

Group benefits

Understand your benefits

JL PROPERTIES, INC.
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:



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



Get details about your coverage by reading the Benefit Summary for each coverage.



Complete and sign the Employee Enrollment and Waiver form.

Keep in mind, you need to elect or decline each coverage. If you decline, please indicate why. For the coverage(s) you elect, tell us how much you want, if applicable. And if electing coverage for dependents, include their names and birth dates.

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

- Dental
- Vision
- Life
- Disability

As you complete the enrollment form, pay special attention to these items. If they're left blank, your benefits could be delayed.

Life – Complete the beneficiary designation section. If the unthinkable happens, you want your loved ones to receive the benefits as soon as possible. And if you name a minor as your beneficiary, complete the UTMA (Uniform Transfers to Minors Act) Beneficiary Designation form because we can't pay benefits directly to a minor.

Life – You're eligible for a certain amount of coverage, also referred to as the guarantee issue amount, no matter what your health status if you enroll during your initial enrollment period. If you want more coverage than this, complete the Statement of Health form.



Mailing Address
Des Moines, IA 50392-0002

Principal Life
Insurance Company

Employee Enrollment
& Waiver-AK

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

Company name JL PROPERTIES, INC.	Division level ALL MEMBERS	Account number/unit number 1053525
-------------------------------------	-------------------------------	---------------------------------------

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)? <input type="checkbox"/> yes <input type="checkbox"/> 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		
Payroll mode <input type="checkbox"/> monthly <input type="checkbox"/> semi-monthly <input type="checkbox"/> weekly <input type="checkbox"/> bi-weekly	Employer ZIP code 99501		Employer county ANCHORAGE

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* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled child**
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> Child <input type="checkbox"/> foster child* <input type="checkbox"/> disabled 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 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*	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	Choose from one of the following plans.		
Plan #1	Design Description: Dental PPO - LOW PLAN		
	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline	<input type="checkbox"/> Elect <input type="checkbox"/> Decline
Plan #2	Design Description: Dental PPO - HIGH PLAN		
	<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
Group Term Life	<input checked="" type="checkbox"/> Elect		
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 \$ _____
Short Term Disability	<input type="checkbox"/> Elect <input type="checkbox"/> Decline		
Long Term Disability	<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 (GP60439).

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

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 <input type="checkbox"/>	Percentage
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
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).

NOTE: You are covered by both group term life and voluntary term life coverage and if you only indicate a beneficiary designation for one of these, the facility of payment provision in the group policy will be used to determine how proceeds will be paid for the other coverage.

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 proof of good health 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. During the first two years coverage is in force, fraud or intentional 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/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. 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

**Employee
Change Form -
AK**

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

Company name JL PROPERTIES, INC.	Account/unit number 1053525
-------------------------------------	--------------------------------

Employee Information (Change of name and address)

Your name (last, first, middle initial)	Date of Birth	Social security number
---	---------------	------------------------

New name (last, first, middle initial)

Your new address (street)	(city)	(state)	(ZIP code)
---------------------------	--------	---------	------------

Home phone number	Email address
-------------------	---------------

Complete for Adding, Canceling or Changing a Coverage. If this is initial enrollment, please complete an Enrollment Form. NOTE: Employee coverage must be elected to elect any dependent coverage.

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
Dental	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:
In the past twelve months, have you, the applicant, had continuous group orthodontia coverage (for yourself or your dependents) with a prior carrier? <input type="checkbox"/> yes <input type="checkbox"/> no			
Vision	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:
Group Term Life	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:
Supplemental Term Life	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: Change to date:		

Coverage	Employee	Spouse or Domestic Partner*	Child(ren)
Voluntary Term Life (VTL)	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____ \$ _____ or _____ X salary	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____ \$ _____	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____
Short Term Disability	<input type="checkbox"/> Add <input type="checkbox"/> Cancel Occupation: _____ Change to: _____ Change to date: _____ \$ _____		
Long Term Disability	<input type="checkbox"/> Add <input type="checkbox"/> Cancel Occupation: _____ Change to: _____ Change to date: _____ \$ _____		
Critical Illness	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____ \$ _____	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____ \$ _____	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____
Accident	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____	<input type="checkbox"/> Add <input type="checkbox"/> Cancel <input type="checkbox"/> Change to: _____ Change to date: _____

Complete if the coverage you are adding or changing is based on your salary.

Salary \$ _____ ☐ yearly ☐ bi-weekly ☐ monthly ☐ weekly ☐ hourly

* Domestic Partners can only be added if your employer allows this coverage. If adding a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60439).

Nicotine Products

Has any person used nicotine products (including cigarette, pipe, cigar or chewing tobacco) in the past 12 months?

Employee: ☐ yes ☐ no Spouse or Domestic Partner: ☐ yes ☐ no

Reason for Adding a Coverage or Dependent

- ☐ marriage ☐ loss of other group coverage* ☐ open enrollment*
☐ birth/adoption ☐ court order (attach a copy) ☐ change in job status
☐ annual enrollment (if available) ☐ other _____

Date of event

*For loss of other group coverage and open enrollment, you must complete the following:

Name of prior dental carrier

Date coverage ended

Name of prior life carrier

Date coverage ended

Name of prior vision carrier

Date coverage ended

Reason for Canceling a Coverage or Dependent

- ☐ divorce ☐ age limit ☐ individual insurance
☐ spouse's or domestic partner's group coverage
☐ other _____

Date of request/ineligibility

Beneficiary Designation

Complete Beneficiary Designation/Change (GP34795) if adding life coverage, accident coverage with AD&D, or changing beneficiary.

Complete for Adding or Canceling a Dependent (Include last name if different from the employee)

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*
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster child*
		<input type="checkbox"/> male <input type="checkbox"/> female		<input type="checkbox"/> child <input type="checkbox"/> foster 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

To determine eligibility for disabled child(ren) (over the maximum age); see your employer for the required forms.

Employee Signature (Read and sign below)**I understand and agree with the following statements:**

- My dependents are not eligible for any coverage for which I am not covered.
- My dependents, including stepchild(ren), foster child(ren) and those over the maximum age, are eligible for coverage based on policy provisions. Eligibility for my dependents over the maximum age will be verified when claims are submitted.
- If I cancel dental or vision coverage, I or my dependents may enroll at a later date; however, enrolling late will affect the level of benefits.
- If I cancel any type of life, disability, or critical illness coverage, I may apply at a later date; however, I must provide proof of good health at my own expense and coverage will only become effective subject to approval from Principal Life Insurance Company.
- If I cancel coverage, I cannot under any circumstance enroll in the policy once I have retired.
- If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.

Employee Signature (Read and sign below) - continued

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.

I declare that the information I have completed on this change 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 _____

Note – Make two copies: one for employer and one for employee

You must complete all pages of this form.



Mailing address:
P.O. Box 4934
Grand Island, NE 68802

Principal Life
Insurance Company

Statement of
Health - AK

Account number 1053525

Instructions

1. The Employee Information section should always be completed with the information about the employee.
2. The employee must ALWAYS sign the last page of this form.
3. When coverage is being requested for an eligible dependent(s), note that this form applies to all persons requesting coverage.
 - a. Complete the Eligible Dependent Information section, if applicable.
 - b. Complete the Health Information section for you and your eligible dependents, if applicable.
 - c. The spouse or domestic partner must sign the last page of this form if spouse or domestic partner coverage is being requested.
4. After completing and signing this form, make a copy for your records.

Why is this Statement of Health being submitted?

☐ over the Guaranteed Issue amount ☐ late entrant (request made outside the eligibility period)

Employee Information

Your name (last, first, middle initial)	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Date of birth
Home address (street)			
City	State	ZIP code	
Home phone number	Company name JL PROPERTIES, INC.		

Eligible Dependent Information

Name (last, first, middle initial)	Gender <input type="checkbox"/> male <input type="checkbox"/> female	Social security number	Date of birth
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		
	<input type="checkbox"/> male <input type="checkbox"/> female		

If additional dependents, list on separate page. Please sign and date the separate page.

To prevent delays give full details to "yes" answers for everyone requesting coverage. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

1. **Employee's height** ___ ft. _____ in. **weight** _____ lbs.

Spouse's or domestic partner's height ___ ft. _____ in. **weight** _____ lbs.

2. ☐ yes ☐ no Is any person receiving medical treatment or taking medication?

3. ☐ yes ☐ no Is any person currently pregnant?

4. ☐ yes ☐ no **In the past 5 years**, has any person had surgery, been hospitalized or consulted with a physician or medical practitioner, had blood or other diagnostic tests (other than for HIV antibody), or been advised to receive medical treatment? Provide results of all tests.

5. ☐ yes ☐ no **In the past 5 years**, has any person been diagnosed with or received treatment for any of the following (check all that apply)?

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> cancer | <input type="checkbox"/> liver disorder | <input type="checkbox"/> bone/joint disorder | <input type="checkbox"/> psychological/mental disorder |
| <input type="checkbox"/> tumor(s) | <input type="checkbox"/> kidney/urinary disorder | <input type="checkbox"/> respiratory disorder | <input type="checkbox"/> blood disorder |
| <input type="checkbox"/> heart or circulatory disorder | <input type="checkbox"/> muscle disorder | <input type="checkbox"/> infertility | <input type="checkbox"/> hepatitis |
| <input type="checkbox"/> stroke | <input type="checkbox"/> multiple sclerosis/neurological disorder | <input type="checkbox"/> skin/eyes/ear/nose/throat disorder | <input type="checkbox"/> organ or other transplants |
| <input type="checkbox"/> alcohol/drug use | <input type="checkbox"/> digestive disorder | <input type="checkbox"/> gland disorder | |
| <input type="checkbox"/> High blood pressure – last reading and date _____ / _____ | | | |
| <input type="checkbox"/> Diabetes – last HbA1c reading and date _____ / _____ | | | |
| <input type="checkbox"/> Other – including medication _____ | | | |

6. ☐ yes ☐ no **In the last 5 years**, has any person had, been treated for or been diagnosed as having HIV (Human Immunodeficiency Virus) infection, positive HIV test or AIDS (Acquired Immune Deficiency Syndrome)?

If applying for Critical Illness, complete question 7.

7. ☐ yes ☐ no Have any of your natural parents, brothers or sisters been diagnosed with coronary artery disease, stroke, diabetes or invasive cancer prior to age 55?

☐ Employee – if yes, disease and age at diagnosis: _____

☐ Spouse or domestic partner – if yes, disease and age at diagnosis: _____

Provide details for all "yes" answers. If more space is needed, attach a separate page giving full details. Sign and date all those pages.

Name	Date diagnosed/treated	Length of illness or condition
Diagnosis of illness or condition	Type of treatment, including medications	

Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

Health Information (continued)**120**

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment, including medications
-----------------------------------	--

Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment, including medications
-----------------------------------	--

Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment, including medications
-----------------------------------	--

Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

Name	Date diagnosed/treated	Length of illness or condition
------	------------------------	--------------------------------

Diagnosis of illness or condition	Type of treatment, including medications
-----------------------------------	--

Describe current symptoms or problems

Names of all current medications

Names and addresses of physicians, medical practitioners, hospitals or other health care providers

In order to properly underwrite and consider your request for coverage, we must collect information to determine if you (and your dependents if also requesting dependent coverage) qualify for insurance with Principal Life Insurance Company. We will do this by having you complete this Statement of Health. In addition, we may contact sources besides yourself for personal data about any proposed insured, including (a) spouse or domestic partner, (b) employer, (c) medical professionals or institutions, and (d) insurance companies to which you may have applied for insurance in the past. The personal data may include age, medical history, job, income, habits and other personal characteristic information. We may also ask that medical exams or other tests be completed.

We will keep your data confidential. Only employees performing business transactions regarding your coverage will see your data. In certain circumstances, we may provide data to (a) government agencies, (b) attending physicians, (c) insurance organizations without identification, (d) the employer, and (e) our reinsurer, if applicable, for the purpose of reporting claims experience or conducting audits.

You or your dependents, if applicable, have certain rights in connection with this request for coverage. Those rights are:

1. to find out what personal information is contained in Principal Life files (medical information may be disclosed only to your attending physician).
2. to correct or amend information in Principal Life files.

Upon written request, Principal Life will furnish to you (or your dependent) information concerning:

1. the nature and scope of personal data in our records;
2. the types of disclosures which may be made; and
3. rights of access to the information collected and how such information may be corrected or amended.

We will respond to such written request within 30 days from the date of receipt.

For further information about your file or rights, you may contact: Group Operations, Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531.

Authorization, Acknowledgment, and Signatures

- I represent information, statements, and answers on this form, and any attachments, are complete and true to the best of my knowledge. They are a part of this request for coverage under the group policies. I agree Principal Life is not liable for anyone's claim which happens or begins before the effective date and approval of coverage.
- I have read, or had read to me, the questions and responses and realize any false statements, omissions or material misrepresentation regarding age or health information could cause coverage, if issued, to be cancelled as never effective.
- 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.
- If approved for coverage, all policy provisions will apply including, but not limited to, preexisting conditions restriction, the Actively at Work and Period of Limited Activity provisions.
- I understand an agent cannot change or waive any rates, benefits, or provisions of any policy, if issued, without the written approval of an officer of Principal Life.
- I authorize any physician, medical practitioner, health care provider, hospital, clinic or medically related facility, insurance company, consumer reporting agency or employer, that has any personal information, including physical, mental, drug or alcohol use history, regarding me or any dependent, to give to Principal Life, its agents, employees or reinsurers performing business transactions, any such data.
- I authorize Principal Life to release any such data as required by law. When signed in connection with any application for, reinstatement of, or request for change in benefits, this form shall be valid for two years after the date shown below. I understand I may revoke this authorization at any time. The request for revocation must be in writing and sent to: Group Operations, Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0531. I understand that a revocation is not effective if Principal Life has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest coverage under the policy itself. A photocopy of this form shall be as valid as the original.
- I understand the data obtained by use of this authorization will be used by Principal Life for claims administration and to determine eligibility for coverage. This information will not be used for any purposes prohibited by law.

Employee's signature X	Date signed
Spouse's or domestic partner's signature X	Date signed

Authorization for Release of Personal Health Information – All States

(Applicable to Group Life and Disability Insurance
Customers)

Principal Life Insurance Company
P.O. Box 4934
Grand Island, NE 68802



This authorization complies with the HIPAA Privacy Rule and permits health care providers and other covered entities to disclose personal health information.

Name of Proposed Insured/Patient (please print)

Date of Birth

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, or coverage to me within the past 10 years to disclose my entire medical record to the Company, its agents, employees, insurance support organizations, reinsurers, and their representatives. This includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness (excluding psychotherapy notes as defined under HIPAA) and the use of alcohol, drugs, and tobacco. *Statements required by §164.508(c)(1)(ii), (c)(1)(iii).*

I understand my personal health information may be used or disclosed as set forth by this authorization. Protected health information includes information created or received by the Company. Protected health information also includes but is not limited to: hospital records, treatment records/office notes, alcohol or drug abuse treatment, consultation reports, workers' compensation information, diagnosis, prescriptions, test results, vocational testing/counseling information, benefit information, claims information, demographic information, and claims payment information. *Statement required by §164.508(c)(1)(i).*

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, other health care provider or health plan, insurer, or other entity subject to HIPAA to release and disclose my medical record without restriction.

I understand that unless prohibited by state and/or federal law the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(iv).*

The following groups of persons employed or working for the Company may use my personal health information which is described above: employees of the underwriting, administration, claim or legal departments and any other personnel of the Company, and its authorized representatives, and business associates that perform functions or services that pertain to any coverage I have, have applied for, or may in the future apply for with the Company. *Statement required by §164.508(c)(1)(ii).*

I understand any information disclosed under this authorization may no longer be covered by the privacy provisions of HIPAA and may be subject to redisclosure. *Statement required by §164.508(c)(2)(iii).*

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. *Statement required by §164.508(c)(v).* I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to: Group Medical Underwriting, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-2070. I understand that a revocation is not effective if the Company has relied on the protected health information disclosed to it or has a legal right to contest a claim under an insurance policy or to contest the policy itself. *Statement required by §164.508(c)(2)(i).* Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

I understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application for life and/or disability coverage, or if coverage has been issued, may not be able to make any such benefit payments. *Statement required by §164.508(c)(2)(ii).* Upon receipt of your signed authorization, a copy will be provided to you. *Statement required by §164.508(c)(4).* Any alteration of this form will not be accepted.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I further understand that My Providers cannot condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

Signature of Proposed Insured/Patient or Personal Representative

Date

This completed document is for restricted use only. No part may be copied nor disclosed without prior consent of The Principal®.



Mailing Address:
Des Moines, IA 50392-0002

Principal Life
Insurance Company

UTMA Beneficiary
Designation

Company Name

Account/Unit Number

Employee Information

Your name (last, first, middle initial)

Social security number

NOTE: This form is a supplement to Employee Enrollment and Waiver.

Minor Beneficiary - UTMA: ONLY COMPLETE IF THE BENEFICIARY LISTED 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 2.

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 2 before signing.

Signature of employee

Date signed

Note: make a copy of Page 1 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.

Beneficiary Designation/Change

Principal Life Insurance Company
Des Moines, Iowa 50392-0002



Company Name

Account/Unit Number

Employee Information

Your name (last, first, middle initial)

Social security number

Section I 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. If designating a minor, please check the applicable box and complete the Minor Beneficiary – UTMA section on Page 4.

Primary Beneficiaries:

Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number

Section II 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 on Page 1, write "same as Section I" in the beneficiary section below.)

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 will be used to determine how proceeds will be paid for the other 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 4.

Primary Beneficiaries:

Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number

Section III Accident Beneficiary Designation (Complete if Accident Insurance includes Accidental Death and Dismemberment (AD&D). If you want to use the same beneficiary designation as indicated for group term life coverage on Page 1, write "same as Section I" in the beneficiary section below)

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 4.

Primary Beneficiaries:

Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number

Contingent Beneficiaries:

Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	Percentage	Relationship
Address			Social security number
Name	Check here if a minor	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 5.

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.

Section III Signature

Read important instructions on Page 5 before signing.

Signature of employee

Date signed

Note: make a copy of Page 1, 2, 3, and 4 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



Your dental benefits



Policyholder: JL PROPERTIES, INC.

Voluntary Dental PPO Benefit Summary

Effective Date: 05/01/2019

Predetermination of Benefits: Before treatment begins for inlays, onlays, single crowns, prosthetics, periodontics and oral surgery, you may file a dental treatment plan with Principal Life Insurance Company. Principal Life will provide a written response indicating benefits that may be payable for the proposed treatment.

This chart provides you a brief summary of the key benefits of the dental coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your dental coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Benefit Choice	Eligible members may select ONE OF THE TWO BENEFIT OPTIONS outlined below

Option 1

Benefits Payable				
Job Class	MBRS ELEC LOW PLAN			
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	\$0	\$0	100%	100%
Unit 2 – Basic	\$50	\$50	80%	80%
Unit 3 – Major	\$50	\$50	50%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for basic and major procedures are combined. In-network Calendar year maximums are \$1,000 per person. Non-network Calendar year maximums are \$1,000 per person.			
Prevailing Charge	When using non-network providers, you pay any amount over the allowable charge.			
Preventive Passport	This exempts preventive charges from applying to the Calendar year maximum benefit. Therefore, the maximum benefit will not be impacted by use of preventive services. Basic and Major charges will continue to be applied to the annual maximum.			
Participating Provider Services	If treatment or service for a listed covered charge is not available through a preferred provider due to network or geographic access and the member receives such treatment or service from a non-preferred provider, that provider will be reimbursed at the same benefit level (i.e. deductibles, coinsurance and other cost sharing requirements) as would have been applied had the member been treated by a preferred provider. Network and geographic access standards include one general dentist or one specialty dentist within 50 miles.			

How Are Dental Procedures Covered Under Option 1?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	<ul style="list-style-type: none"> • Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 19) • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months • X-rays - Bitewing (one set every six months), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	<ul style="list-style-type: none"> • Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Emergency exams – subject to Routine exam frequency limit • Harmful Habit Appliance - covered only for dependent children under age 19 • Fillings and stainless steel crowns • Composite fillings on molars • Simple Oral Surgery • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth)
Unit 3 – Major Procedures	<ul style="list-style-type: none"> • General Anesthesia (covered only for specific procedures)/IV Sedation • Complex Oral Surgical Procedures • Periodontal Surgical Procedures – one each quadrant each 36 months • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 60 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup - each 60 months per tooth • Implants – each 60 months • Bridges - Initial placement / Replacement of bridges 60 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

VOLUNTARY DENTAL

Option 2

Benefits Payable				
Job Class	MBRS ELEC HIGH PLAN			
Network	Dental Preferred Provider Organization (PPO)			
	Calendar Year Deductible		Coinsurance (Policy Pays)	
	In-Network	Non-Network	In-Network	Non-Network
Unit 1 – Preventive	\$0	\$0	100%	100%
Unit 2 – Basic	\$50	\$50	80%	80%
Unit 3 – Major	\$50	\$50	50%	50%
Family Deductible Maximum	3 times the per person deductible amount			
Combined Deductible	In-network deductibles for basic and major procedures are combined. Non-network deductibles for basic and major procedures are combined.			
Combined Maximums	Maximums for basic and major procedures are combined. In-network Calendar year maximums are \$3,000 per person. Non-network Calendar year maximums are \$3,000 per person.			
Prevailing Charge	When using non-network providers, you pay any amount over the allowable charge.			
Preventive Passport	This exempts preventive charges from applying to the Calendar year maximum benefit. Therefore, the maximum benefit will not be impacted by use of preventive services. Basic and Major charges will continue to be applied to the annual maximum.			

How Are Dental Procedures Covered Under Option 2?

The list of common procedures shows what unit the procedure is included in and how often they are covered.

Unit 1 – Preventive Procedures	<ul style="list-style-type: none"> • Routine exams - one per six months • Routine cleaning (prophylaxis) - one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Second Opinion Consultation • Fluoride – one treatment each calendar year (covered only for dependent children under age 19) • Space maintainers - covered only for dependent children under age 19; repairs not covered • Sealants – on first and second permanent molars for dependent children under age 19; one each tooth each 36 months • X-rays - Bitewing (one set every six months), occlusal, periapical • X-rays – Full mouth survey (one every 60 months), extraoral
Unit 2 – Basic Procedures	<ul style="list-style-type: none"> • Periodontal prophylaxis - if three months have elapsed after active surgical periodontal treatment; one per six months (Expectant mothers, diabetics and those with heart disease receive one additional routine or periodontal cleaning.) • Emergency exams – subject to Routine exam frequency limit • Harmful Habit Appliance - covered only for dependent children under age 19 • Fillings and stainless steel crowns • Composite fillings on molars • Simple Oral Surgery • Non-surgical Periodontics, including scaling and root planing - once each quadrant each 24 months (For expectant mothers, diabetics and those with heart disease, this procedure is provided with no deductible and 100% coinsurance.) • Simple Endodontics (root canal therapy for anterior teeth) • Complex Endodontics (root canal therapy for molar teeth)
Unit 3 – Major Procedures	<ul style="list-style-type: none"> • General Anesthesia (covered only for specific procedures)/IV Sedation • Complex Oral Surgical Procedures • Periodontal Surgical Procedures – one each quadrant each 36 months • Repairs to Partial Denture, Bridge, Crown, Relines, Rebasing, Tissue Conditioning and Adjustment to Bridge/Denture, within policy limitations • Crowns – each 60 months per tooth if tooth cannot be restored by a filling. • Inlays, Onlays, Cast Post and Core, Core Buildup- each 60 per tooth • Implants – each 60 months • Bridges - Initial placement / Replacement of bridges 60 months old. • Dentures - Initial placement of complete or partial dentures / Replacement of complete or partial dentures over 60 months old

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Dental Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for dental coverage before it can be offered to your dependents. Eligible dependents include your spouse (if not also enrolled as an employee) , qualified domestic partner and children, including those of your qualified domestic partner. Additional eligibility requirements may apply.

An annual enrollment applies. Members can enroll for dental coverage during the annual enrollment period and not be subject to the late entrant waiting period. Certain restrictions apply.

How Do I Find A Participating Provider?

Use the Provider Directory on www.principal.com to locate nearby dentists or see if your dentist participates in your network.

1	Visit www.principal.com/dentist .
2	Begin your search by picking the state where you would like to find a provider. Next, specify a network . Depending on the network chosen, you may be transferred to a partner site.
3	Enter the name of the provider you are looking for (if known). If you are looking for a nearby dentist, enter the city and state and/or ZIP code . Be sure to indicate how far you are willing to travel .
4	Select the desired specialty or use the No Specialty Preference default. Click Continue .
5	Select a language if your preference is other than English. Click Continue .

You may nominate your dentist for inclusion in our network. Please submit the dentist's name, address, phone and specialty by calling 1-800-832-4450, or submit through www.principal.com/refer-dental-provider.

What Are The Restrictions Of My Coverage?

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

Limitations & Exclusions	
Late Entrant Provision	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to policy guidelines.
Missing Tooth	Benefits for the initial placement of bridges, partials and dentures are not covered if those teeth were missing prior to becoming insured under the Principal Life policy. When the policy replaces coverage under a prior plan, continuous coverage under the prior plan may be applied to the missing tooth provision requirement.
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of dental coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP55773-25 | 12/2018 | © 2019 Principal Financial Services, Inc.

Save money with network dentists

You'll enjoy lower out-of-pocket costs and pay less for dental services when you visit a dentist in our large network.

When it comes to visiting a dentist, you want quality dentists to choose from and value for your money. That's where we can help. With dental coverage from Principal®, you have access to a preferred provider organization (PPO). These network dentists include general dentists and those who specialize in root canals, pulling teeth and more.

When you receive services from a dentist in our network, your cost may be lower. Why? Network dentists agree to lower their fees for dental services and not charge you the difference. But, if you use a non-network dentist, you're responsible for paying any fees above the amount most dentists charge for a dental service in the area.* This means you may pay more for the same procedure if you visit a non-network dentist.

Let's look at an example

Phil has an infected tooth that requires a root canal. His out-of-pocket expenses will be lower if he visits a network (PPO) dentist.

Comparing out-of-pocket costs on a root canal

Phil visits a network dentist		Phil visits a non-network dentist	
Dentist charge	\$1,400	Dentist charge	\$1,400
Negotiated fee	\$980	Fee most dentists charge in area	\$1,370
Coinsurance 20% (\$980 x .20)	\$196	Coinsurance 20% (\$1,370 x .20)	\$274
Difference of dentist charge and negotiated fee. Phil isn't responsible for the difference because it's in-network.	\$420	Difference of dentist charge and fee most dentists charge in the area. Phil is responsible for the difference because it's non-network.	\$30
Coverage pays	\$784	Coverage pays	\$1,096
Phil pays	\$196	Phil pays (\$274 + 30)	\$304

Example is for illustrative purposes only.

*The difference may also be determined by the amount agreed to by network dentists.

Find a
network
dentist

Go to principal.com/dentist. You can find a network dentist, listed by specialty. And if your favorite dentist isn't in the network, click the link to refer your provider.



principal.com

Dental insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This is an overview of the benefits dental insurance provides, but there are limitations and exclusions. For additional details, contact your employer. If your dental benefits are self-funded, then your employer assumes financial responsibility for paying claims, and Principal® is contracted to administer the coverage on your employer's behalf.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP51727-12 (Spanish SP943-06) | 07/2018 | © 2018 Principal Financial Services, Inc.

Save money – and your smile – with preventive dental care

Taking care of your teeth to prevent the big stuff from happening shouldn't count against you. With Preventive Passport from Principal®, it doesn't.

Preventive Passport helps you maximize your dental benefits. That's because with Preventive Passport, preventive dental services – like exams, cleanings and fluoride treatments – don't reduce your annual maximum benefit.

That means your benefit stretches farther if you need it for more extensive dental procedures during the year.



How does Preventive Passport work?

When you or a covered family member visits the dentist for preventive care, the charge for these services won't decrease the annual maximum benefit for any of you.

Let's look at an example. This table shows typical services for an adult during the year, and how the maximum yearly balance would vary with and without Preventive Passport.

	With Preventive Passport	Without Preventive Passport
Preventive services		
2 exams (\$61 each)	\$122	\$122
2 cleanings (\$107 each)	\$214	\$214
Bitewing x-rays/4 films	\$75	\$75
Total preventive	\$411	\$411
Basic services		
1 composite filling (1 surface, front tooth)	\$205	\$205
Yearly maximum	\$1,500	\$1,500
Total applied to your maximum benefit	\$205	\$616 (\$411 + \$205)
Maximum remaining	\$1,295	\$884

Fee information based on nationwide average costs using FAIR Health, a third-party resource for independent healthcare claims data.

That's \$411 more to cover more costly procedures if they come up.

The good news – getting routine, preventive care can help you ward off expensive dental issues in the future.



principal.com

Dental insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This is an overview of the benefits dental insurance provides, but there are limitations and exclusions. For additional details, contact your employer.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP59270-05 | OR form GC 7100-1 (0415) | 04/2017 | © 2017 Principal Financial Services, Inc.



Your vision
benefits

Focus on your eye health

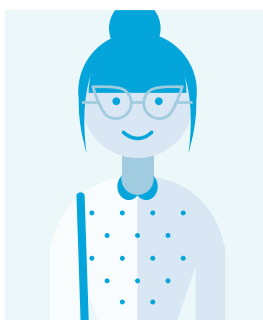
Taking good care of your vision can be simple and affordable. And it's important — after all, you only have one pair of eyes. In fact, did you know healthy vision plays a big role in your overall health?

It's a digital world. For most of us, a day doesn't go by without using our eyes to read, scan or view a smart phone, tablet, laptop or computer screen. That can lead to eye strain and potential long-term vision problems. For this reason alone, vision care is more important than ever.

And healthy vision is also an important component of your overall wellness. Regular eye exams can help uncover serious health conditions, like diabetes, hypertension, high cholesterol, cancer, thyroid disorders and more.

That's what vision insurance is all about, helping you take control of your eye health – and your overall health. Being covered by insurance makes it more likely you'll make regular visits to your eye doctor and catch health issues early, when it matters most.

Let's look at an example



In her job, Alisa deals with customer accounts, and that means she views names and numbers on her computer screen — all day, every day. And like many of us, she keeps in touch with her friends via social media on her smartphone.

It's safe to say she relies on her eyes in all areas of her life. So since glaucoma and diabetes run in the family, Alisa can't afford to let a year go by without a visit to the eye doctor. That's why access to vision insurance through her employer is important to her.

Enroll in **vision insurance** and make the most of a benefit that can help you protect your eyes and your overall health.



principal.com

Vision insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This is an overview of the benefits vision insurance provides, but there are limitations and exclusions. For additional details, contact your employer. If your vision benefits are self-funded, then your employer assumes financial responsibility for paying claims, and Principal® is contracted to administer the coverage on your employer's behalf.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP54288-08 (Spanish SP1212-06) | 08/2018 | © 2018 Principal Financial Services, Inc.



Policyholder: JL PROPERTIES, INC.

Vision Benefit Summary

Effective Date: 05/01/2019

This chart provides you a brief summary of the key benefits of the vision coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your vision coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility		
Job Class	ALL MEMBERS	
Your Coverage with a VSP Preferred Provider		
Doctor Network	VSP Choice Network	
Covered Charges	Benefit	Frequency
Exams	\$10 copay	One exam every 12 months
Prescription Glasses	\$25 copay	Two lenses (one pair) every 12 months
Lenses	Single vision, lined bifocal, lined trifocal and lenticular lenses; polycarbonate lenses for dependent children under age 18	
Frames*	Members pay for lens enhancements as an out-of-pocket expense after the copay; they are discounted 20-25% by VSP providers.*** \$150 allowance for a wide selection of frames; 20% off amount over allowance***	
Elective Contacts	Up to \$60 copay for your elective contact lens exam (fitting and evaluation) \$150 allowance for elective contacts	Once every 12 months Contacts are instead of frames and lenses
Necessary Contacts**	\$25 copay Covered in full for members who have specific conditions	Once every 12 months Contacts are instead of frames and lenses

Additional Savings ***	
Glasses and Sunglasses	Members save an average of 20-25% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last covered vision exam
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities

VISION

Your Coverage with Other Providers (Non-Network)		
Covered Charges	Scheduled Benefit Amount	Frequency
Vision Exams	Up to \$45	One per 12 month period
Single Vision lenses	Up to \$30	One pair per 12 month period
Lined bifocal lenses	Up to \$50	One pair per 12 month period
Lined trifocal lenses	Up to \$65	One pair per 12 month period
Lenticular lenses	Up to \$100	One pair per 12 month period
Frames	Up to \$70	One set per 24 month period
Elective Contacts	Up to \$105	In lieu of lenses and frame benefits
Necessary Contacts**	Up to \$210	In lieu of lenses and frame benefits

*VSP has agreements established with some Participating Retail Chain Providers that may also provide benefits for this covered service. Up to a \$80 allowance is given for a wide selection of frames from Costco. Please talk to your provider or contact VSP customer care for further details.

** Necessary contact lenses are prescribed to correct extreme visual problems that cannot be corrected with regular lenses.

*** Based on applicable laws; benefits may vary by doctor location.

There is Coordination of Benefits, which is a procedure for limiting benefits from two or more carriers to 100% of the claimant's covered expenses.

Understanding Your Vision Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You must be enrolled for vision coverage before it can be offered to your dependents. Eligible dependents include your spouse (if not also enrolled as an employee), civil union partner, and children. Additional eligibility requirements may apply.

How Do I Find a VSP Provider?

Use the Provider Directory on www.vsp.com to locate nearby VSP providers or to see if your current eye care professional participates in the VSP network. To speak to a representative by phone, please call 800-877-7195.

If treatment or service for a listed covered charge is not available through a Preferred Provider due to network or geographic access and you or one of your Dependents receive such treatment or service from a Non-Preferred Provider, that provider will be reimbursed at the same rate as would have been applied had you or one of your Dependents been treated by a Preferred Provider.

How Do I Submit A Claim?

When visiting a VSP provider for services, the provider submits the claim for payment. If visiting a non-network provider for services, you are responsible for submitting the claim to VSP. Obtain a claim form by logging on to vsp.com or by calling 800-877-7195. Include a copy of your itemized receipt with your claim form and mail it to the following address.

Vision Service Plan
P.O. Box 385018
Birmingham, AL 35238-5018

What Are The Restrictions Of My Coverage?

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

Late Entrant Waiting Period	Those members enrolling more than 31 days after becoming eligible will be subject to an individual benefit waiting period, subject to coverage guidelines.
Non-Medically Necessary Services	The coverage does not pay for visual analysis or vision aids that are not medically necessary.
Benefit Limitations	The following items are excluded under this coverage: <ul style="list-style-type: none"> • Two pairs of glasses instead of bifocals • Replacement of lenses, frames or contacts • Medical or surgical treatment • Orthoptics, vision training or supplemental testing • Plano lenses (lenses with refractive correction of less than $\pm .50$ diopter)
Contact Lens Limitations	The following items are not covered under the contact lens coverage: <ul style="list-style-type: none"> • Insurance policies or service agreements • Artistically painted or non-prescription lenses • Additional office visits for contact lens pathology • Contact lens modification, polishing or cleaning • Refitting of contact lenses after the initial (90 day) fitting period
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of vision coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of the rights, benefits, limitations or exclusions of the coverage. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP61101-9 | 11/2018 | © 2019 Principal Financial Services, Inc.



Your life
benefits

Protect what means the most to you

It's a fact of life. We don't always know what the future will bring. So have you planned ahead to ensure the security of the people you love?

Life has its twists and turns, and the only thing you can really expect is the unexpected. That's why being prepared for the future – protecting your dreams and the dreams of your loved ones – should be priority #1. While it's not easy to think about what would happen to your family if you passed away, it doesn't have to be complicated. What plans have you made to protect your loved ones if something were to happen to you?

Here's how life insurance works

Life insurance helps you put the people in your life first. If something were to happen to you, your life insurance proceeds would go to the people you've designated as your beneficiaries. Those funds can help them manage financial obligations, such as:

- Funeral expenses
- Childcare
- Mortgage/rent
- Daily living expenses
- Paying off debts
- College funding

Let's look at an example



Marc worked full-time to support his family, while his wife Mia stayed home with their three young children. For them, childcare costs outweighed the income Mia would bring home, so they'd decided to rely on Marc's paycheck for all their expenses. But Marc and Mia were planners, and they'd prepared for the unexpected by purchasing life insurance.

So when a sudden heart attack took Marc's life, Mia knew her financial future – and that of her three kids – would be taken care of. She could mourn Marc's loss and reassure their children, all while knowing their world wouldn't be disrupted more than they'd already experienced.

How much coverage do you need?

To determine the amount of coverage you need, it's important to consider your expenses and resources to identify gaps in your overall protection. Use this table to calculate how much life insurance you may need, or log on to principal.com to use our online life insurance calculator.

A. Final expenses	Funeral, burial, etc.	\$ _____
Subtotal A		\$ _____
B. Long-term expenses (total annual amount)	Mortgage/rent	\$ _____
	Car loan(s)	\$ _____
	Student loan(s)	\$ _____
	Credit cards/other loans and debts	\$ _____
	Childcare	\$ _____
	College funding	\$ _____
	Other long-term expenses	\$ _____
Subtotal B		\$ _____
C. Living expenses (total annual amount)	Taxes	\$ _____
	Internet/utilities/cable	\$ _____
	Food/household supplies	\$ _____
	Other expenses (clothes, entertainment)	\$ _____
Subtotal C		\$ _____
Number of years you want to cover these expenses ×		[years] _____
Total financial commitment =		\$ _____
Subtract current financial resources (life insurance, bank accounts, investments) -		\$ _____
Total life insurance need =		\$ _____

Enrolling in [life insurance](#) through your employer can help you protect the people you love from the unexpected. No one knows what the future holds, but life insurance can help ensure your family has the financial resources to handle expenses and is prepared financially for life's milestones.

principal.com

Group life insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This is an overview of the benefits group term life insurance provides, but there are limitations and exclusions. For additional details, contact your employer.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.



Policyholder: JL PROPERTIES, INC.

Group Term Life Benefit Summary

Effective Date: 05/01/2019

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS
Benefits Payable	
Employee Life Benefits	
Benefit Amount	\$10,000
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are Under 70: \$10,000 If you are 70 and older: The lesser of \$10,000 or the amount with the prior carrier
Age Reductions	35% benefit reduction at age 65, with an additional 15% reduction at age 70. Age reductions apply to the benefit amount after proof of good health .
Additional Employee Benefits	
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived.
Accelerated Death Benefit	If you are terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
Individual Purchase Rights	If you terminate employment, you may be able to convert coverage to an individual policy.
Limitations & Exclusions	
Coverage Outside of the US	Benefits will not be paid if you are outside the United States for certain reasons for more than six months.

GROUP TERM LIFE

Accidental Death & Dismemberment (AD&D) Coverage	
Benefit Amount	<p>Your benefit is equal to your group term life benefit amount if loss is due to accident or injury. If loss is due to exposure to the elements or disappearance, your loss may be covered.</p> <p>You may be paid:</p> <ul style="list-style-type: none"> • Full benefit when you lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • Half of the benefit when you lose: one hand / one foot / sight of one eye. • One-fourth of the benefit when you lose the thumb and index finger on the same hand. <p>The loss must occur within 365 days of the accident.</p>
Additional Benefits	
Seatbelt/Airbag	\$10,000 if you are wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	\$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of your death
Repatriation	Up to \$2,000 for preparation and transportation of your body if you die at least 100 miles from your permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months, the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Other Limitations	The Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Understanding Your Life Coverage Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Spouse and child coverage is not available.

What Additional Benefits Are Included?

What Additional Benefits Are Included?	
Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived. You must be totally disabled for 12 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	<p>If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed \$250,000, as long as:</p> <ul style="list-style-type: none"> • Your life expectancy is 12 months or less (as diagnosed by a physician), and • Your death benefit is at least \$10,000. <p>If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in the premium.</p>
Individual Purchase Rights	If you terminate employment, you may be able to convert coverage to individual life coverage. Upon coverage termination your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation. Contact Principal Life for details.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails. Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP55984-14 | 11/2018 | © 2019 Principal Financial Services, Inc.



Policyholder: JL PROPERTIES, INC.

Voluntary Term Life Benefit Summary

Effective Date: 05/01/2019

This chart provides you a brief summary of the key benefits of the life coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your life coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility			
Job Class	ALL MEMBERS		
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. If you are covered as an employee, your dependents may also be eligible. Additional eligibility requirements may apply.		
Benefits Payable			
	Employee Life Benefits	Spouse Life Benefits	Child Life Benefits
Benefit Amount	You may choose to purchase benefits in increments of \$10,000	You may choose to purchase benefits in \$5,000 increments	For eligible children 14 days or older, you may choose to purchase benefits of <ul style="list-style-type: none">• \$2,500, or• \$5,000, or• \$10,000 Eligible children under 14 days of age receive \$1,000.
Minimum	\$10,000	\$5,000	Not Applicable
Maximum	\$500,000	\$100,000	Not Applicable
		Cannot exceed 100% of your benefit amount	
Proof of Good Health	Proof of good health is required for life insurance amounts greater than: If you are under age 70: \$130,000 If you are age 70 and over: \$10,000	Proof of good health is required for life insurance amounts greater than: If your spouse is under age 70: \$30,000 If your spouse is age 70 and over: \$10,000	Not Applicable
Age Reductions	35% benefit reduction at age 65, with an additional 15% reduction at 70 Age reductions apply to the benefit amount after proof of good health.		Not Applicable

VOLUNTARY TERM LIFE

Additional Employee Benefits	
Coverage During Disability	If you become disabled before age 60, coverage will continue and premium may be waived for you and your covered dependents.
Accelerated Death Benefit	If you become terminally ill, you may be able to receive a portion of your life coverage benefit as a lump sum.
Open Enrollment	If you and your enrolled dependents have existing coverage you may be able to increase coverage one increment per year during your open enrollment period without proof of good health.
Individual Purchase Rights	If you terminate employment, you may be able to convert benefits to an individual policy.
Limitations & Exclusions	
Suicide Exclusion	Benefits are not paid if you or your dependents commit suicide within the first 24 months of coverage (prior group voluntary life coverage applies towards the 24 month time period).
Coverage Outside of the US	Benefits will not be paid if you or your dependents are outside the United States for certain reasons for more than six months.

VOLUNTARY TERM LIFE

Accidental Death & Dismemberment (AD&D) Coverage	
Eligible Members	All active, full-time employees (except seasonal, temporary or contract workers) who work at least 30 hours per week. AD & D coverage does not apply to children.
Benefit Amount	<p>Your employee benefit is equal to your voluntary term life benefit amount, if loss is due to accident or injury.</p> <p>Your spouse's benefit is equal to their voluntary term life benefit amount, if loss is due to accident or injury.</p> <p>If loss is due to exposure to the elements or disappearance, the loss may be covered.</p> <p>Benefits may be paid:</p> <ul style="list-style-type: none"> • Full benefit when you or your spouse lose: your life / both hands / both feet / sight of both eyes / one hand and sight of one eye / one foot and sight of one eye / one hand and one foot. • Half of the benefit when you or your spouse lose: one hand / one foot / sight of one eye. • One-fourth of the benefit when you or your spouse lose the thumb and index finger on the same hand. <p>The loss must occur within 365 days of the accident.</p>
Additional Benefits	
Seatbelt /Airbag	\$10,000 if wearing a seatbelt or are protected by an airbag and die in an automobile accident
Education	\$3,000 per year for up to four years for dependent(s) enrolled at an accredited post-secondary school at the time of death
Repatriation	Up to \$2,000 for preparation and transportation of the body if the insured dies at least 100 miles from their permanent residence
Loss of Use/Paralysis	For total and irrevocable loss of voluntary movement for 12 consecutive months or paralysis that is permanent, complete and irreversible, the benefit is: 100% for quadriplegia; 50% for paraplegia, hemiplegia, loss of use of both hands or both feet, or loss of use of one hand and one foot; or 25% for loss of use of one arm, one leg, one hand or one foot
Loss of Speech and/or Hearing	When loss is irrevocable and continues for 12 consecutive months the benefit is: 100% for loss of both speech and hearing; 50% for loss of speech or hearing; 25% for loss of hearing in one ear
Limitations & Exclusions	
Occupational Coverage	For your covered spouse, benefits will not be paid for an injury arising from or during employment for wage or profit
Other Limitations	This Benefit Summary is a summary only. For a complete list of benefit restrictions, please refer to your booklet.

Understanding Your Voluntary Term Life Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

Are My Dependents Eligible For Coverage?

If you are covered as a member, your dependents may also be eligible. Additional eligibility requirements may apply.

Eligible dependents include your spouse (if not also enrolled as an employee), if not hospital or home confined and provided they do not elect benefits as an employee, and children.

Special eligibility requirements may exist for step, foster, adopted, legal age or other child relationships. Additional information may be necessary to determine child eligibility.

Additional eligibility requirements may apply.

What Additional Benefits Are Included?

Coverage During Disability	If you become totally disabled before age 60, coverage will continue and premium will be waived for you and your covered dependents. You must be totally disabled for 12 months before the waiver begins. Coverage continues without premium payment until you recover or turn age 65, whichever occurs first.
Accelerated Death Benefit	<p>If you are terminally ill you can receive up to 75% of your benefit amount in a lump sum, not to exceed \$250,000, as long as:</p> <ul style="list-style-type: none"> Your life expectancy is 12 months or less (as diagnosed by a physician), and Your death benefit is at least \$10,000. <p>If you use the accelerated benefit, your death benefit is reduced by the accelerated benefit payment. There are possible tax consequences to receiving an accelerated benefit payment. You should contact your tax advisor for details. Receipt of accelerated benefits could also affect eligibility for public assistance. The charge for this benefit is included in your premium.</p>
Open Enrollment	An open enrollment period will be available to you and your enrolled dependents each year during the calendar month prior to the policy anniversary. You and your dependents can request an increase of one benefit increment per year up to the guaranteed coverage amount without proof of good health. Once approved for coverage over the guaranteed coverage amount you can request an increase of one benefit increment per year up to the policy maximum benefit without proof of good health.

VOLUNTARY TERM LIFE

Individual Purchase Rights	If you terminate employment, you, your spouse and your children may be able to convert coverage to individual life coverage. Upon coverage termination, your employer is required to inform you of your individual purchase rights to convert to an individual policy without proof of good health. The amount you can purchase varies depending on the termination situation.
Claim Processing	Principal Life makes claim administration easy and convenient for employers by offering an online life claim form. Once the form is complete, employers submit the information directly over a secure, confidential Web site, expediting the claim review process. The employer can choose to use the online form or a printable version that can be faxed or mailed. Along with the online claim form, Principal Life also provides Express Claim Processing for claims that meet certain criteria. Through the Express Claim Process, decisions are reached within five working days without the employer or beneficiary submitting paperwork.



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails. Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP55985-16 | 11/2018 | © 2019 Principal Financial Services, Inc.

JL PROPERTIES, INC.

Voluntary-term life/AD&D

Estimated employee semi-monthly premium amounts

End of the rate guarantee period: 04/30/2020

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Reduced benefit	65-69	Reduced benefit	70 & over
\$10,000	\$0.49	\$0.53	\$0.73	\$1.09	\$1.61	\$2.54	\$3.92	\$5.39	\$6,500	\$6.38	\$5,000	\$8.05
\$20,000	\$0.98	\$1.05	\$1.45	\$2.18	\$3.22	\$5.08	\$7.83	\$10.77	\$13,000	\$12.77	\$10,000	\$16.09
\$30,000	\$1.47	\$1.58	\$2.18	\$3.27	\$4.83	\$7.62	\$11.75	\$16.16	\$19,500	\$19.16	\$15,000	\$24.14
\$40,000	\$1.96	\$2.10	\$2.90	\$4.36	\$6.44	\$10.16	\$15.66	\$21.54	\$26,000	\$25.55	\$20,000	\$32.18
\$50,000	\$2.45	\$2.63	\$3.63	\$5.45	\$8.05	\$12.70	\$19.58	\$26.93	\$32,500	\$31.93	\$25,000	\$40.23
\$60,000	\$2.94	\$3.15	\$4.35	\$6.54	\$9.66	\$15.24	\$23.49	\$32.31	\$39,000	\$38.32	\$30,000	\$48.27
\$70,000	\$3.43	\$3.68	\$5.08	\$7.63	\$11.27	\$17.78	\$27.41	\$37.70	\$45,500	\$44.70	\$35,000	\$56.32
\$80,000	\$3.92	\$4.20	\$5.80	\$8.72	\$12.88	\$20.32	\$31.32	\$43.08	\$52,000	\$51.09	\$40,000	\$64.36
\$90,000	\$4.41	\$4.73	\$6.53	\$9.81	\$14.49	\$22.86	\$35.24	\$48.47	\$58,500	\$57.48	\$45,000	\$72.41
\$100,000	\$4.90	\$5.25	\$7.25	\$10.90	\$16.10	\$25.40	\$39.15	\$53.85	\$65,000	\$63.87	\$50,000	\$80.45
\$110,000	\$5.39	\$5.78	\$7.98	\$11.99	\$17.71	\$27.94	\$43.07	\$59.24	\$71,500	\$70.25	\$55,000	\$88.50
\$120,000	\$5.88	\$6.30	\$8.70	\$13.08	\$19.32	\$30.48	\$46.98	\$64.62	\$78,000	\$76.63	\$60,000	\$96.54
\$130,000	\$6.37	\$6.83	\$9.43	\$14.17	\$20.93	\$33.02	\$50.90	\$70.01	\$84,500	\$83.02	\$65,000	\$104.59
\$140,000	\$6.86	\$7.35	\$10.15	\$15.26	\$22.54	\$35.56	\$54.81	\$75.39	\$91,000	\$89.40	\$70,000	\$112.63
\$150,000	\$7.35	\$7.88	\$10.88	\$16.35	\$24.15	\$38.10	\$58.73	\$80.78	\$97,500	\$95.80	\$75,000	\$120.68
\$160,000	\$7.84	\$8.40	\$11.60	\$17.44	\$25.76	\$40.64	\$62.64	\$86.16	\$104,000	\$102.18	\$80,000	\$128.72
\$170,000	\$8.33	\$8.93	\$12.33	\$18.53	\$27.37	\$43.18	\$66.56	\$91.55	\$110,500	\$108.57	\$85,000	\$136.77
\$180,000	\$8.82	\$9.45	\$13.05	\$19.62	\$28.98	\$45.72	\$70.47	\$96.93	\$117,000	\$114.95	\$90,000	\$144.81
\$190,000	\$9.31	\$9.98	\$13.78	\$20.71	\$30.59	\$48.26	\$74.39	\$102.32	\$123,500	\$121.34	\$95,000	\$152.86
\$200,000	\$9.80	\$10.50	\$14.50	\$21.80	\$32.20	\$50.80	\$78.30	\$107.70	\$130,000	\$127.73	\$100,000	\$160.90
\$210,000	\$10.29	\$11.03	\$15.23	\$22.89	\$33.81	\$53.34	\$82.22	\$113.09	\$136,500	\$134.11	\$105,000	\$168.95
\$220,000	\$10.78	\$11.55	\$15.95	\$23.98	\$35.42	\$55.88	\$86.13	\$118.47	\$143,000	\$140.50	\$110,000	\$176.99
\$230,000	\$11.27	\$12.08	\$16.68	\$25.07	\$37.03	\$58.42	\$90.05	\$123.86	\$149,500	\$146.88	\$115,000	\$185.04
\$240,000	\$11.76	\$12.60	\$17.40	\$26.16	\$38.64	\$60.96	\$93.96	\$129.24	\$156,000	\$153.27	\$120,000	\$193.08
\$250,000	\$12.25	\$13.13	\$18.13	\$27.25	\$40.25	\$63.50	\$97.88	\$134.63	\$162,500	\$159.65	\$125,000	\$201.13
\$260,000	\$12.74	\$13.65	\$18.85	\$28.34	\$41.86	\$66.04	\$101.79	\$140.01	\$169,000	\$166.05	\$130,000	\$209.17
\$270,000	\$13.23	\$14.18	\$19.58	\$29.43	\$43.47	\$68.58	\$105.71	\$145.40	\$175,500	\$172.43	\$135,000	\$217.22
\$280,000	\$13.72	\$14.70	\$20.30	\$30.52	\$45.08	\$71.12	\$109.62	\$150.78	\$182,000	\$178.82	\$140,000	\$225.26
\$290,000	\$14.21	\$15.23	\$21.03	\$31.61	\$46.69	\$73.66	\$113.54	\$156.17	\$188,500	\$185.20	\$145,000	\$233.31
\$300,000	\$14.70	\$15.75	\$21.75	\$32.70	\$48.30	\$76.20	\$117.45	\$161.55	\$195,000	\$191.59	\$150,000	\$241.35
\$310,000	\$15.19	\$16.28	\$22.48	\$33.79	\$49.91	\$78.74	\$121.37	\$166.94	\$201,500	\$197.97	\$155,000	\$249.40
\$320,000	\$15.68	\$16.80	\$23.20	\$34.88	\$51.52	\$81.28	\$125.28	\$172.32	\$208,000	\$204.36	\$160,000	\$257.44
\$330,000	\$16.17	\$17.33	\$23.93	\$35.97	\$53.13	\$83.82	\$129.20	\$177.71	\$214,500	\$210.75	\$165,000	\$265.49
\$340,000	\$16.66	\$17.85	\$24.65	\$37.06	\$54.74	\$86.36	\$133.11	\$183.09	\$221,000	\$217.13	\$170,000	\$273.53
\$350,000	\$17.15	\$18.38	\$25.38	\$38.15	\$56.35	\$88.90	\$137.03	\$188.48	\$227,500	\$223.52	\$175,000	\$281.58

Voluntary Term Life Insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This summary is not a complete statement of the rights, benefits, limitations and exclusions of the coverage described here. For cost and coverage details, contact your Principal® representative.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.



GP55136-08 | 11-2017 | ©2017 Principal Financial Services, Inc.

JL PROPERTIES, INC.

Voluntary-term life/AD&D

Estimated employee semi-monthly premium amounts

End of the rate guarantee period: 04/30/2020

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Reduced benefit	65-69	Reduced benefit	70 & over
\$360,000	\$17.64	\$18.90	\$26.10	\$39.24	\$57.96	\$91.44	\$140.94	\$193.86	\$234,000	\$229.90	\$180,000	\$289.62
\$370,000	\$18.13	\$19.43	\$26.83	\$40.33	\$59.57	\$93.98	\$144.86	\$199.25	\$240,500	\$236.29	\$185,000	\$297.67
\$380,000	\$18.62	\$19.95	\$27.55	\$41.42	\$61.18	\$96.52	\$148.77	\$204.63	\$247,000	\$242.68	\$190,000	\$305.71
\$390,000	\$19.11	\$20.48	\$28.28	\$42.51	\$62.79	\$99.06	\$152.69	\$210.02	\$253,500	\$249.07	\$195,000	\$313.76
\$400,000	\$19.60	\$21.00	\$29.00	\$43.60	\$64.40	\$101.60	\$156.60	\$215.40	\$260,000	\$255.45	\$200,000	\$321.80
\$410,000	\$20.09	\$21.53	\$29.73	\$44.69	\$66.01	\$104.14	\$160.52	\$220.79	\$266,500	\$261.83	\$205,000	\$329.85
\$420,000	\$20.58	\$22.05	\$30.45	\$45.78	\$67.62	\$106.68	\$164.43	\$226.17	\$273,000	\$268.22	\$210,000	\$337.89
\$430,000	\$21.07	\$22.58	\$31.18	\$46.87	\$69.23	\$109.22	\$168.35	\$231.56	\$279,500	\$274.61	\$215,000	\$345.94
\$440,000	\$21.56	\$23.10	\$31.90	\$47.96	\$70.84	\$111.76	\$172.26	\$236.94	\$286,000	\$281.00	\$220,000	\$353.98
\$450,000	\$22.05	\$23.63	\$32.63	\$49.05	\$72.45	\$114.30	\$176.18	\$242.33	\$292,500	\$287.38	\$225,000	\$362.03
\$460,000	\$22.54	\$24.15	\$33.35	\$50.14	\$74.06	\$116.84	\$180.09	\$247.71	\$299,000	\$293.77	\$230,000	\$370.07
\$470,000	\$23.03	\$24.68	\$34.08	\$51.23	\$75.67	\$119.38	\$184.01	\$253.10	\$305,500	\$300.15	\$235,000	\$378.12
\$480,000	\$23.52	\$25.20	\$34.80	\$52.32	\$77.28	\$121.92	\$187.92	\$258.48	\$312,000	\$306.54	\$240,000	\$386.16
\$490,000	\$24.01	\$25.73	\$35.53	\$53.41	\$78.89	\$124.46	\$191.84	\$263.87	\$318,500	\$312.93	\$245,000	\$394.21
\$500,000	\$24.50	\$26.25	\$36.25	\$54.50	\$80.50	\$127.00	\$195.75	\$269.25	\$325,000	\$319.32	\$250,000	\$402.25

Note: Proof of good health/evidence of insurability is required to apply for benefit amounts greater than those highlighted above.

If your age changes to a different rate band during the guarantee period, your premium will change to reflect the new rate band effective on the next policy anniversary date.

Voluntary Term Life insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.
This summary is not a complete statement of the rights, benefits, limitations and exclusions of the coverage described here. For cost and coverage details, contact your Principal® representative.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.



GP55136-08 | 11-2017 | ©2017 Principal Financial Services, Inc.

JL PROPERTIES, INC.

Voluntary-term life/AD&D

Estimated spouse semi-monthly premium amounts

End of the rate guarantee period: 04/30/2020

Benefit amount	29 & under	30-34	35-39	40-44	45-49	50-54	55-59	60-64	Reduced benefit	65-69	Reduced benefit	70 & over
\$5,000	\$0.25	\$0.27	\$0.37	\$0.55	\$0.81	\$1.28	\$1.96	\$2.70	\$3,250	\$3.19	\$2,500	\$4.02
\$10,000	\$0.49	\$0.53	\$0.73	\$1.09	\$1.61	\$2.54	\$3.92	\$5.39	\$6,500	\$6.38	\$5,000	\$8.05
\$15,000	\$0.74	\$0.79	\$1.09	\$1.64	\$2.42	\$3.82	\$5.88	\$8.08	\$9,750	\$9.58	\$7,500	\$12.07
\$20,000	\$0.98	\$1.05	\$1.45	\$2.18	\$3.22	\$5.08	\$7.83	\$10.77	\$13,000	\$12.77	\$10,000	\$16.09
\$25,000	\$1.23	\$1.32	\$1.82	\$2.73	\$4.03	\$6.36	\$9.79	\$13.47	\$16,250	\$15.96	\$12,500	\$20.11
\$30,000	\$1.47	\$1.58	\$2.18	\$3.27	\$4.83	\$7.62	\$11.75	\$16.16	\$19,500	\$19.16	\$15,000	\$24.14
\$35,000	\$1.72	\$1.84	\$2.54	\$3.82	\$5.64	\$8.90	\$13.71	\$18.85	\$22,750	\$22.36	\$17,500	\$28.16
\$40,000	\$1.96	\$2.10	\$2.90	\$4.36	\$6.44	\$10.16	\$15.66	\$21.54	\$26,000	\$25.55	\$20,000	\$32.18
\$45,000	\$2.21	\$2.37	\$3.27	\$4.91	\$7.25	\$11.44	\$17.62	\$24.24	\$29,250	\$28.74	\$22,500	\$36.20
\$50,000	\$2.45	\$2.63	\$3.63	\$5.45	\$8.05	\$12.70	\$19.58	\$26.93	\$32,500	\$31.93	\$25,000	\$40.23
\$55,000	\$2.70	\$2.89	\$3.99	\$6.00	\$8.86	\$13.98	\$21.54	\$29.62	\$35,750	\$35.12	\$27,500	\$44.25
\$60,000	\$2.94	\$3.15	\$4.35	\$6.54	\$9.66	\$15.24	\$23.49	\$32.31	\$39,000	\$38.32	\$30,000	\$48.27
\$65,000	\$3.19	\$3.42	\$4.72	\$7.09	\$10.47	\$16.52	\$25.45	\$35.01	\$42,250	\$41.51	\$32,500	\$52.29
\$70,000	\$3.43	\$3.68	\$5.08	\$7.63	\$11.27	\$17.78	\$27.41	\$37.70	\$45,500	\$44.70	\$35,000	\$56.32
\$75,000	\$3.68	\$3.94	\$5.44	\$8.18	\$12.08	\$19.06	\$29.37	\$40.39	\$48,750	\$47.89	\$37,500	\$60.34
\$80,000	\$3.92	\$4.20	\$5.80	\$8.72	\$12.88	\$20.32	\$31.32	\$43.08	\$52,000	\$51.09	\$40,000	\$64.36
\$85,000	\$4.17	\$4.47	\$6.17	\$9.27	\$13.69	\$21.60	\$33.28	\$45.78	\$55,250	\$54.28	\$42,500	\$68.38
\$90,000	\$4.41	\$4.73	\$6.53	\$9.81	\$14.49	\$22.86	\$35.24	\$48.47	\$58,500	\$57.48	\$45,000	\$72.41
\$95,000	\$4.66	\$4.99	\$6.89	\$10.36	\$15.30	\$24.14	\$37.20	\$51.16	\$61,750	\$60.67	\$47,500	\$76.43
\$100,000	\$4.90	\$5.25	\$7.25	\$10.90	\$16.10	\$25.40	\$39.15	\$53.85	\$65,000	\$63.87	\$50,000	\$80.45

Note: Proof of good health/evidence of insurability is required to apply for benefit amounts greater than those highlighted above.

Child(ren) premium amounts (per family)

\$2,500	\$0.25
\$5,000	\$0.50
\$10,000	\$1.00

If your age changes to a different rate band during the guarantee period, your premium will change to reflect the new rate band effective on the next policy anniversary date.

Voluntary Term Life insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This summary is not a complete statement of the rights, benefits, limitations and exclusions of the coverage described here. For cost and coverage details, contact your Principal® representative.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.



GP55136-08 | 11-2017 | ©2017 Principal Financial Services, Inc.



Your disability benefits



Policyholder: JL PROPERTIES, INC.

Voluntary Short Term Disability (STD) Benefit Summary

Effective Date: 05/01/2019

This chart provides you a brief summary of the key benefits of the short-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your short-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 30 hours per week
Benefits Payable	
Primary Weekly Benefit	60% of your predisability earnings up to \$1,800
Benefit Amount	Primary Weekly Benefit less other income sources
Definition of Earnings	Base wage
Benefit Qualification	
Elimination Period	Benefits begin on the 1st day for accident and 8th day for sickness
Benefit Payment Period	Up to 13 weeks after the elimination period is satisfied
Maternity	Treated the same as any other disability
Additional Benefits	
Rehabilitation Incentive Benefit	5% increase in the primary weekly benefit
Survivor Benefit	3 weeks of pre-tax primary weekly benefit to your survivor
Limitations & Exclusions	
Pre-Existing Conditions	3 months prior/12 months insured
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Understanding Your Short-Term Disability Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short-term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

- 1) **Meet the Definition of Disability.** Disabilities must be solely and directly caused by sickness, injury, or pregnancy.

During the elimination period and the benefit payment period, one of these situations must apply:

- You cannot perform the majority of the substantial and material duties of your own job.
- You are performing the duties of your own job on a modified basis and lose at least 20% of the income you earned before becoming disabled.
- You are performing the duties of any other job and lose at least 20% of the income you earned before becoming disabled.

- 2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Benefits begin on the 1st day when due to injury and begin on the 8th day when due to sickness. The elimination period can be satisfied with days of total or partial disability.

How Much Weekly Benefit Will I Receive?

Your benefits will be determined by using your base wage.

The benefit payment period is the length of time you will receive benefits for a qualifying disability after the elimination period is satisfied. When you are unable to work in any capacity during the benefit payment period, your primary weekly benefit is equal to 60% of your predisability earnings, up to \$1,800. Your primary weekly benefit less income from other sources is the benefit amount you will receive. Your benefit amount will never be less than the \$15 minimum benefit.

Benefits if Working If you are able to work while disabled, you may still be eligible to receive a disability benefit.

VOLUNTARY SHORT-TERM DISABILITY

If you are working during the benefit payment period, your benefit amount is the lesser of:

- 100% of your predisability earnings, less income from other sources, less current earnings; or
- Your primary weekly benefit, less income from other sources.

Income you receive from other sources can be deducted from your primary weekly benefit. For a complete list of other sources, please refer to your booklet. Other sources may include: All retirement or disability benefits that you and your dependents receive or could have received from Social Security or other government agencies/ Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / Severance pay / All payments for the month that the member receives under state unemployment laws.

How Long Will I Receive My Benefits?

You are eligible to receive short-term disability benefits for 13 weeks after the elimination period is satisfied.

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Fail to provide any required proof of disability / Fail to submit to a required medical examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits or Workers' Compensation benefits / Die.

If you recover and return to work for less than 30 continuous days during the benefit duration and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

Work Incentive Benefit	The Work Incentive Benefit is paid to you if you are disabled and you return to work on a limited or part-time basis. The Work Incentive Benefit equals the primary weekly benefit with no offset for work earnings unless the combination of work earnings, disability benefits and other income sources exceeds 100% of your predisability earnings. If this occurs, the Work Incentive Benefit will be reduced by the amount in excess of 100% of your predisability earnings.
Survivor Benefit	A Survivor Benefit is a lump sum payment issued to your survivors, should you die while receiving disability benefits. The benefit payment is equal to 3 weeks of pre-tax primary weekly benefits.
Rehabilitation Plan	While disabled, you may qualify to participate in a rehabilitation plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own job, preventive rehabilitation services may be offered.
Rehabilitation Incentive Benefit	The Rehabilitation Incentive Benefit can increase the primary weekly benefit by 5% if you become totally disabled and participate in and satisfy the requirements of an individual rehabilitation plan.
Mandatory Rehabilitation	Your Mandatory Rehabilitation provision indicates that, if appropriate, you may be required to participate in an individual rehabilitation plan.

What Are The Restrictions Of My Coverage?

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

<p>Pre-existing Conditions</p>	<p>A pre-existing condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the three months prior to your effective date under this policy, for which you:</p> <ul style="list-style-type: none"> • Received medical treatment, consultation, care or service; or • Were prescribed or took prescription medications <p>In the event an investigation is necessary to determine if a disability is pre-existing, benefits may be payable for up to six weeks while The Principal is conducting its pre-existing condition investigation. Once the investigation is complete and if the disability is deemed to be a pre-existing condition, no further benefits will be payable. Benefits will not be paid beyond the date six weeks following the date of disability for disabilities resulting from pre-existing conditions unless, when you become disabled, you have been actively at work for one full day after being covered under the policy for 12 consecutive months. No benefits will be paid for a subsequent claim subject to a pre-existing condition investigation for the same condition.</p> <p>No benefits will be paid for any disability that is caused by, a complication of, or resulting from the same pre-existing condition that you had previously received benefits for.</p> <p>Pre-existing condition limitations also apply to benefit increases due to:</p> <ul style="list-style-type: none"> • Policy amendments • Changes in earnings of 25% or greater
---------------------------------------	---



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails. Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP55813-7 | 07/2016 | © 2019 Principal Financial Services, Inc.

JL PROPERTIES, INC.

Short term disability

Estimated weekly benefit & semi-monthly deduction amount

End of rate guarantee period: 04/30/2020

To determine your estimated weekly benefit amount,
multiply your weekly earnings by your benefit percentage.
See your benefit summary for the definition of earnings.

Weekly earnings: \$ _____

If your weekly earnings are greater than \$3,000 then use
\$3,000 as your earnings.

X Benefit percentage: 0.60

= Estimated weekly benefit amount: \$ _____

To determine your estimated semi-monthly deduction,
multiply your estimated weekly benefit amount by your
age rate in the box at the right.

Age	Semi-Monthly rate
Age 24 & Under	0.0275
25-29	0.0380
30-34	0.0380
35-39	0.0280
40-44	0.0190
45-49	0.0180
50-54	0.0225
55-59	0.0275
60-64	0.0350
65-69	0.0375
70+	0.0395

Estimated weekly benefit amount: \$ _____

X Age rate: \$ _____

X Employee Contribution Percent: 100%

= Employee's estimated semi-monthly deduction: \$ _____

Example

Age 30; weekly earnings: \$900; age rate is 0.038; Employee Contribution: 100%

Estimated weekly benefit amount : $\$900.00 \times 0.60 = \540.00

Employee's estimated semi-monthly deduction : $\$540.00 \times 0.038 \times 1.00 = \20.52



If your age changes to a different rate band during the guarantee period, your deduction amount will change to reflect the new rate band effective on the next policy anniversary date.

This is a general statement of Short Term Disability insurance underwritten by Principal Life Insurance Company. It is not an insurance contract and does not contain all of the qualifications and restrictions of the coverage being offered to you. If any provision presented here is found to be in conflict with federal or state law, that provision will be applied to comply with federal or state law. The group policy determines all rights, benefits, exclusions and limitations of the insurance described here. For more details about the coverage, refer to the policy that will be issued to each member.



Policyholder: JL PROPERTIES, INC.

Voluntary Long Term Disability (LTD) Benefit Summary

Effective Date: 05/01/2019

This chart provides you a brief summary of the key benefits of the long-term disability coverage available from Principal Life Insurance Company. Following the chart, you will find additional information to answer questions you may have. For a complete list of all your long-term disability coverage benefits and restrictions, please refer to your booklet or contact your employer.

Eligibility	
Job Class	ALL MEMBERS
Eligible Members	All active, full time employees (except seasonal, temporary, or contract workers) who work at least 30 hours per week
Benefits Payable	
Primary Monthly Benefit	60% of your predisability earnings up to \$8,000.
Benefit Amount	Primary monthly benefit less other income sources
Definition of Earnings	Base wage
Benefit Qualification	
Elimination Period	90 days
Own Occupation Period	2 years
Maximum Benefit Payment Period	To age 65
Additional Benefits	
Rehabilitation Incentive Benefit	5% increase in the monthly benefit percentage
Survivor Benefit	Three times your primary monthly benefit less other income sources to your survivor.
Limitations & Exclusions	
Pre-Existing Conditions	6 months prior/12 months insured
Other Limitations	There are additional limitations to your coverage. A complete list is included in your booklet.

Understanding Your Long-Term Disability (LTD) Benefits

Am I Eligible For Coverage?

To be eligible for coverage, you must qualify as an eligible member and be considered actively at work.

You will be considered actively at work if you are able and available for active performance of all of your regular duties. Short term absence because of a regularly scheduled day off, holiday, vacation day, jury duty, funeral leave, or personal time off is considered active work provided you are able and available for active performance of all of your regular duties and were working the day immediately prior to the date of your absence.

How Do I Qualify For Benefits?

1) **Meet the Definition of Disability.** Disabilities must be solely and directly caused by injury or sickness (including pregnancy).

During the elimination period and the own occupation period, one of these situations must apply:	<ul style="list-style-type: none">You cannot perform the majority of the substantial and material duties of your own occupation.You are performing the duties of your own occupation on a modified basis or any occupation and are unable to earn more than 80% of your indexed predisability earnings.
After completing the own occupation period, one of these situations apply:	<ul style="list-style-type: none">You cannot perform the majority of the substantial and material duties of any occupation for which you are or may reasonably become qualified based on education, training, or experience.You are performing the substantial and material duties of your own occupation or any occupation on a modified basis and are unable to earn more than 80% of your indexed predisability earnings.

2) **Satisfy the Elimination Period.** The amount of time you must be disabled before receiving benefits is called the elimination period. Long-Term Disability benefits begin after you have been disabled for 90 days. The elimination period can be satisfied with days of total or partial disability.

If you recover and return to work during the elimination period and become disabled again, you may not have to satisfy a new elimination period. If you become disabled again, your elimination period will pick up at the point where it was left off when you recovered. You have a period twice as long as the elimination period to satisfy the required number of days of disability.

How Much Monthly Benefit Will I Receive?

Your benefits will be determined based on your Base wage.

When you are unable to work in any capacity during the benefit payment period, your **monthly benefit** equals your primary monthly benefit, less income from other sources.

VOLUNTARY LONG-TERM DISABILITY

Your primary monthly benefit is equal to 60% of your predisability earnings, but will not exceed \$8,000.

Your monthly benefit will not be less than the minimum monthly benefit of \$50.

Benefits if Working

If you are able to work while disabled, you may still be eligible to receive a disability benefit.

If you are working during the benefit payment period, your monthly benefit for the 12 month work incentive period is the lesser of:

- 100% of the indexed earnings you received before becoming disabled, less income from other sources, less current earnings; or
- Your primary monthly benefit, less income from other sources.

After the work incentive period, your monthly benefit equals your primary monthly benefit, less income from other sources and multiplied by your income loss percentage.

Income you receive from other sources can be deducted from your primary monthly benefit. Other sources include: All retirement or disability benefits that you and your dependents receive, or could have received, from Social Security, or other government agencies /Salary continuance, personal time off or sick pay / Workers' Compensation benefits / Income from state disability plans / Payments from policies that provide coverage for time away from work, if paid in part by or deducted from payroll by the policyholder / Income from other group disability coverage policies / Disability or retirement benefits paid by pension plans sponsored by the policyholder / Income received from no-fault auto laws / Renewal commissions received from the policyholder / Severance pay / All payments for the month that the member receives under state unemployment laws / Any income you receive for services rendered prior to your Date of Disability will not be considered Other Income Sources.

How Long Will I Receive My Benefits?

The benefit payment period is the length of time you'll receive benefits for a qualifying disability after the elimination period is satisfied. Your age at the time disability occurs determines the length of time you are eligible to receive disability benefits.

Age Disability Occurs	Benefits are Payable:
Under Age 62	<i>Until the later of the date you reach age 65 or 42 months</i>
Age 62	<i>42 months</i>
Age 63	<i>36 months</i>
Age 64	<i>30 months</i>
Age 65	<i>24 months</i>
Age 66	<i>21 months</i>
Age 67	<i>18 months</i>
Age 68	<i>15 months</i>
Age 69 and over	<i>12 months</i>

Your disability benefits will end when you: Recover / Cease to be under the regular and appropriate care of a physician / Fail to provide any required proof of disability / Fail to submit to a required medical

VOLUNTARY LONG-TERM DISABILITY

examination / Fail to report income from other sources, or any other required earnings information / Fail to pursue Social Security disability benefits or Workers' Compensation benefits / Die.

If you recover and return to work for six months or less during the benefit payment period and then again become disabled from the same or related cause, you are not required to complete a new elimination period.

What Additional Benefits Are Included?

Work Incentive Benefit	The Work Incentive Benefit is paid to you if you are disabled and you return to work on a limited or part-time basis. To receive benefits, you must be working. The Work Incentive Benefit equals the primary monthly benefit with no offset for work earnings unless the combination of work earnings, disability benefits and other income sources exceeds 100% of your predisability earnings. If this occurs, the Work Incentive Benefit will be reduced by the amount in excess of 100% of your predisability earnings.
Survivor Benefit	The Survivor Benefit is a lump sum payment issued to your survivors, should you die while receiving disability benefits. The benefit payment is equal to three times your primary monthly benefit less other income sources.
Accelerated Survivor Benefit	If you are diagnosed with a terminal illness and your life expectancy is 12 months or less, you may elect to receive the survivor benefit on an accelerated basis. You may receive the full amount of the survivor benefit before death. Survivor benefits paid on an accelerated basis may affect eligibility for public assistance and may be taxable. You should consult your tax advisor with any questions.
Rehabilitation Plan	While disabled, you may qualify to participate in a Rehabilitation Plan. Our rehabilitation staff works with you, your physician(s) and your employer to create an individual rehabilitation plan to assist you in returning to work. If you are not disabled, but have a condition that could prevent you from performing the substantial and material duties of your own occupation, preventive rehabilitation services may be offered.
Rehabilitation Incentive Benefit	The Rehabilitation Incentive Benefit can increase the benefit percentage by 5% if you become totally disabled and participate in and satisfy the requirements of an individual rehabilitation plan.
Return to Work Child Care Benefit	The Return to Work Child Care Benefit helps you remain on the job or return to work by helping you cover the cost of child care expenses. We will reimburse you for 100% of your child care expenses, up to \$350 per month for up to twelve months. Return to work child care benefits begin after work incentive benefit payments end.
Mandatory Rehabilitation	The Mandatory Rehabilitation provision indicates that, if appropriate, you may be required to participate in an individual rehabilitation plan. Any expenses associated with the rehabilitation plan will be paid for by Principal Life.

What Are The Restrictions Of My Coverage?

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

Preexisting Conditions	<p>A preexisting condition is an injury or sickness (including pregnancy) and all related conditions and complications, in the six months prior to your effective date under this policy, for which you:</p> <ul style="list-style-type: none"> • Received medical treatment, consultation, care or service; or • Were prescribed or took prescription medications; or • Had symptoms or conditions which would cause a reasonably prudent person to seek diagnosis, care or treatment <p>Benefits will not be paid for disabilities resulting from preexisting conditions unless, when you become disabled, you have been actively at work for one full day after being covered under the policy for 12 consecutive months.</p> <p>Preexisting condition exclusions also apply to benefit increases due to policy amendments and changes in earnings of 25% or greater.</p>
Treatment of Mental Health Conditions, Drug and Alcohol Abuse Conditions and Special Conditions	<p>A disability is considered due to alcohol, drug or chemical abuse, dependency or addiction or a mental health condition or a special condition if the disability is caused by one of these condition(s) and not by other disabling conditions.</p> <p>Maximum benefit payment periods for: Mental health conditions – 24 months Alcohol, drug or chemical abuse conditions – 24 months Special conditions – 24 months</p> <p>The benefit payment period listed above is a lifetime maximum for all periods of disability. All disabilities from conditions with the same maximum benefit payment period contribute towards one lifetime maximum.</p> <p>However, if at the end of the benefit payment period, you are confined in a hospital or any other type of facility providing treatment for any of these conditions, the benefit payment period may be extended to include the time period you are confined for treatment.</p> <p>Special conditions are considered to be Thoracic outlet syndrome / Headaches, such as functional, migraine, organic, sinus and tension / Chronic fatigue syndrome / Fibromyalgia/ Temporomandibular joint (TMJ) / Cumulative trauma disorder, overuse syndrome, or repetitive stress disorder including carpal tunnel and ulnar tunnel syndrome / Environmental allergies and multiple chemical sensitivity / Musculoskeletal and connective tissue disorders of the neck and back, including any disease or disorder of the cervical, thoracic and lumbosacral back and surrounding soft tissue, including sprains and strains of joints and adjacent muscles.</p>



Principal Life Insurance Company, Des Moines, Iowa 50392-0002, www.principal.com

This is a summary of life coverage underwritten by or with administrative services provided by Principal Life Insurance Company. This benefit summary is for administrative purposes and is not a complete statement of benefits and restrictions. You'll receive a benefit booklet with details about your coverage. If there is a discrepancy between this summary and your benefit booklet, the benefit booklet prevails. Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP55672-13 | 04-2017 | © 2019 Principal Financial Services, Inc.

JL PROPERTIES, INC. - FEMALE

Long term disability

Estimated monthly benefit amount & semi-monthly deduction amount

End of rate guarantee period: 04/30/2020

To determine your estimated semi-monthly deduction, multiply your covered monthly earnings by your age rate in the box at the right. See your benefit summary for the definition of earnings.

Covered monthly earnings: \$ _____

If your monthly earnings are greater than \$13,333.33 then use \$13,333.33 as your earnings.

X Age rate: _____

X Employee Contribution Percent: 100%

= Employee's estimated semi-monthly deduction : \$ _____

Age	Semi-monthly rate
Under age 24	0.00145
25-29	0.00205
30-34	0.00270
35-39	0.00285
40-44	0.00440
45-49	0.00820
50-54	0.00855
55-59	0.00855
60-64	0.00665
65-69	0.00470
70+	0.00225

To determine your estimated monthly benefit amount, multiply your covered monthly earnings by your benefit percentage.

Covered monthly earnings: \$ _____

If your monthly earnings are greater than \$13,333.33 then use \$13,333.33 as your earnings.

X Benefit percentage: 0.60

= Estimated monthly benefit amount: \$ _____

Example

Age 30; covered monthly earnings: \$4,000; age rate is 0.0027; Employee Contribution: 100%

Employee's estimated semi-monthly deduction : $\$4,000.00 \times 0.0027 \times 1.00 = \10.80

Estimated monthly benefit amount : $\$4,000.00 \times 0.60 = \$2,400.00$



If your age changes to a different rate band during the guarantee period, your monthly deduction will change to reflect the new rate band effective on the next policy anniversary date.

This is a general statement of Long Term Disability insurance underwritten by Principal Life Insurance Company. It is not an insurance contract and does not contain all of the qualifications and restrictions of the coverage being offered to you. If any provision presented here is found to be in conflict with federal or state law, that provision will be applied to comply with federal or state law. The group policy determines all rights, benefits, exclusions and limitations of the insurance described here. For more details about the coverage, refer to the policy that will be issued to each member.

JL PROPERTIES, INC. - MALE

Long term disability

Estimated monthly benefit amount & semi-monthly deduction amount

End of rate guarantee period: 04/30/2020

To determine your estimated semi-monthly deduction, multiply your covered monthly earnings by your age rate in the box at the right. See your benefit summary for the definition of earnings.

Covered monthly earnings: \$ _____
If your monthly earnings are greater than \$13,333.33 then use \$13,333.33 as your earnings.

X Age rate: _____

X Employee Contribution Percent: 100%

= Employee's estimated semi-monthly deduction : \$ _____

Age	Semi-monthly rate
Under age 24	0.00120
25-29	0.00115
30-34	0.00170
35-39	0.00215
40-44	0.00360
45-49	0.00420
50-54	0.00595
55-59	0.00760
60-64	0.00760
65-69	0.00505
70+	0.00240

To determine your estimated monthly benefit amount, multiply your covered monthly earnings by your benefit percentage.

Covered monthly earnings: \$ _____
If your monthly earnings are greater than \$13,333.33 then use \$13,333.33 as your earnings.

X Benefit percentage: 0.60

= Estimated monthly benefit amount: \$ _____

Example

Age 30; covered monthly earnings: \$4,000; age rate is 0.0017; Employee Contribution: 100%

Employee's estimated semi-monthly deduction : $\$4,000.00 \times 0.0017 \times 1.00 = \6.80

Estimated monthly benefit amount : $\$4,000.00 \times 0.60 = \$2,400.00$



If your age changes to a different rate band during the guarantee period, your monthly deduction will change to reflect the new rate band effective on the next policy anniversary date.

This is a general statement of Long Term Disability insurance underwritten by Principal Life Insurance Company. It is not an insurance contract and does not contain all of the qualifications and restrictions of the coverage being offered to you. If any provision presented here is found to be in conflict with federal or state law, that provision will be applied to comply with federal or state law. The group policy determines all rights, benefits, exclusions and limitations of the insurance described here. For more details about the coverage, refer to the policy that will be issued to each member.



Discounts and services

Save money while improving your life

Everybody loves a discount! Use these to help improve your life — financially, mentally and physically. Offered by some of the most trusted companies in the U.S., these discounts and services are available through your group benefits from Principal®. **These discounts are not insurance.**

Laser Vision Correction	<p>Imagine your life free from glasses and contacts. You, your spouse and dependent children receive 15% off standard pricing or 5% off promotional pricing on LASIK through the National Lasik Network, administered by LCA-Vision, Inc.</p> <p>principallasik.com 888-647-3937</p>
Hearing Aid Program/AHB	<p>Consider how hearing loss affects the entire family. That's why you, your spouse, children, parents and grandparents can receive free annual hearing consultations and a 60-day trial on hearing aids through American Hearing Benefits, Inc. (AHB). Plus, you all get discounts on hearing aids through their nationwide network of 3,000+ hearing professionals.</p> <p>principal.com/hearingbenefits/ahb 877-890-4694</p>
Hearing Aid Program/EPIC	<p>Take care of your family's hearing. You and your family have access to a large network of audiologists and ear, nose and throat (ENT) physicians through Ear Professionals International Corporation (EPIC). All of you get up to 60% off major brand hearing aids. Follow-up care and batteries for one year are included for hearing aids purchased through EPIC.</p> <p>principal.com/hearingbenefits/epic 866-956-5400 and identify yourself as a Principal customer</p>

Available with your dental and vision insurance

Vision Care	<p>Protect and improve your family's vision. You, your spouse and dependent children can get discounts on LASIK surgery from a nationwide network of VSP providers.</p> <p>You'll also receive discounts on eye exams, prescription glasses and lenses, and contact lens evaluations and fittings through VSP.</p> <p>principal.com/vsp and select the VSP Choice Network 800-877-7195</p>
Dental Health EdgeSM	<p>Get the information you need to make better decisions about oral health care. You can go online and submit a dental care question and get a response from a dentist in one business day. A dental cost estimator shows approximate costs in a ZIP code. And you can access articles about dental health topics plus get information about how dental coverage works.</p> <p>http://c3.go2dental.com/scontent/</p>

Available with your disability insurance

Employee Assistance Program	<p>Count on help to be there when you need it. From concerns like decreasing stress to more complex issues such as divorce, your Employee Assistance Program provides recommendations and information to help you with life's everyday, and not so everyday, challenges.</p> <p>You and your immediate family have access to free, confidential service, as well as referrals to supportive and community resources, from Magellan Healthcare.</p> <p>MagellanHealth.com/member 800-450-1327</p>
------------------------------------	--

Available with your life insurance

Travel Assistance	<p>Ease some of the worries of traveling – whether in the U.S. or internationally. You, your spouse and dependent children have access to a variety of benefits provided through AXA Assistance¹. These services include travel and medical assistance plus emergency medical evacuation benefits.</p> <p>Assistance is available for travel 100+ miles away from home for up to 120 consecutive days. Available with group term life insurance only.</p> <p>principal.com/travelassistance</p>
Will & Legal Document Center	<p>Consider creating your simple legal documents online. These online resources and tools, provided by ARAG^{®2}, are easy-to-use.</p> <p>You and your spouse can create, print and store essential legal documents — such as a will, living will, healthcare power of attorney, durable power of attorney, and medical treatment authorization for minors. Plus, you can access estate planning tools and a personal information organizer.</p> <p>www.ARAGwills.com/Principal.</p> <p>Enter your group policy number: 1053525</p>
Identity Theft Kit	<p>Be proactive in protecting one of your most important assets – your identity. If your identity is stolen, despite your best efforts, you’ll get valuable tips on how to restore it.</p> <p>www.ARAGwills.com/Principal.</p> <p>Enter your group policy number: 1053525</p>
Beneficiary Support	<p>Get help coping with the death of a loved one. Beneficiaries receive help coping with the emotions and financial decisions that surface when a loved one dies. Services include grief support from Magellan Healthcare and financial review from Principal[®]. Spouses and dependents receive three months of free online will preparation services provided by ARAG.²</p> <p>Information is provided after the loss of a loved one.</p>

principal.com

The discounts and services listed here are available to members, and/or their dependents or beneficiaries, with group coverage underwritten by or with administrative services provided by Principal Life Insurance Company. For group policies issued in New York: Employee Assistance Program, Travel Assistance, Will & Legal Document Center, Identity Theft Kit and Beneficiary Support are not available; Laser Vision Correction and Hearing Aid Programs are only available with dental or vision insurance. The discounts and services are not a part of the policy or contract and may be changed or discontinued at any time. Although Principal has arranged to make these programs available to you, the third party providers are solely responsible for their products and services.

If your benefits are self-funded, then your employer assumes financial responsibility for paying claims, and Principal[®] is contracted to administer the coverage on your employer’s behalf.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP58554C-14 (SP1285C-14) 10/2018 © 2018 Principal Financial Services, Inc.

¹ Participants are responsible for any incurred fees or expenses. Indemnified transportation services are administered by AXA Assistance USA, Inc. and underwritten by a third party licensed insurance company.

² The use of the services provided by ARAG Services, LLC should not be considered as a substitute for consultation with an attorney.

Principal and its affiliates are not responsible for any loss, injury, claim, liability or damages related to the use of the discounts and services.

Protect and improve your family's vision

Immediate savings on eye care and eyewear with VSP® Vision Savings Pass™

Everybody loves a discount! Save money when you or your dependents use this discount program offered by VSP. The VSP Vision Savings Pass is available with your dental or vision coverage from Principal®. And with 77,000 access points in VSP's nationwide network, you're sure to find an eye doctor near you.

*Based on applicable laws, benefits may vary by location.

This discount program is not vision insurance.

Service and eyewear	Reduced prices and discounts*
Eye exam	\$50 with purchase of a complete pair of glasses. 20% off without purchase.
Prescription glasses or sunglasses	When you purchase a complete pair of glasses, you save on lenses and frames. <ul style="list-style-type: none"> • Single vision lenses \$40 • Lined bifocal lenses \$60 • Lined trifocal lenses \$75 • Lenticular lenses \$75 25% off frames
Lens enhancements	Average 20-25% off enhancements such as progressive, scratch-resistant and anti-reflective coatings
Non-prescription sunglasses	20% off unlimited sunglasses purchased within 12 months of last covered exam
Contact lens exam	15% off
Laser vision correction	15-25% off standard pricing or 5% off promotional pricing through VSP-contracted facilities
Retinal screening	Your eye doctor takes a high-resolution image of the inside of your eye to identify potential or existing vision and health problems. \$39 maximum fee

Keep this card.

You don't need to give it to your VSP eye doctor. But you may want to keep it as a reminder of the discounts.

Using VSP is easy

- Step 1 | Find a VSP eye doctor near you** – Go to principal.com/vsp and select the VSP Choice network or call 800-877-7195.
- Step 2 | Make an appointment** – Identify yourself as a VSP member to receive the discount.
- Step 3 | Let VSP take it from there** – Your VSP eye doctor will handle the rest. Fees are automatically reduced at the time of service.

This discount program is not vision insurance.



Principal®

Using VSP is easy. Just follow these steps.

- Step 1** | **Find a VSP eye doctor near you** – Go to principal.com/vsp and select the VSP Choice network or call 800-877-7195.
- Step 2** | **Make an appointment** – Identify yourself as a VSP member to receive the discount.
- Step 3** | **Let VSP take it from there** – Your VSP eye doctor will handle the rest. Fees are automatically reduced at the time of service.



principal.com

Dental and vision insurance from Principal® are issued by Principal Life Insurance Company, Des Moines, Iowa 50392

The VSP Vision Savings Pass is not vision insurance. This discount is not a part of any Principal policy or contract and may be changed or discontinued at any time. VSP is solely responsible for the goods and services provided through this program. VSP is not a member of the Principal Financial Group®. If your vision benefits are self-funded, then your employer assumes financial responsibility for paying claims, and Principal® is contracted to administer the coverage on your employer's behalf.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP52272-17 (Spanish SP946-07) | 11/2018 | © 2018 Principal Financial Services, Inc.

Service and eyewear	Reduced prices and discounts*
Eye exam	\$50 with purchase of a complete pair of glasses. 20% off without purchase.
Prescription glasses or sunglasses	When you purchase a complete pair of glasses, save: Lenses – Single vision \$40, lined bifocal \$60, lined trifocal \$75, lenticular \$75 Frames – 25% off
Lens enhancements	Average 20-25% off enhancements such as progressive, scratch-resistant and anti-reflective coatings
Non-prescription sunglasses	20% off unlimited sunglasses purchased within 12 months of last covered exam
Contact lens exam	15% off
Laser vision correction	15-25% off standard pricing or 5% off promotional pricing through VSP-contracted facilities
Retinal screening	\$39 maximum fee

*Based on applicable laws, benefits may vary by location.

Help handling life's ups and downs

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the Employee Assistance Program (EAP), provided by Magellan Healthcare, is all about.



With an EAP, you and your immediate family have access to free, confidential resources to help handle life's everyday — and not so everyday — challenges.

Services for you and your family

Your EAP offers these services to help you and your family deal with the big and little things:

- LifeMart Discount Center, with savings on a variety of products and services
- Self-assessments for identifying issues with stress, depression or substance use
- Health and wellness articles, guides, webinars, podcasts and calculators
- Online assistance with eldercare, child care and other family life resources
- Help with teen and adolescent issues, including eating disorders and relationships
- Tips on parenting and grandparenting
- 24/7 phone consultation with licensed mental health professionals and referrals to supportive resources*
- Ongoing personal coaching sessions with scheduled telephonic appointments

Help when and where you need it — day or night

Life's challenges don't always happen during regular business hours. That's why you and your family have 24/7 access to your EAP.



800-450-1327

International: 800-662-4504

TTY: 800-456-4006



MagellanHealth.com/member

Help is just a click or phone call away

Online: MagellanHealth.com/member

Toll-free: 800-450-1327

TTY for hearing impaired: 800-456-4006

International access only: 800-662-4504

* You're responsible for any fees resulting from referrals outside the EAP, including those associated with medical benefits.



principal.com

Disability insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

Principal has arranged with Magellan Healthcare to make its Employee Assistance Program available to employees with disability coverage insured by or with administrative services provided by Principal Life Insurance Company. The EAP isn't part of the contract or policy and may be changed or cancelled at any time. Not available to group policies issued in New York. Magellan is responsible for all EAP services provided through this program. EAP services in California are provided through Magellan Health Services of California, Inc. — Employer Services. Magellan isn't a member of the Principal Financial Group®.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP59489-04 (core) (Spanish SP1351-04) | 10/2018 | © 2018 Principal Financial Services, Inc.

Count on help to be there when you need it. Use the Employee Assistance Program services available with your Principal group disability insurance.



Group life insurance

Protect your family, your finances — and your future

Create and store your important documents using the Will & Legal Document Center

If you're like most of us, you want to be in the driver's seat when it comes to your wishes for the future, like who will inherit your assets or make medical decisions for you if you're not able to. Especially since life can be so unpredictable.

That's why it's important to be proactive and make a plan to protect your family and finances. With your group term or voluntary term life insurance through Principal®, you can do just that, with access to resources from the **Will & Legal Document Center** provided by ARAG®.



Resources for help with legal documents

Having the proper documents in place can help ensure you're still in control in case something happens to you. With ARAG's free online resources, you and/or your spouse can create these documents:

- **Will** — Specify what happens to your property after you die, and appoint the person to execute your estate. You can also name a custodian for your minor children.
- **Healthcare power of attorney** — Grant someone permission to make medical decisions in case you're no longer able to make them yourself.
- **Durable power of attorney** — Grant someone permission to make financial decisions in case you're no longer able to make them yourself.
- **Living will** — Let your family and health care providers know your wishes for medical treatment if you're unable to speak for yourself.
- **Medical treatment authorization for minors** — Grant consent for medical personnel to treat your child(ren) if you're away.

Plus, you can also access:

- **Personal Information Organizer** — Record your personal and financial information – as well as funeral arrangements – in one convenient spot.
- **Estate planning education and tools** — Get access to a variety of articles and legal resources.



Protect your identity

It's not just inconvenient to have your identity stolen. It can have a direct impact on your credit rating and your financial security. The good news is, you can protect your identity with free online resources from ARAG, including:

- **An Identity Theft Prevention Kit** to help protect you from identity theft.
- **An Identity Theft Victim Action Kit** to help speed your recovery if you experience identity theft.

It's easy to get started

Follow these simple steps to start using these free resources today.

- 1 | Visit www.aragwills.com/principal.
- 2 | Register using your group policy number (your employer's account number with Principal). Find it by logging in on Principal.com, or ask your employer.
- 3 | You're in! Complete the forms or download the materials you need.



Need help with registration? Call ARAG Customer Care at **800.546.3718**.
Or, if you have questions about the services, call Principal at **866.539.1728**.



Group term life insurance from Principal® is issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392.

This value-added service is not a part of any insurance contract and may be changed or canceled at any time. Not available to group policies issued in New York. The use of services provided by ARAG® Services, LLC should not be considered a substitute for consultation with an attorney. Principal is not responsible for any loss, injury, claim, liability, or damages related to the use of the ARAG Will & Legal Document Center. ARAG is not a member of the Principal Financial Group®.

Please remember that the legal documents are accurate and useful in many situations. Whether or not the document is right for you and your situation depends on your circumstances. If you want specific advice regarding your situation, consult an attorney.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP54930-09 (SP1348-05) | 10/2018 | © 2018 Principal Financial Services, Inc.

Ease some of the worries of traveling

Travel assistance program offers reassurance. Anytime. Anywhere.

Whether you're traveling right here in the United States or leaving the country, you can rely on AXA to help your travel experience go off without a hitch. And because you're covered by group term life insurance from Principal®, you have access to many travel assistance services for free — no matter if you're traveling for business or pleasure.

Who's eligible? You, your spouse and your dependent children can access this service when traveling 100+ miles away from home for up to 120 consecutive days. And your spouse and dependent children are covered whether or not they're traveling with you.



Near or far, you're covered

No matter where you're going — on a cross-country flight, a short road trip or a destination requiring a passport — consider AXA your trusted travel companion. This program helps address the challenges of travel like:

Lost or stolen items

We all hope it won't happen to us, but it could. Lost items are a travel reality. AXA can help you recover or replace lost or stolen items (including cash and credit cards) so you don't miss a beat.

Medical assistance

Getting sick or hurt while traveling is no picnic. AXA is there when you need it most to assist with medical and dental needs when you're away from home.



Easily connect

Sometimes you need more than the phone book. And when you do, AXA is there to help with message delivery, overcoming language barriers or legal concerns.



Traveling even farther away from home?

The more miles you're away from home, the more you may need to do additional planning. AXA helps you get ready to head out with pre-trip research, including travel requirements, cultural differences and precautions you should be aware of.

Travel assistance program

Call us when you're traveling and need assistance.

888-647-2611 in the U.S.
630-766-7696 call collect outside the U.S.



Learn more and plan for your trip with our website.
principal.com/travelassistance





Emergency medical transportation

Unfortunately, medical emergencies sometimes interrupt a trip, and you just need to get to a hospital — or get home. This benefit is per person per trip for emergency situations including:

- Emergency medical transportation to a different facility if medically necessary
- Medically supervised return to your home country (known as repatriation)
- Transportation for a family member to join you
- Transportation for a traveling companion to join you in a different hospital or treatment facility
- Transportation home for dependent child(ren)
- Return of mortal remains

To be eligible for services under this program, your treatment must be authorized and arranged by designated staff from AXA. Claims for reimbursement won't be accepted. Please contact AXA for further benefit details.

How to use this service

With two convenient ways to connect, you'll be ready for anything that comes your way.

- 1 | Website or mobile app** – Plan for your trip with helpful resources at principal.com/travelassistance. Learn how to create an account giving you access to travel information online or on your mobile device. You can get medical and security information about a country, search for a local medical provider, and view practical information like business culture and currency descriptions.
- 2 | Phone** – When you're traveling and need assistance, call **888-647-2611 in the U.S.** Or call collect when **outside the U.S. 630-766-7696**. Help is available 24/7 — 365 days a year.

This program is not insurance.

Travel assistance services will be provided as permitted under applicable law.

Group life insurance from Principal® is issued by Principal Life Insurance Company, Des Moines, IA 50392.

Exclusions – services won't be provided or available for any loss or injury that's caused by, or results from: normal childbirth, normal pregnancy (except complications of pregnancy), voluntary induced abortion, mental or nervous conditions (unless hospitalized), traveling against the advice of a physician, or traveling for medical treatment.

Participants are responsible for any incurred fees or expenses, including medical. Indemnified transportation services are administered by AXA Assistance USA, Inc., and underwritten by a third-party licensed insurance company. This service is not a part of any Principal Life insurance contract and may be changed or discontinued at any time. Not available to group policies issued in New York. Although Principal® has arranged to make this program available to you, the third-party provider is solely responsible for its products and services. AXA is not a member of the Principal Financial Group®.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP60039-04 | 10/2018 | © 2018 Principal Financial Services, Inc.

Name _____
Company _____ Contract number _____

The participant is entitled to AXA Assistance USA, Inc. medical and travel services. El portador de esta tarjeta es miembro de AXA Assistance USA, Inc. y tiene derecho a los servicios personales y de asistencia médica de AXA Assistance USA, Inc.

This program is not insurance.
All services must be provided by AXA Assistance USA, Inc.
No claims for reimbursement will be accepted.
Travel assistance services will be provided as permitted under applicable law.



Your benefit
resources

eService

Go online to check your benefits

Keeping track of your benefits has never been easier

When you want information about your benefits from Principal®, simply go online. Best of all, this service is available at no charge.

How to create an online account

It's easy! We'll have you up and running in no time.

- 1 | Go to **principal.com**.
- 2 | Select **Log In**, then **Personal**.
- 3 | After selecting **Create an account**, enter personal information such as your date of birth and identification number.
- 4 | **Create a username** and password, and provide an email address.

You'll receive an email within a few minutes to confirm your account is ready to go. You can access your account information anytime, 24/7, with the username and password you've just set.

Manage your benefits online

After logging in, you can manage your benefits, as well as other products you may have with Principal. Your online account allows you to:

- View and manage claims (for applicable benefits)
- Get a 24-month history of your explanation of benefits (EOB)
- Access your summary of benefits, as well as benefit booklets and policies
- Find a list of covered dependents
- View and print your dental ID card
- Find discounts and services
- Calculate coverage needs and more



Keeping your account safe

Your information is important to us. And because of that, we use a security feature that prevents others from accessing your account – even if they have your password. Verification codes add an extra layer of security. The first time you log in, you'll **need to choose where you want us to send the verification codes – either by text or email**.

If you log in from an unrecognized computer or mobile phone, forget your password, or we notice anything out of the ordinary, these codes help us confirm it's really you accessing your account – not someone pretending to be you.

You can choose to receive these codes every time you log in or only when we detect unusual activity.



Need help setting up your login, or have other questions? Call us at **800-986-3343**.
We're happy to help.

You have the right to receive, free of charge, a paper copy of your benefit booklet and any changes at any time. Please contact your employer if you'd like to request a paper copy.



principal.com

Insurance issued by Principal Life Insurance Company, Des Moines, Iowa 50392-0002, principal.com

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP59610-07 | 09/2017 | © 2017 Principal Financial Services, Inc.



Notice of Privacy Practices for Health Information

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes the practices of Principal Life Insurance Company for safeguarding individually identifiable health information. The terms of this Notice apply to members, their spouses and dependents for their group medical expense, group dental expense and/or group vision care expense insurance with us ("insurance"). As used in this Notice, the term "health information" means information about you that we create, receive or maintain in connection with your insurance; that relates to your physical or mental condition or payment for health care provided to you; and that can reasonably be used to identify you. This Notice was effective April 14, 2003 and revisions to this Notice are effective November 1, 2017.

We are required by law to maintain the privacy of our members' and dependents' health information and to provide notice of our legal duties and privacy practices with respect to their health information. We are required to abide by the terms of this Notice as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make the new Notice effective for all health information maintained by us. Copies of revised Notices will be mailed to plan sponsors for distribution to the members then covered by our insurance. You have the right to request a paper copy of the Notice, although you may have originally requested a copy of the Notice electronically by e-mail.

Uses and Disclosures of Your Health Information

Authorization. Except as explained below, we will not use or disclose your health information for any purpose unless you have signed a form authorizing a use or disclosure. Unless we have taken any action in reliance on the authorization, you have the right to revoke an authorization if the request for revocation is in writing and sent to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, Des Moines, IA 50392-0002. A form to revoke an authorization can be obtained from the Health Information Protection Analyst.

Disclosures for Treatment. We may disclose your health information as necessary for your treatment. For instance, a doctor or healthcare facility involved in your care may request your health information in our possession to assist in your care.

Uses and Disclosures for Payment. We will use and disclose your health information as necessary for payment purposes. For instance, we may use your health information to process or pay claims, for subrogation, to perform a hospital admission review to determine whether services are for medically necessary care or to perform prospective reviews. We may also forward information to another insurer in order for it to process or pay claims on your behalf. Unless we agree in writing to do otherwise, we will send all mail regarding a member's spouse or dependents to the member, including information about the payment or denial of insurance claims.

Uses and Disclosures for Health Care Operations. We will use and disclose your health information as necessary for health care operations. For instance, we may use or disclose your health information for quality assessment and quality improvement, credentialing health care providers, premium rating, conducting or arranging for medical review or compliance. We may also disclose your health information to another insurer, health care facility or health care provider for activities such as quality assurance or case management. We participate in an organized health care arrangement with the health plan of a member's employer. We may disclose your health information to the health plan for certain functions of its health care operations. This Privacy Notice does not cover the privacy practices of that plan. We may contact your health care providers concerning prescription drug or treatment alternatives.

Other Health-Related Uses and Disclosures. We may contact you to provide reminders for appointments; information about treatment alternatives; or other health-related programs, products or services that may be available to you.

Information Received Pre-enrollment. We may request and receive from you and your health care providers health information prior to your enrollment under the insurance. We will use this information to determine whether you are eligible to enroll under the insurance and to determine the rates. We will not use or disclose any genetic information we obtain about you or provided from your family history. If you do not enroll, we will not use or disclose the information we obtained about you for any other purpose. Information provided on enrollment forms or applications will be utilized for all coverages being applied for, some of which may be protected by the state, not federal, privacy laws.

Business Associate. Certain aspects and components of our services are performed by outside people or organizations pursuant to agreements or contracts. It may be necessary for us to disclose your health information to these outside people or organizations that perform services on our behalf. We require them to appropriately safeguard the privacy of your health information. Principal Life Insurance Company may itself be a business associate of your health plan or health insurance company. We may disclose your health information to your health plan or insurance company and its business associates as needed to fulfill our contractual obligations to them. Please see the notice of privacy practices issued by your plan or insurance company for information about how it uses and discloses your health information.

Plan Sponsor. When permitted by law, we may disclose to the plan sponsor the minimum necessary amount of your health information that it needs to perform administrative functions on behalf of the plan (if any), provided that the plan sponsor certifies that the information will be maintained in a confidential manner and will not be utilized or disclosed for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor.

Family, Friends, and Personal Representatives. With your approval, we may disclose to family members, close personal friends, or another person you identify, your health information relevant to their involvement with your care or paying for your care. If you are unavailable, incapacitated or involved in an emergency situation, and we determine that a limited disclosure is in your best interests, we may disclose your health information without your approval. We may also disclose your health information to public or private entities to assist in disaster relief efforts.

Other Uses and Disclosures. We are permitted or required by law to use or disclose your health information, without your authorization, in the following circumstances:

- For any purpose required by law;
- For public health activities (for example, reporting of disease, injury, birth, death or suspicion of child abuse or neglect);
- To a governmental authority if we believe an individual is a victim of abuse, neglect or domestic violence;
- For health oversight activities (for example, audits, inspections, licensure actions or civil, administrative or criminal proceedings or actions);
- For judicial or administrative proceedings (for example, pursuant to a court order, subpoena or discovery request);
- For law enforcement purposes (for example, reporting wounds or injuries or for identifying or locating suspects, witnesses or missing people);
- To coroners and funeral directors;
- For procurement, banking or transplantation of organ, eye or tissue donations;
- For certain research purposes;
- To avert a serious threat to health or safety under certain circumstances;
- For military activities if you are a member of the armed forces; for intelligence or national security issues; or about an inmate or an individual to a correctional institution or law enforcement official having custody; and
- For compliance with workers' compensation programs.

We will adhere to all state and federal laws or regulations that provide additional privacy protections. We are prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of determining eligibility for coverage, the amount of benefits or premiums or discounts, including rebates, payments in kind, or other premium or benefit differential mechanisms in return for activities such as completing a health risk assessment or participating in a wellness program. We will not request, use or disclose psychotherapy notes without your authorization (except to defend ourselves in a legal action brought by you.) We will not sell your protected health information or use or disclose it for marketing purposes without your authorization, except as permitted by law. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information.

Your Rights

Restrictions on Use and Disclosure of Your Health Information. You have the right to request restrictions on how we use or disclose your health information for treatment, payment or health care operations. You also have the right to request restrictions on disclosures to family members or others who are involved in your care or the paying of your care. To request a restriction, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request a restriction can be obtained from the Health Information Protection Analyst. We are not required to agree to your request for a restriction. If your request for a restriction is granted, you will receive a written acknowledgement from us.

Receiving Confidential Communications of Your Health Information. You have the right to request communications regarding your health information from us by alternative means (for example by fax) or at alternative locations. We will accommodate reasonable requests. To request a confidential communication, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request a confidential communication can be obtained from the Health Information Protection Analyst.

Access to Your Health Information. You have the right to inspect and/or obtain a copy of your health information we maintain in your designated record set, subject to certain exceptions. To request access to your information, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request access to your health information can be obtained from the Health Information Protection Analyst. A fee will be charged for copying and postage.

Amendment of Your Health Information. You have the right to request an amendment to your health information to correct inaccuracies. To request an amendment, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request an amendment to your health information can be obtained from the Health Information Protection Analyst. We are not required to grant the request in certain circumstances.

Accounting of Disclosures of Your Health Information. You have the right to receive an accounting of certain disclosures of your health information made by us during the 6 year period before your request. To request an accounting, you must send a written request to: Health Information Protection Analyst, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002. A form to request an accounting of your health information can be obtained from the Health Information Protection Analyst. The first accounting in any 12-month period will be free; however, a fee will be charged for any subsequent request for an accounting during that same time period.

Complaints. If you believe your privacy rights have been violated, you can send a written complaint to us at Grievance Coordinator, Group Compliance, Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002 or to the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

If you have any questions or need any assistance regarding this Notice or your privacy rights, you may contact the Group Call Center at Principal Life Insurance Company at (800) 843-1371.



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

Insurance issued by Principal Life Insurance Company, 711 High Street, Des Moines, IA 50392-0002.

Principal, Principal and symbol design and Principal Financial Group are trademarks and service marks of Principal Financial Services, Inc., a member of the Principal Financial Group.

GP61990C-01 (Spanish SP1883C-01) | 05/2018 | © 2018 Principal Financial Services, Inc.