term disability	☐ Elect ☐ Decline		

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 ☐	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	

Contingent beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	

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
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	

Contingent beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Mailing address (street)	(city)	(state)	(ZIP code)	Phone Number	
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	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).

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/certificate 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 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 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:
 - o Use eService to submit enrollment information at www.principal.com. Employer retains the original form.
 - o Or, email the form to groupbenefitsadmin@principal.com.
 - o Or, send the original form to Principal Life Insurance Company. Employer retains a copy of the form.