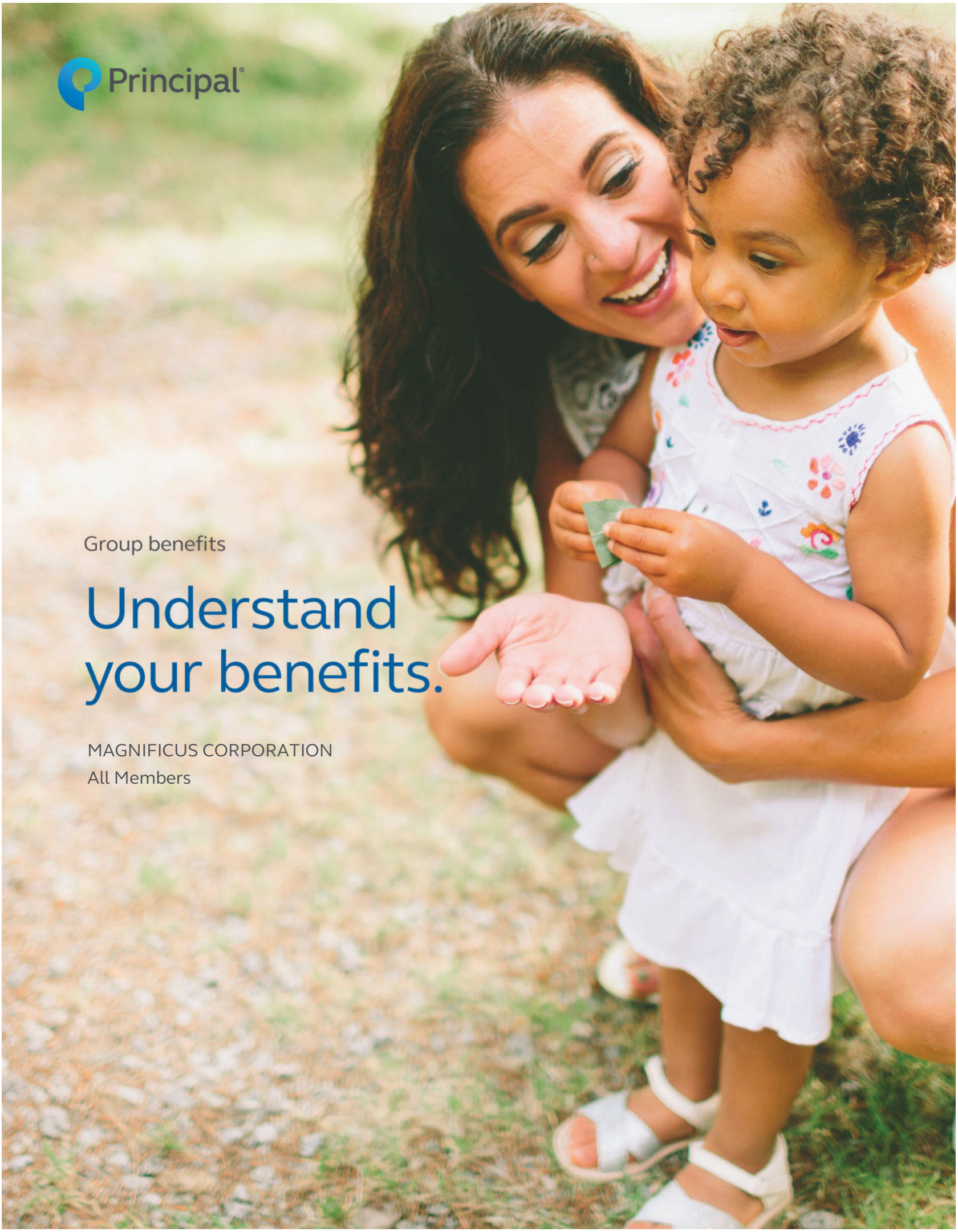

Principal®

Group benefits

Understand your benefits.

MAGNIFICUS CORPORATION
All Members

Enroll in your benefits today. It's easy.

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

1. Evaluate the insurance you need to protect what's most important to you.
2. Get details about your coverage by reading the Benefit Summary for each coverage.
3. 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
- Critical illness
- Accident

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

Life and accident – 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 and critical illness – You're eligible for a certain amount of coverage, also referred to as the guaranteed 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, also referred to as evidence of insurability (EOI). You'll receive an email from Principal telling you how to submit this information to be considered for the additional coverage.

Employee Enrollment & Waiver-MD

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

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

Company name	Division level	Account number/unit number
MAGNIFICUS CORPORATION	All Members	1131089

Employee information

Name			Social security number	
Mailing address (street)			Birth date	☐ male ☐ female
(City)		(State)		(ZIP code)
Date employed full-time	Hours worked per week	Job occupation/class		Location
Email address			Home number	Mobile number
Salary (for owners, include business income)	Salary mode ☐ yearly ☐ weekly ☐ hourly ☐ monthly ☐ bi-weekly			
Employer ZIP code		Employer county		

Eligible dependent information (Complete if you are electing benefits for your spouse [1] or children)

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ domestic partner[1]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled or mentally or physically incapacitated child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled or mentally or physically incapacitated child[3]
		☐ male ☐ female		☐ child ☐ foster child[2] ☐ disabled or mentally or physically incapacitated child[3]

[1]Spouse will include Domestic Partners if your employer allows this coverage. If enrolling a Domestic Partner, please attach a separate Declaration of Domestic Partnership / Enrollment Form Addendum (GP60457-01).

[2]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

[3]When your child, who is developmentally disabled or mentally or physically incapacitated, reaches/exceeds the maximum age, an Application to Continue Mentally or Physically Incapacitated Child form must be completed and reviewed to determine eligibility.

Is your spouse[1] employed by this company?
☐ yes ☐ no

If you and your spouse[1] are both employed at the same company, and eligibile for benefits, you are not eligible to have benefits as both a Member and a Dependent.
If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.

Coverage	Employee	Spouse[1]	Child(ren)
NOTE: Employee coverage must be elected to elect any dependent coverage.			
Dental	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Vision	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline
Voluntary term life benefit amount:	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**	☐ Elect ☐ Decline $_____ **Cannot exceed 100% of the employee election**
Critical illness benefit amount:	☐ Elect ☐ Decline $_____	☐ Elect ☐ Decline $_____	
Accident	☐ Elect ☐ Decline	☐ Elect ☐ Decline	☐ Elect ☐ Decline

Voluntary term life beneficiary designation (Complete if covered for voluntary term life coverage.)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Contingent beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Accident beneficiary designation (Complete if accident insurance includes Accidental Death and Dismemberment)

All primary and contingent beneficiaries, whether adults or minors, should be included in the beneficiary designation below. Additional beneficiaries can be added as an attachment.

Primary beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage

Contingent beneficiaries:

Name	SSN	Date of birth	Relationship	Check here if a minor ☐	Percentage
Name	SSN	Date of birth	Relationship	Check here if a minor ☐	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 designated a minor child(ren) as your beneficiary, complete the Uniform Transfers to Minors Act form (GP55229-02).

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 or accident, I cannot enroll until the next open enrollment.
- If I refuse life, disability, or critical illness coverage, I may apply later but I must show evidence of insurability and coverage will be subject to approval by Principal Life Insurance Company.
- If the group policy does not require my contribution, I cannot decline coverage unless the policy indicates otherwise.
- If the group policy requires my contribution, I authorize my employer to deduct from my pay.
- I represent all information on this form and attachments is complete and true to the best of my knowledge. They are part of this request for coverage. I agree Principal Life is not liable for a claim before the effective date of coverage and all policy provisions apply. I have read, or had read to me, the information and my answers on this form. Statements made to effectuate insurance cannot be used to contest or reduce my insurance unless the statement is in writing and signed by me and a copy of the form containing the statement is given to me or my beneficiary at the time insurance is contested.
- Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
- I understand collection of social security numbers for myself and/or my dependents will be used by Principal Life Insurance Company only as allowed by law.
- I 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 coverage. Information will not be used for any purposes prohibited by law.
- I understand that as the employee, the insurance I and my dependents have applied for will begin on the effective date of coverage provided I am at work on that date. If I am not actively at work on such date, subject to the terms of the group policy, coverage may not go into effect until after my return to work. Furthermore, I understand that no insurance may become effective for any member of my family while he/she is in a period of limited activity.

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

I declare that the information I have completed on this enrollment form is complete and true to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature X_____ Date signed _____

Instructions

After this form is completed and signed:

- Employee retains a copy of the form, and
- Enrollment is submitted to Principal Life:
  - Use eService to submit enrollment information at www.principal.com. Employer retains the original form.
  - Or, email the form to groupbenefitsadmin@principal.com.
  - Or, send the original form to Principal Life Insurance Company. Employer retains a copy of the form.

Employee Change Form – MD

Principal Life Insurance Company
Des Moines, IA 50392-0002

Principal®

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

Company name	Account/unit number
MAGNIFICUS CORPORATION	1131089

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 number	Mobile 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[1]	Child(ren)
Dental	☐ Add ☐ Cancel ☐ Change to[2]: _____ 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? ☐ yes ☐ no	☐ Add ☐ Cancel	☐ Add ☐ Cancel
Vision	☐ Add ☐ Cancel ☐ Change to[2]: _____ Change to date: _____	☐ Add ☐ Cancel	☐ Add ☐ Cancel
Group Term Life	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____
Voluntary Term Life (VTL)	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____ or _____ X salary	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____

Coverage	Employee	Spouse[1]	Child(ren)
Short Term Disability	☐ Add ☐ Cancel Occupation: _____ Change to: _____ Change to date: _____ $ _____		
Long Term Disability	☐ Add ☐ Cancel Occupation: _____ Change to: _____ Change to date: _____ $ _____		
Critical Illness	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	☐ Add ☐ Cancel ☐ Change to: _____ Change to date: _____ $ _____	
Accident	☐ Add ☐ Cancel	☐ Add ☐ Cancel	☐ Add ☐ Cancel
Hospital Indemnity	☐ Add ☐ Cancel ☐ Change to[2]: _____ Change to date: _____	☐ Add ☐ Cancel	☐ Add ☐ Cancel

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

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

1 Spouse will include Domestic Partner if your employer allows this coverage. If adding a Domestic Partner, please attach a separate Declaration of Domestic Partnership/Enrollment Form Addendum (GP60457-01).

2 Change will apply to all eligible dependents.

Nicotine Products

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

Employee: ☐ yes ☐ no Spouse[1]: ☐ yes ☐ no

Reason for Adding or Increasing Coverage

	Date of event
☐ marriage ☐ loss of other group coverage[3] ☐ change in job status	
☐ birth/adoption ☐ court order (attach a copy) ☐ other _____	
☐ open enrollment (if available)	

[3]For loss of other group coverage 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
Name of prior critical illness carrier	Date coverage ended
Name of prior accident carrier	Date coverage ended
Name of prior hospital indemnity carrier	Date coverage ended

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

Dependent name	Birth date	Gender	Social security number	Relationship
		☐ male ☐ female		☐ spouse ☐ domestic partner[1]
		☐ male ☐ female		☐ child ☐ foster child[4] ☐ disabled or mentally or physically incapacitated child[5]
		☐ male ☐ female		☐ child ☐ foster child[4] ☐ disabled or mentally or physically incapacitated child[5]
		☐ male ☐ female		☐ child ☐ foster child[4] ☐ disabled or mentally or physically incapacitated child[5]

[4] 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

[5] When your child, who is developmentally disabled or mentally or physically incapacitated, reaches/exceeds the maximum age, an Application to Continue Mentally or Physically Incapacitated Child form must be completed and reviewed to determine eligibility.

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

Beneficiary Designation

Complete Beneficiary Designation/Change (GP34795-16) if adding life coverage, accident coverage with AD&D, or changing beneficiary.

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, vision, accident, or hospital indemnity, coverage, I cannot enroll again until the next open enrollment period.
- If I cancel any type of life, disability, or critical illness coverage, I may apply at a later date; however, I must provide evidence of insurability at my own expense and coverage will only become effective subject to approval from Principal Life Insurance Company.
- If you and your spouse[1] are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.
- If you and a parent are both employed at the same company, and eligible for benefits, you are not eligible to have benefits as both a Member and a Dependent.
- 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.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I declare that the information I have completed on this enrollment form is complete and true to the best of my knowledge and belief. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Principal Life.

Your signature **X** _____ **Date signed** _____

After this form is completed and signed:

- Employee retains a copy of the form, and
- Enrollment is submitted to Principal Life:
    - Use eService to submit enrollment information at www.principal.com. Employer retains the original form.
    - Or, email the form to groupbenefitsadmin@principal.com.
    - Or, send the original form to Principal Life Insurance Company. Employer retains a copy of the form.

Beneficiary Designation/Change

Principal Life Insurance Company
Des Moines, Iowa 50392-0002

Principal®

Company Name	Account/Unit Number
MAGNIFICUS CORPORATION	1131089

Employee Information

Your name (last, first, middle initial)	Social security number

NOTE: Any beneficiary change made below will replace any prior beneficiary designation.

Section I **Group Life Beneficiary Designation** (Complete if covered for group life coverage. If Section II isn't completed the beneficiaries in this section will apply to all group life insurance coverages).

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

Contingent Beneficiaries:

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

Section II **Voluntary Term Life Beneficiary Designation** (Only complete if you want different beneficiaries for voluntary term life than what you have for group life. If this section isn't completed the beneficiaries in section I will be for all life group life insurance coverages.)

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

Contingent Beneficiaries:

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

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

Contingent Beneficiaries:

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

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 IV 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