Principal Financial Group

Mailing Address:
PO Box 10310
Des Moines, IA 50306-0310

**Principal Life Insurance Company**

***Enrollment Form***

**950/310**

# FLEXIBLE SPENDING ACCOUNT

**Account number** H28799

## Employee Information

| Your name (last, first, middle initial) | | Social security number/ID number |
|---|---|---|
| Address (street) | | |
| City | State | ZIP code |
| Date of birth | male female | Your email address |
| Spouse's name | Spouse's social security number/ID number | Spouse's date of birth |

**I want to participate in our Flexible Spending Account (FSA).**

Reduce my future compensation by the total annual election shown below. This amount will be contributed on my behalf to our FSA. I understand this reduces my wages for social security purposes, and may reduce my social security disability and retirement benefits. I understand I will not earn interest on my contribution. I also understand that once I have made this election, I can only change it during the election period prior to the next plan year, or if there has been a qualifying change in my family's status, employment, or group health care coverage as determined by IRS regulations. I further understand that any contributions in the FSA not used for my eligible expenses at the time I terminate participation, or at the end of any plan year, will be forfeited. Because Section 125(b) of the Internal Revenue Code establishes limits on participation in FSA by highly compensated employees and key employees which cannot be determined until the participation of all employees in both contributions and benefits has been tested under the applicable rules, it may be required by law that a portion of your salary reduction contributions to this FSA be returned to you regardless of the terms of your election to participate. Any amount so returned will be a part of your taxable income. I certify that I have not been and will not be reimbursed for these expenses from this or any other benefit plan and have/will not include them as itemized deductions or as a tax credit on my personal income tax returns.

**NOTE: Changes in election allowed due to a qualifying change in family status must be made no later than 30 days after the date of the qualifying change in status.**

Pay period: (Check the box which indicates the frequency of your paychecks.)

weekly bi-weekly monthly twice-monthly other ____________

| | Health Care | Dependent Care | **Note:** Dependent Care spending accounts are not medical spending accounts for a participant's spouse or children. It's day care (baby-sitting) for children or elderly dependents. |
|---|---|---|---|
| ***Total *Annual* election** | $ ________ | ________ | |

* The annual election should be based on the number of pay periods remaining.

**I decline to participate in our FSA.**

I realize that if my election form is not received by the end of the election period, I have declined to participate by default. I understand that I will not be eligible to participate again until the following plan year unless there has been a qualifying change in my family's status or employment.

Signature ____________ *Date signed ____________

* Date signed **must** be prior to effective date of the plan year. If change of status occurs during plan year, date signed **must** be prior to pay period in which the above listed contributions will go into effect.

If you would like your reimbursements deposited into your bank account, complete the following information.

| **Your name (last, first, middle initial)** | **Social security number/ID number** |
|---|---|
| | |

**Banking Information** **Checking Account Information** **or** **Savings Account Information**

new set-up* change current set-up* cancel current set-up

| Financial institution | City |
|---|---|
| | |

| State | ZIP |
|---|---|
| | |

| Bank transit / ABA number | Account number |
|---|---|
| | |

I hereby authorize Principal Life Insurance Company to credit my FSA Reimbursement in the bank listed above. This authorization is to remain in full force and effect until I send written notice of a change or cancellation.

| Signature | Dept/office name | Date |
|---|---|---|
| | | |

* Your account will be prenoted for one pay period. The prenote process is done to detect any problems with your bank transit and account numbers. You will receive a regular FSA reimbursement check for the prenote pay period.

## Direct Deposit Choices and Information

### Your First Deposit and Account Changes

- New direct deposit participants and those who change banks or accounts will receive one regular check before direct deposit takes effect.
- This “prenote” process allows FSA to verify the new account or bank to ensure safe and accurate deposits.
- If you change or close your account(s) complete a new Direct Deposit Authorization form.
- Make your account changes as soon as possible to ensure that your funds are deposited correctly. Check the deadline schedule.
- Direct deposit transactions occur on the third business day following reimbursement.

## Employer to Complete this Section

| Company name as it appears on your billing | Location/unit |
|---|---|
| | |

| Beginning pay period date (Refer to Quick Reference Guide) | Reason for change |
|---|---|
| | initial request change |

| Effective Date | |
|---|---|
| | |