



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee Enrollment
& Waiver-MD

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

Company name Magnificus Corporation	Division level All Members	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)	
Date employed full-time	Hours worked per week	Job occupation/class	Location
Email address		Phone number	

Do you have an eligible spouse or domestic partner or child(ren)?
 yes no

Salary amount (for owners, include business income)	Salary mode <input type="checkbox"/> yearly <input type="checkbox"/> weekly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> bi-weekly
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Payroll mode <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly	Employer ZIP code 20706	Employer county PRINCE GEORGE'S
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Eligible Dependent Information (Complete if you are electing benefits for your spouse or domestic partner or children)

Dependent name	Birth date	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Relationship <input type="checkbox"/> Spouse <input type="checkbox"/> domestic partner <input type="checkbox"/> Child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled or mentally or physically incapacitated child**
		<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* <input type="checkbox"/> disabled or mentally or physically incapacitated child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled or mentally or physically incapacitated child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled or mentally or physically incapacitated child**

*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

**When your child, who is developmentally disabled or mentally or physically incapacitated, reaches/exceeds the maximum age, an Application to Continue Mentally or Physically incapacitated 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*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Vision	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Voluntary Term Life (VTL) Benefit Amount:	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____ Cannot exceed 100% of the employee election	<input type="checkbox"/> Elect <input type="checkbox"/> Decline \$ _____

*NOTE: 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 (GP60457).

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary 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

Contingent Beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor <input type="checkbox"/>	Percentage

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 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 (GP55229).

Declining Coverage

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 coverage offered by my employer
- other _____

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, 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 or vision 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 I refuse life, disability, or critical illness coverage, I may apply later but I must show evidence of insurability and coverage will be subject to approval by Principal Life Insurance Company.
- 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. Statements made to effectuate insurance cannot be used to contest or reduce my insurance unless the statement is in writing and signed by me and a copy of the form containing the statement is given to me or my beneficiary at the time insurance is contested.
- Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- 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/or my dependents will be used by Principal Life only as allowed by law.
- 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, disability, and critical illness. Information will not be used for any purposes prohibited 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, 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.

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 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



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Beneficiary Designation/
Change - VTL

Company Name

Account/Unit Number

Employee Information

Your name (last, first, middle initial)

Social security number

Voluntary Term Life Beneficiary Designation (Complete if covered for voluntary term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. If designating a minor, please check the applicable box and complete the Minor Beneficiary – UTMA section on Page 2.

Primary Beneficiaries:

Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	Percentage	Relationship
Address			Social security number
Name	Check here if a minor <input type="checkbox"/>	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 said company.

Minor Beneficiary - UTMA: ONLY COMPLETE IF THE BENEFICIARY LISTED ABOVE IS A MINOR.

If any proceeds become payable to a beneficiary who is then a "minor" as defined in the applicable Uniform Transfers to Minors Act, as specified herein, such proceeds shall be paid to _____

(Name)

(Address)

as custodian for such beneficiary:

(Check One Only) See instructions on Page 3.

- under the Iowa Uniform Transfers to Minor Act.
- under the Uniform Transfers to Minor Act of the state where the beneficiary shall reside at the time of payment. In the event the beneficiary resides in California or Ohio at the time of payment, the custodianship is to continue until the beneficiary reaches the age of ___ for California (insert 18, 19, 20, 21, 22, 23, 24 or 25) or ___ for Ohio (insert 18, 19, 20 or 21).

In the event a substitute custodian is needed, the following is/are nominated, in the order named:

Name	Address
Name	Address

If no state is specified (by name or description) above, or if the state so specified has not enacted the Uniform Transfers to Minors Act, or if the law of the state so specified does not provide for such payment to a custodian, the custodianship shall be established under the Iowa Uniform Transfers to Minors Act. If the specified Uniform Transfers to Minors Act would require the beneficiary's custodianship to terminate at or before the time of payment, the proceeds payable to that beneficiary shall be paid to the beneficiary rather than to a custodian.

Signature

Read important instructions on Page 3 before signing.

Signature of employee

Date signed

Note: make a copy of Page 1 and 2 for your records and distribute copy to employee.

Minor Beneficiary - UTMA Instructions - Please Note the Following:

1. You may wish to consult with your attorney about the completion of this beneficiary designation. The following comments are of a general nature and are not intended to be legal advice, or to substitute for legal advice.
2. **Naming a custodian and substitutes.** A custodian must be named in the blank following the words "paid to" in the designation. It is strongly recommended that you also name at least one (and preferably two or more) substitute custodians on the lines provided for that purpose. A substitute custodian would serve if, at the time of payment, the first-named custodian is deceased or otherwise unable or unwilling to serve. The custodian (and each substitute) listed on the beneficiary designation should be either: (1) an individual who is now an adult; or (2) a trust company, such as a financial institution with a trust department.
3. **Specifying the state law.** You may specify that the custodianship be established under the Iowa Uniform Transfers to Minors Act, regardless of where the minor lives. Principal Life Insurance Company is based in Iowa and therefore may transfer funds to a custodian in any state for the benefit of a minor in any state if the beneficiary designation specifies that the transfer shall be made under the Iowa Uniform Transfers to Minors Act. The Iowa Uniform Transfers to Minors Act defines a "minor" as an individual who has not reached age 21.

Alternatively, you may specify that the custodianship be established under the law of whatever state the beneficiary may live in at the time of payment. If this happens to be a state that has not enacted the Uniform Transfers to Minors Act, the designation specifies that the custodianship will be established under the Iowa Uniform Transfers to Minors Act. If there is a possibility that the minor beneficiary will live in California or Ohio at the time of payment, you may wish to fill in one or both of the blanks specifying the age at which the custodianship is to terminate (see below). The ability to specify such an age in the beneficiary designation is a unique feature of the Ohio and California Uniform Transfers to Minors Acts.

The state specified in the designation may affect the age at which the beneficiary will have control of the money. Under the Uniform Transfers to Minors Act as enacted in many states, a custodianship created pursuant to a beneficiary designation terminates when the beneficiary reaches the legal age of majority (usually 18), even though custodianships created pursuant to a lifetime gift may terminate at a later age. However, under the Iowa Uniform Transfers to Minors Act, and in a few states, a custodianship created pursuant to a beneficiary designation continues until the beneficiary reaches age 21. As noted above, custodian nominations under the California Uniform Transfers to Minors Act may specify an age (up to the age of 25) for the custodianship to terminate. If no age is specified, the California custodianship will terminate at age 18. Custodianships under the Ohio Transfers to Minors Act terminate at age 21 unless the beneficiary designation specifies that it will terminate at age 18, 19 or 20.

Sample Beneficiary Designations

Be sure to use given names such as "Mary M. Doe," not "Mrs. John Doe" and include address and relationship of the beneficiary or beneficiaries to you.

Proposed Beneficiary	Suggested Wording for Beneficiary "name"
Insured's Estate	My Estate
Trust with Individual Trustees	Richard Doe and John Smith, Trustees, or a Successor in Trust under (Trust Name) established XX/XX/XXXX
Present or Living Trust	ABC Bank & Trust Company, Des Moines, Iowa. Trustee under (Trust Name) established XX/XX/XXXX
Testamentary Trust	Trustee of Mary I Doe Trust or Successor in Trust established by the Last Will & Testament of the Insured Dated XX/XX/XXXX