



Account & Unit Number \_\_\_\_\_

Employee Information

Your Name (Last) (First) (MI) Social Security Number
Mailing Address (Street) (City) (State) (ZIP)
Date Employed Full-Time (Month, Day, Year)
Birth Date (Month, Day, Year)
Location
Hrs Wrkd Per Wk Job Occupation/Class
Do you have an eligible spouse or child? Yes No What is your payroll mode? Mnthly Bi-mnthly Wkly Bi-wkly

Benefit Options

Coverage Employee Spouse Children
Dental Elect Decline Elect Decline Elect Decline

Important! If declining any coverage for yourself or any dependent, give reason. Covered under:
Spouse's Group Coverage Individual Insurance Other

Eligible Dependent Information (Complete if you have elected benefits for your spouse and/or children.)

Spouse's Name Birth Date Social Security Number
Name(s) of Child(ren) Birth Date Social Security Number
Male Female
Foster Child \*

\* If you checked Foster Child, do you provide principal support and does the child(ren) live with you at least 50% of the time? Yes No
If your child is over the maximum age and handicapped, see your employer for the necessary form.

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 step and foster children and those over the maximum age, are eligible for coverage based on plan provisions.
If I decline dental coverage, I and/or my dependents may enroll at a later 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.
If the group policy requires that I make contributions, I authorize my employer to deduct them from my pay.
I declare that the information I have completed on this enrollment form is complete and true.
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 employer One for the employee